OPD TREATMENT – CLAIM SHEET - Policy Year 2026-2027

Name of Patient			
PF Number			
Samadhan ID			
Class and Grade			
Policy Number			
Claim for	SELF ☐	SPOUSE ☐	Dependent Children ☐
Address (in Block letters)			
Mobile Number			
E Mail ID			
Nature of Illness			
Period of Illness			

Expenses Incurred (Please fill each line separately for each bill)

Type of Expenses	**Bill Date**	**Bill Number**	**Name of Clinic/ Doctor/ Lab/ Pharmacy/ Other**	**Amount (Rs.)**	**Whether all original documents attached (Yes/No)**
Consultation					
Medicines					
Pathological & other tests					
Any other					

			Total Amount		

Place _____

_____

Date _____ (Signature of Insured)

Note: Please enclose the above documents in original along with the OPD claim sheet. Please keep a copy of the claim sheet for future claims.