HIMALAYAN EVEREST INSURANCE CO. LTD.

Thapagaun, GPO Box - 148, Kathmandu, Nepal
Tel: 4231790, 4231580 Fax: 977-1-5245099

HEALTH INSURANCE CLAIM FORM

(For Domiciliary & Hospitalization Treatment)

1. **Name of the Insured/Office** : _____
2. Policy No & Period of Insurance : _____
3. Business Address / Phone No : _____
4. **Claimant i.e. Employee's Name** : _____
5. Age/Sex : _____ Address: _____
6. **Name of the Patient** : _____ Age/Sex: _____
7. Claimant's relation to the Patient : _____ Contact No. : _____
8. **Details of Domiciliary Treatment**

   (A) Date of Illness/Injury : _____ (B) Date of Treatment: _____
9. Give details of illness/injury & diagnosis: _____

   _____
10. Name of attending doctor : _____
11. NMC No. : _____ Doctor's contact address/ Ph. No. : _____
12. Can the patient be available at above given address for visit by Co's Doctor? If so, when? _____
13. **Details of Hospitalization (If admitted in hospital)**

    Name of Hospital: _____

    Date admitted: _____ Date discharged: _____ Total stay: _____
14. **Details of Surgery (If surgical procedure performed)** _____
15. Was the claimant outside Nepal for more than 90 consecutive days? If yes, please give details of visit & period of stay:

    _____
16. Total Claimed Amount: NRs.

    We hereby declare that the foregoing statements are true to the best of our knowledge.

Signature of Policy holder _____ _____

with official seal/ stamp Signature of Claimant

Date: _____ Date: _____

Details of Treatment Expenses

Sr. No.	Description	Claimed Amount (NPR)	Remarks *(for official use only)*
1	Doctor/consultation charges		
2	Medicine, Dressing & Procedure charges		
3	Pathology including X-ray, USG, ECG, CT scan, MRI, Physiotherapy etc.		
4	Dental Treatment		
5	Eye Treatment		
6	Bed Charges		
7	Surgery Expenses		
8	Maternity/Child Delivery Expenses		
	Total Amount		