



CLAIM INTIMATION

(To be filled and submitted to MDINDIA on admission of the patient in the Hospital)



Date: _____

Name of Policyholder: _____

Name of Patient: _____ Age: _____ yrs Sex: M / F

MDIndia ID number: _____ Policy No. _____

Name of Hospital: _____

Address: _____ City: _____ State: _____

Diagnosis: _____ Date of Admission: ____ / ____ / ____

Name of Treating Doctor: _____ Approximate Expenses: Rs. _____

Any other Relevant Information: _____

Signature / Thumb Impression of Policyholder / Nominee

Name: _____ Contact No: _____

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