CLAIM FORM

Settlement Name		Member Code	
District/State		Name	

LIST OF DOCUMENTS ATTACHED

Document's Serial No	Document Date	Name and Address of the Hospital	Type of Document	Amount Paid

I declare that the information provided above is true to the best of my knowledge. The bills of expenditures attached with this form have not been submitted and shall not be submitted to any other organization for reimbursement.

I, Mr./Ms. …………………………...…...……… (name) …………..…………. (relation) of Mr./Ms. ………………..….………................... (name of patient) hereby authorize the TMS representative to obtain all the orignal medical/hospital records/ other records/ information (including photocopies) pertaining to the treatment of the patient.

Date …………………………..

Signature of Policy Holder …...…..……...…………………

For Office Use Only

Received by SO/ES

Date …………………………

Signature of SO/ES ………...…..…..…………………

…..…..…..……..✂……………..…….....…✂……...……..……. Cut here! ……..…......……...✂…………..……………✂………..…..……

Claim Receipt (for Claimant)

Received the claim from ………………………………….. / ………………….. (Name of Claimant/ Member Code) on …………...…… (Date) with ………… (No.) bills/documents attached.

Name of SO/ES …………………………………………………

Signature ….………..….……………………