NON-HOSPITAL (OPD) CLAIM FORM

(TO BE FILLED IN DUPLICATE BY THE CLAIMER)

THE ORIENTAL INSURANCE COMPANY LIMITED
Laxmi Commercial Centre, 2nd Floor,
Senapati Bapat Marg, Dadar (W), Mumbai- 400028 Mumbai

Mobile No.	
Email ID	
RESIDENCIAL ADDRESS	

FOR OFFICE USE ONLY

LOT YEAR AND NO.	CLAIM NO.

OIC ID/MA-ID Card No:

EMPLOYEE CODE NO.	AGE (YEAR)

NAME OF PATIENT (IN CAPITAL LETTERS) :

NAME OF ILLNESS (IN CAPITAL LETTERS) :

PERIOD OF ILLNESS

FROM (DATE)	TO (DATE)

NATURE OF EXPENSES	SUB-ITEM	TOTAL AMOUNT INCURRED (in Rs.)	REMARKS
(A) DOCTOR'S CONSULTATION FEES 1) --------- NO. OF CONSULTATIONS @ Rs……..			
(B) 1) MEDICINES GIVEN BY DOCTOR			
2) INJECTIONS GIVEN BY DOCTOR			
3) MEDICINES BOUGHT FROM CHEMISTS			
4) INVESTIGATION CHARGES			
(C) DENTAL TREATMENT (1) CONSULTATION FEES @ Rs…….. (DENTAL)			
(2) X Ray @ Rs. _____(DENTAL)			
(3) FILLINGS MEDICINES ORTHODONTIC TREATMENT			
(4) NO. OF EXTRACTIONS @ Rs……			
(D) TOTAL COST OF DENTURES/OTHER TREATMENTS			
GRAND TOTAL (Rs.)			

I HEREBY DECLARE THAT THE FOREGOING STATEMENTS ARE TRUE IN EVERY RESPECT AND ARE MADE WITHOUT ANY RESERVATION I ALSO DECLARE THAT I DO NOT GET ANY MEDICAL BENEFITS FOR THE ABOVE ILLNESS FROM ANY OTHER SOURCE

SIGNATURE OF EMPLOYEE:	DATE :

NOTES

- **ALL FIELDS IN THIS FORM ARE MANDATORY.**
- Please send the claim within **45 days** from the date of treatment/purchase of medicines.
- Please use separate claim form for each member of your family.
- **Please attach all Prescriptions, Medical Bills, Stamped Payment Receipts from Doctor, Investigation Reports etc. with the claim form.**
- Please ensure that correct **Employee Code No. and the Bank details** are mentioned, otherwise claim will be rejected.