IMA Kerala Health Scheme

Claim form

Claim No:

(For office use only)

1. Name of claimant : Age: Sex:
2. Scheme Enrolment No: Date of joining scheme: Renewal date:
3. Address - Permanent: For communication
4. Phone: (R) (O) Mob:
5. Details of previous claims - if any (in the current year)

   Date: Amount claimed: Amount received

7. Details of present claim:

   Date of Admission: Discharge: No. of days in hospital:

8. Diagnosis :
9. Details of hospital(s) treated:

   Name of Hospital Address: Phone:

10. Name(s) of Doctors(s) treated:
11. Amount of claim:
    - (a) Investigation charges :
    - (b) Doctor's fee :
    - (c) Inpatient expenses (room rent etc.) :
    - (d) Treatment cost :

    Total :

12. Details of documents submitted
13. Whether you request to get original documents returned:Yes / No.
14. Place to which DD to be taken.
14. Status of IMA membership: *Life member / Annual member: Renewed/Not renewed*

Affidavit:

I, ...do herby declare that the details submitted above is true and correct to best of my knowledge and are bonafide record of the charges incurred during the treatment.

Date: Signature:

Place: Name:

For office use

Status of scheme membership : *Valid / Not renewed* Status of IMA membership : *Valid / Not renewed*

Total Amount Claimed			Remarks
Deductions			
Calculation:			
Upper limit of the claim			
Payment allotted:			

Signature of Scheme Secretary