Vijaya Bank Retirees’ Association(Regd)

Dear friends,

As already informed, the renewed health insurance policies are not yet received from the United Insurance  Company.

The Bank has since received the Policy number for WITH DOMICILIARY BENEFIT on 8/12/16.

The Policy No is **5001002816P111644969.** Please enter it at the relevant place in Part A of the claim application and in Domiciliary claim statement

The bank has suggested us to claim the Domiciliary expenses for the time being , as per the procedure in vogue for serving employees.

Accordingly, our claim for re-imbursement of domiciliary expenses should be made as follows:

1.Attending/treating doctors certificate cum prescription which should not be older than 90 days. A suggested form is attached herewith.

2. If the certificate does not contain, prescription of medicines, a separate prescription.

3.The Doctor's certificate/prescription should contain the signature, name of the doctor, registration no and  his rubber stamp.

4.Bills( Original) issued by the chemist/drug store, with serial numbers of the bill.

5. Claim form, Part- A, duly filled and signed by the insured. The policy number is **5001002816P111644969**. Certificate number under item Nos. b in section A may be left blank. Under item No:C in part A, TPA ID No may be filled up clearly. Please write" For Domiciliary Treatment" on the top of the form. Please read instructions contained in the form, for correctly filling it up.

 A copy of the form is attached.

6. Attach Domiciliary Treatment Claim Reimbursement statement, which is forwarded herewith.

7. Enclose ECS mandate- which is attached herewith.

8.Photocopy of first page of Bank's pass book, containing account number, name and other details of account holder is to be enclosed. This page should contain signature of the Bank official/br. manager.

9. One cancelled cheque leaf of the account, to which the sanctioned amount are to be credited as per ECS mandate.

10. Copy of Vidal TPA ID card. If I D Card is not received, enclose a sheet of paper on which the TPA Id no is written clearly.

11. While submitting Claim for the first time, original medical certificate is to be enclosed. For subsequent claims, photo copy of the same is to be attached.

12. All these papers are to be sent to the office of the Vidal TPA, by Registered Post/speed post or by a courier, who provides a Proof Of Delivery(POD).

Address of the Head Office of the TPA is as follows:

Vidal Health TPA Pvt Ltd

Tower 2, 1st Floor, SJR I Park,

Plot No: 13,14 and 15, EPIP Area,

White Field, Banagalore-560066

Toll Free No: 1800-425-9510

E-Mail: jayanth.c@vidalhealthtpa.com

Please share this information with all those who have taken policy with Domiciliary benefit.

Please inform this to all concerned.

ALL THESE FORMS ARE AVAILABLE ON OUR WEBSITE   [vbra.in](http://vbra.in/).

Those who want forms by e.mail, may please send their e. to us, for sending the forms.

Greetings

K Vishwanath Naik

Gen.Secretary

**Doctor’s Certificate:**

**To be filled in Hospital/ Doctor’s Letter head**

**Date**

**TO WHOM SO EVER IT MAY CONCERN**

**This is to certify that**

**Smt./Sri……………………………………………………………………………**

**………………(name of the patient) aged ……years, wife/husband of**

**Sri/Smt……………………………………………………………………………………**

**(name of ex-employee) is under my treatment for ……………………………….**

**…………..…………………………………………………………………… (name of the ailment).**

**I have prescribed to take the following medicine on domiciliary basis for a period of ……………(Months).**

|  |  |  |
| --- | --- | --- |
| **Sl No** | **Name of the medicine** | **Dosage per day** |
|  |  |  |
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**He/she is advised to undergo the following one time/ periodical investigation for diagnosis/monitoring of his/her health condition.**

**1.**

**2.**

**3.**

**Advised Review after …………..Months.**

**Signature of the doctor**

**Name of the Doctor**

**Designation**

**Seal with Regn No.**

**ECS Mandate:**

**Electronic Clearing Service/Credit Clearing ) Mandate Form :**

For claiming under

Policy No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| 1 A | Insured Name |  | |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |
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| B | Address |  | |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |
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| City |  | |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |
| State |  | |  |  | |  |  |  |  |  |  |  |  |  |  | PIN | |  |  |  |  |  | |  |
| C | Telephone /Mobile No. | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |
| D | E Mail ID | |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |

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| 2 | TTD ID No. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

3. Particulars of Bank Account

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| A | Bank Name | | | | |  | |  | |  | |  | |  | |  | |  |  | |  | |  | |  |  |  | |  | |  | |  | |  |  | |  | |  |
| B | Branch Name | | | | |  | |  | |  | |  | |  | |  | |  |  | |  | |  | |  |  |  | |  | |  | |  | |  |  | |  | |  |
| C | | Branch Address | | | |  | |  | | |  |  | |  | |  | |  |  | |  | |  | |  |  |  | |  | |  | |  | |  |  | |  | |  |
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| City | | | |  | |  | | |  |  | |  | |  | |  |  | |  | |  | |  |  |  | |  | |  | |  | |  |  | |  | |  |
| State | | | |  | |  | | |  |  | |  | |  | |  |  | |  | |  | |  |  | PIN | |  | |  | |  | |  |  | |  | |  |
| D | | 9 Digit Code Number Of the Bank & Branch Appearing on the MICR Cheque Issued by the Bank | | | | | | | | | | | | | | | | | | | | | | | |  |  | |  | |  | |  | |  |  | |  | |  |
| E | | Account Type (Savings Account/Current Account) | | | | | | | | | | | | | | | | | | | | | | | |  |  | |  | |  | |  | |  |  | |  | |  |
| F | | Account Number (As Appearing on the Cheque Book) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  |  |  | |  | |  | | | |  | |  | |  | | |  | |  | |  | |  | |  | |  | |  | |  | | |  | |  | |
| G | | Bank Account Holder Name | | |  | |  | |  | | | |  | |  | |  | | |  | |  | |  | |  | |  | |  | |  | |  | | |  | |  | |
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| 4 | Date Of Effect |  |  |  |  |  |  |  |  |

INFORMATION FIOR PAYMENT THROUGH RTGS OR NEFT

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 5 | IFSC Code (Indian Financial System Code) |  |  |  |  |  |  |  |  |  |  |  |
| 6 | NEFT Code (National Electronic Fund Transfer Code) |  |  |  |  |  |  |  |  |  |  |  |

By submission of the above, I authorize M/S TTK Health Care TPA Pvt. Ltd/The Insurance Company to settle the claim under reference through direct payment by ECS. I hereby declare & confirm that the particulars given above are correct and complete . I agree that I shall not hold TPA/Insurance Company responsible for delay or non receipt of payment for any reason whatsoever after issue of instructions for transfer of payment by Insurer/TPA based on the above.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date |  |  |  |  |  |  |  |  |
| Place |  | | | | | | | |

Signature of the insured

Domiciliary Claim form:

**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

Claim form- Part A is separately attached.

Please write on the top of this form as

“ For Domiciliary Treatment Reimbursement”