Insurance Assistance Services

FORM **01**

A. Patient details:

1. Name of the patient: _____ _____ _____
   (First Name) (Middle Name) (Last Name)
2. Age: _____ 3. Gender: _____
4. Mobile number: _____ 5. Email Id: _____

B. Hospital details:

1. Name of the hospitals: _____ 2. AHNA ID: _____
3. Name of doctor: _____ 4. Contact no. of doctor: _____

C. Insurance details:

1. Name of the insurance company: _____
2. Policy number: _____
3. Policy validity from: _____ to _____
4. Name of the TPA (if applicable): _____
5. Policy amount: _____ 6. Policy since: _____

D. Claim details:

1. Hospitalisation from: _____ to _____
2. Diagnosis: _____
3. Surgery procedures: _____
4. Amount authorised: _____ Amount received: _____
5. Type of claim: ☐ Cashless
   ☐ Reimbursement

E. Grievance details:

1. Claim rejected fully

   Reason: _____

   Amount: _____

2. Direction in the claim

   Reason: _____

   Amount: _____

3. No reimbursement received

4. Reimbursement received late beyond. _____Days

5. Details for multiple documents

F. Fees to be paid: _____