PREMIER INSURANCE CO. (Nepal) LTD.
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HOSPITALIZATION / DOMICILIARY TREATMENT
MEDICAL CLAIM FORM

ISSUE OF THIS FORM DOES NOT CONSTITUTE ADMISSION OF LIABILITY.
PLEASE RETURN THIS FORM DULY COMPLETED.

Insured :	
Policy No. :	
Period of Insurance :	to
Name of Staff :	Age :
Name of Claimant : *(if other than staff)*	Age: Relation:
Medical Attendant/s *(Name and Address of Doctor/s with NMC Number)*	

Details of Illness	**If injured in an accident**
.....	Date & time: .....
.....	Place: .....
.....	Nature of injury: .....
.....	.....
Please fill up the items under which the benefits are claimed in respect of the above illness/given amount claimed and enclosing original receipts, billls, prescriptions and the certificate completed by Doctor/s giving the medical attention in respect of which a claim is made.	.....
	Personal Accident Policy No.: .....
	.....

s. No.	Particulars	Claimed Amount NRs.	*(For Insurance Company use only)*
A	Doctor Charge		.....
B	Medicine and Drugs Prescribed		.....
C	Pathology / Lab Test/s		.....
D	Electrical Treatment (X-ray, ECG, USG etc)		.....
E	Acupuncture / Physiotherapy Treatment		.....
F	Plaster / Bandage Charge and Materials		.....
G	Eye Treatment		.....
H	Dental Treatment		.....
I	Room and Nursing Expenses		.....
J	Surgeon's and Anesthetist's and Operation Theater Charges		.....
K	Other, if any, as per Policy		.....
	Total Amount		.....

We declare that our member has suffered the above described injuries / illness and that to the best of our knowledge and belief the foregoing particulars are in every respect true.

We also declare that there is no other insurance or other source to cover the items claimed.

Date: .....

Signature of Claimant