Claim Intimation Form
HEALTH ASSIST INSURANCE TPA PVT LTD

1. Member ID/ Health Assist ID Card :	
2. Policy Number :	
3. Name of Policyholder : (in whose name policy is issued)	First Name :
	Last Name :
4. Name of person admitted :	First Name :
	Last Name :
5. Date of Birth / Age :	(DD_____ /MM _____/YYYY _____) _____Years
6. Address :	City : State : Pin Code :
7. Date & Time of admission :	
8. Admission Type (Planned/Emergency)	
9. Provider Name :	
10. Provider address in case of non network :	City : State : Pin Code :
11. Provisional Diagnosis :	
12. Treatment Planned :	
13. Estimated Expenses :	Rs.
14. Estimated length of stay (if it is an inpatient treatment) :	_____ Days
15. Contact details, if changed :	
16. Intimating Persons with relationship :	
17. Admitting Doctor details :	

Date :

Place :

Signature of person who intimating the claim