Bajaj Allianz General Insurance Company Ltd

OPD Claim Form

I. POLICY DETAILS

Proposer Name: _____

OPD_Policy Number: _____

Address: _____

Mobile Number: _____Email ID:-_____

II. OUTPATIENT CONSULTATION DETAILS:

Name of the Member in respect of whom claim is made: _____

Date of Consultation: _____

Diagnosis: _____

Total Claim Amount: _____

III.POLICY HOLDER BANK ACCOUNT DETAILS (FOR ECS TRANSFER OF CLAIM SETTLEMENT):

Please furnish the details below along with copy of cancelled cheque

Name of the Account Holder (As per Bank Account):_____

Bank Account No: _____

Bank Name: _____Bank Branch: _____

IFSC Code: _____MICR Code: _____

Account Type ☐ Saving ☐ Current ☐ Cash Credit

PAN: _____

IV. Details of Bills Enclosed

Sr. No.	Bill No.	Bill Date	Issued By	Amount

Regd & Head office: Bajaj Allianz House, Airport Road, Yerwada Pune 411006. Tele (+91 20) 66026666 Fax (+9120) 66026667, Email: bagichelp@bajajallianz.co.in
Website: https://www.bajajallianz.com/general-insurance.html

Bajaj Allianz General Insurance Company Ltd

V.CHECK LIST OF ENCLOSURES:

- Duly filled and signed Claim Form. ☐
- Photocopy of ID card / Photocopy of current year policy. ☐
- Original Medicine bills, original payment receipt. ☐
- Original Investigations bills, original payment receipt with report. ☐
- Original Consultation bills, original payment receipt with prescription. ☐
- Details of any Outpatient Procedures, If any ☐
- Dental X-ray film ☐

IV.DECLARATION BY THE INSURED:

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize Bajaj Allianz General Insurance Company Limited, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made.

Date: _____

Place: _____ Signature of Insured _____

I/We authorize Insurance Company/TPA to contact me/us through SMS/Email/WhatsApp for any update on this claim.