OPD CLAIM FORM

(TO BE FILLED BY CLAIMANT EMPLOYEE)

1	NAME OF COMPANY/ CLIENT:				
2	NAME OF EMPLOYEE:				
3	EMPLOYEE NO.:				
4	IGI HEALTH CARD ID NO.:				
5	NAME OF PATIENT:				
5	RELATION WITH EMPLOYEE (mark the right choice)	Self	Spouse	Daughter	Son
6	PERIOD FOR WHICH CLAIM IS MADE (MONTH)				
7	DETAILS OF CLAIMED AMOUNT:	AMOUNT IN RUPEES:			
	INVOICE #:				
	INVOICE #:				
	INVOICE #:				
	INVOICE #:				
	TOTAL AMOUNT CLAIMED:				

CHECKLIST:

- Use separate claim forms if bills are for more than one patients / persons .
- Please ensure to attach the following documents along with this claim form.
  - Copy of the prescription of the doctor/ lab request (if amount claimed is more than Rs. 500/-)
  - Original invoices of the pharmacy /doctor /lab etc.

DECLARATION:

We, the undersigned, do hereby declare that, to the best of our knowledge and belief, the foregoing particulars are true and correct. We authorize IGI to obtain information from Doctor/Hospital/Pharmacy/Lab concerning the treatment for which claim is made.

_____ _____

Employee's Signature with date

Employer’s Signature & Stamp