Grievance against insurance Company

(Claim rejections due to number of beds)

Kindly fill in all required information and mail a scanned copy of the form to info@ahna.org.in

Date : _____ Time : _____

Particular:

Name of the Patient : _____ Age : _____Yrs. Gender : ☐ F ☐ M ☐ O

Name of the Insured : _____ Policy No : _____

Insurance Details:

Name of Insurance Co.: _____

Sum Insured: _____ Policy Inception Since: _____

Policy Period: From _____ To _____

Hospitalization Details:

Name of the Hospital _____ No. of Beds_____

Disease for which hospitalized _____

Length of Stay _____ Date of Admission _____Date of Discharge _____

Name of Procedure / Surgery _____

Name of Doctor _____

Qualifications _____ Speciality_____

Bill Details:

Total Amount of Bill : _____

Bill Amount Submitted for Reimbursement : _____

Amount Reimbursed : _____

Amount Deducted : _____

Reason for Rejection _____

_____

_____

_____

Sign of Insured / Patient