



Kollam Dist. Co-Operative Hospital Society Ltd. No: Q952

Palathara, Thattamala P.O., Kollam

Ph: 0474-2723199, 2724823, Fax: 2726701

CLAIM FORM

Membership No. Share Amount

Name & Address of share Holder

Details of claimant :

(in respect of whom claim is made)

a) Name & Relationship with share holder :

b) Present completed Age :

c) Contact Address :

e) Phone No. :

f) Mobile No. :

g) E-mail Address :

AILMENT / DISEASE/INJURY

Date of Injury sustained of disease/illness first

Delected : Name of the Hospital

a Have you been insured under any mediclaim
scheme earlier (held with us or any other insurance)

Have you preferred any claim for the same under
the mediclaim scheme earlier, if so give details :

a) Previous Claim File Ref. No./ Office :

b) Diagnosis :

c) Whether settled/Repudiated :

d) Amount (if settled) : Rs.

Date of Admission : Date of Discharge :

Total Amount Claimed : Rs.

If the claim is of Domiciliary Hospitalization please
indiate

a) Date of Commencement of the treatment :

b) Date of Completion of treatment :

c) Name & Address of attending Medical Practitioner
with Telephone No. & Registration No. :

Date of Submission

Signature of the Claimant



Form No. 2

Kollam Dist. Co-Operative Hospital Society Ltd. No: Q952

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1. Name of the Patient & Age	
2. Date of Admission	Date of Discharge
3. Name of Surgeon/Physician	
4. Diagnosis	
5. Date of first consultation (Prior to hospitalization)	
6. (a) With what complaints was the patient admitted for	
(b) Since when was the patient suffering from the said complaints	
7. Past History of the Patient (if any) With the duration of illness	
8. Whether the present ailment is a Complication of Pre-existing disease?	
If yes, please, specify the disease (or) Complication of any previous surgery done? If yes, please specify details	
9. Whether the disease/Disorder is congenital in nature	
10. Nature of Surgery/treatment given for the present ailment	
11. (a) Whether Hospital/Nursing Home is Registered, if yes, Regn. No.	
(b) No. of in-patient beds in the Hospital (including ICU)	
(c) Whether the hospital is having fully equipped Operation Theatre of its own/qualified nurses Round the clock/Qualified doctors round the Clock?	
Signature of the Doctor with Seal	
Date:	

Documents Needed For Insurance Claim

1. Form No. 1 duly filled and signed by share holder/
patient
2. Form No. 2 duly filled, signed and sealed by the
treating officer
3. All original bills signed and sealed by the doctor
4. Detailed bill
5. Investigation reports
6. Original discharge summary