## 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.	<b>Details of Domiciliary Treatment</b>				
	(A) Date of Illness/Injury :	(I	B) Date of Treatment:		
9.	Give details of illness/injury & diagnosi	is:			
10.	Name of attending doctor :				
11.	. NMC No. : Doctor's contact address/ Ph. No. :				
12.	2. Can the patient be available at above given address for visit by Co's Doctor? If so, when?				
13.	3. Details of Hospitalization (If admitted in hospital)  Name of Hospital:				
	Date admitted:				
14.	Details of Surgery (If surgical proced	ure performed)			
15.	. Was the claimant outside Nepal for more than 90 consecutive days? If yes, please give details of visit & period of stay:				
16.					
	We hereby declare that the foregoing statements are true to the best of our knowledge.				
Sig	nature of Policy holder				
_	h official seal/ stamp		Signature of Claimant		
Dat	e:		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		