**VIDAL Health TPA Pvt. Ltd**

IBA domiciliary Treatment Claim Reimbursement Statement

( This form should be attached along with claim FORM A)

|  |  |
| --- | --- |
| Name of the Bank | VIJAYA BANK |
| Branch | Ex-Employee |
| Policy No. |  |
| Name of the Insured |  |
| Employee ID |  |
| Designation |  |
| Vidal ID Card No. |  |
| Name of the claimant |  |
| Date of submission |  |
| Relationship |  |
| Period |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Sl No** | **Bill Date** | **Description** | **Name of Pharmacy/Lab** | **Prescribed Doctor/Hospital Name** | **Name of the domiciliary treatment** | **Amount claimed** | | | | | **Remarks** | |
|  |  |  |  |  |  |  |  |  |  |  | |  | |
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|  |  |  |  |  |  |  |  |  |  |  | |  | |
| Total amount Claimed | | | | | |  |  |  |  |  | | | |

(Signature of the Insured)