

fraud or untrue statement, suppression or concealment, my right to claim reimbursement of the expenses shall be forfeited.

I also consent and authorize HealthIndia/ Insurance Company to seek medical information from any Hospital Medical Practitioner who has any time attended on the insured person.

I hereby declare that I have included all bills / receipts for purpose of this claim and that I will not be making any supplementary claim in respect thereof, except the post Hospitalization claim if any.

Signature of Policy Holder

MEDICLAIM MEDICAL REPORT (MMR)

CERTIFICATE FROM ATTENDING DOCTOR OF CLAIMANT FROM THE NURSING HOME/HOSPITAL

1. Name of Patient:- _____
2. Age:- _____ DOB:- ____ / ____ / ____ Sex: M F
3. Are you a family doctor of patient?:- Yes / No Since:- _____ yrs
4. Who referred the case to you? _____
5. When did the patient approach you for the first time in connection with present disease suffered?

- Date of First Consultation: _____
6. Details of previous history of disease / surgery (if any) of patient? _____

7. Is the patient suffering from Diabetes, Hypertension (Blood Pressure), Kidney problems, Cancer, T.B., Heart Problem and AIDS or other disease? If yes (Since how long he or she may be suffering from the same.):- _____

9. Present disease suffered (Diagnosis):- _____

10. Duration of present disease suffered (i.e. since how long he or she may be suffering from present disease before approaching you) :- _____

11. Is the present disease suffered connected to previous disease or Diabetes, Hypertension (Blood Pressure), Surgery or other existing disease? :- _____

12. Is disease suffered Acute or Chronic? :- _____
13. Whether the disease is caused due to any congenital defects (Yes/No)? _____
14. Whether the patient had any complications during or after pregnancy (Yes/No)? _____

15. Whether the disease/injury is caused directly or indirectly due to the use of alcohol or drugs (Yes/No): _____

16. Could the patient have been aware the illness or disease of which treatment is being taken now?

If yes since when? (Approx. period of illness):- _____

Date when the illness / injury was sustained: - _____

17. Is the disease suffered requires hospitalization? :- Yes / No

a) Nature of treatment given :-Operative / I.V.Fluid / Injection / Oral Treatment /
Other Parenteral Treatment

b) Indoor case no. of the patient Hospital / Nursing home: _____

18. Date of Admission : _____ Time of admission: _____

19. Date of Discharge: _____ Time of discharge: _____

20. Is your hospital registered with local authority? If yes, please attaché xerox copy of certificate
Registration Number of Hospital: _____

21. No. of total beds in your Nursing Home / Hospital:- _____

22. Other comments you would like to make (if any) connected to present disease suffered by the
patient:- _____

23. "Whether the patient is fully cured or not?" Yes / No

Certified that the details furnished above are true to the best of my knowledge and as per the records available at this hospital.

Doctor's Name: _____ Qualification: _____ Registration No: _____

Contact No: _____

Date: ____ / ____ / ____

Signature of Attending Doctor

(With rubber stamp and registration no. of your Nursing Home / Hospital)

Name of Policy Holder: _____

Date: ____ / ____ / ____

Signature of Policy Holder

