TRUST Islami Life Insurance PLC

Claim Form - IPD (Hospitalization)

(Please use **BLOCK** letters all through)

Name of the Organization:

Contract No:

Employee Name:	
Employee ID No.:	
Patient Name:	
Relationship of Employee (if the patient is dependent):	
Date of Prior Intimation: (DD/MM/YYYY)	Membership No:
Name & Address of Hospital:	
Date of Admission: (DD/MM/YYYY)	Date of Discharge: (DD/MM/YYYY)
Bank/MFS Account Name:	
Bank/MFS Account No.:	
Bank Name:	
Bank Branch:	Routing No.:
Breakup of Hospitalization Expenses	
Cost, Charge & Fees in respect of	**Amount (Taka)**
Hospital Accommodation	
Consultation Fee	
Routine Investigations	
Medical & Drugs	
Surgical Charges	
Ancillary Services	
Others	
Total	
_____ Signature of Employee Date:	_____ Signature of the Div./Dept. Head Date:
To be filled in by Head Office – HRD, ...) Forwarded for necessary action to _____ Signature of Plan Secretary with Seal	CORPORATE INSURNACE DEPT.

N.B: Please note that reimbursement of the claim can only be made when all original documents and bills are submitted together with this form as mentioned on leaf.

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ALL CLAIMS SHOULD BE SUBMITTED THROUGH THIS FORM.

Required during submission of the claim for reimbursement:

1. Copy of Claim Intimation Record
2. Consultant/ Attending Physician's recommendation for hospitalization.
3. Claim Form duly filled in by the employee
4. Copy of Discharge Certificate from the hospital/clinic
5. Photocopy of patient's Treatment Records while confined in hospital/clinic
6. Photocopy of patient's Investigation Report while confined in hospital/clinic
7. Original Bills specifying :-
    a. Accommodation Charges (mentioning daily charges with number of days in hospital)
    b. Consultant's Fee (receipts with date)
    c. Routine Investigation (mention charge for each investigation separately)
    d. Medicine & Drugs (original bills mentioning name, quantity & price of each)
    e. Surgical Charges (mentioned fees for surgeons, O.T., Anesthetist, Assistant etc.)
    f. Charges for Ancillary Services (Labor Room Service, Post Operative Care Facilities, Oxygen Therapy, Intensive Care Facility, Blood Transfusion, Ambulance Service, Dressing, Tests other than Routine Investigation, Ambulance Services etc.)
    g. Service charge, telephone, food & beverage
    h. VAT etc.

FOR OFFICIAL USE OF TRUST ISLAMI LIFE INSURANCE PLC.

Date of Receipt: **Prior Intimation Date:**

Signature of Recipient:

Head of Corporate Department

Date of Receipt of Complete Papers:

Reimbursed Amount: TK **Date of Reimbursement:**

Authorized Signature with Date

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