CLAIM INTIMATION

(To be filled and submitted to Rothshield within 24 hrs on Admission of the patient in the Hospital by fax / mail / currier)

Date : _____

Name of Policy holder :_____

Name of Patient:_____Age:_____yrs. Sex: M/F

Mobile No:_____ Email ID:_____

RS ID Numbar:_____ Policy No:_____

Name of Hospital:_____

Address:_____ City:_____

State:_____ Date of Admission:____/____/_____

Diagnosis:_____

Name of Treating Doctor:_____

Approximate Expenses: RS._____

Any Other Relevant Information:_____

Signature/Thumb Impression of Policyholder/Nominee : _____

Name:_____ Contact No:_____

Account Details:

Name of Bank:_____ Branch Name:_____

Account No:_____ IFSC Code:_____

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