SAGARMATHA LUMBINI INSURANCE CO. LTD.
NAXAL, KATHMANDU, NEPAL
TOLL FREE NO. 1660 01 66666, TEL: 01-4511707/01-4512367
EMAIL: claims@salico.com.np

MEDICAL CLAIM FORM

Insured: **S.N.:**

Policy No: **Date:**

Member's Name: Department:		Designation: Age:	
Dependent's Name:		Age:	Relation:
ACCIDENT: Date & Time: Place of Accident: How did it occur? Details of Injury: Name of Attending Doctor:	**SICKNESS:** Date of Illness: Name of Hospital: Name of Doctor: Diagnosis: Sick Leave if any: From: To:		
Particulars of Treatment	**Hospitalization (Rs.)**	**Domiciliary (Rs.)**	**For Office Use**
A. Room Charge/Bed Charge: B. Surgeon & Anesthetist's Fee: OT charges, use of Surgical Appliances, Oxygen, Anesthesia, Blood Transfusion: C. Consultant's and Specialist fees including services of specialists for use of diagnostic materials (i.e. X-Ray, E.C.G, all types of pathological tests, physiotherapy, radiological and radium examination and treatment, all types of investigation): D. Nursing Charges: E. Fees of Medical Practitioners: E. Cost of Medicines, Drugs & Injections: F. Other, if any			
Total Claimed Amount (Rs.)			

NOTE: Original bills/invoices should be submitted. For other documents, Copies are considered.

Encls: Supporting documents as Doctor's prescriptions, pathology test reports, Discharge Summary (In hospitalization cases), etc. are attached herewith.

DECLARATION

I hereby declare that I have/my dependent has suffered due to the above described injuries/illness and that to the best of my knowledge and belief the foregoing particulars are in every respect true. I also declare there is no any other source to cover the amount claimed.

Stamp of Insured Company ***Signature of Claimant***