

To

The Head,
Medical Record Department,
GMCH, Chandigarh.

Subject:- Request for filling of Insurance Form of C.R. No. _____ &
IPD No. _____.

Sir,

Kindly fill insurance form of the C.R. No. _____. For this the
necessary details are as under:-

| | | |
|----|------------------------|--|
| 1. | Patient Name | |
| 2. | D/o, S/o, W/o | |
| 3. | Correspondence Address | |
| | | |
| 4. | Phone No./ Mobile No. | |
| 5. | Policy No. | |

Thanking you.

Yours faithfully,

Dated:-

Signature _____

Name (in Block Letters) _____

Relation _____

Address _____

Note:- The following documents are required to be enclosed with this application:-

1. Blank Insurance Claim Form alongwith Photocopy of Insurance Policy.
2. Discharge / Death Report
3. I.D. Proof of Nominee (s) with residence address.
4. Authorization letter/ NOC from Nominee (s), if he/she unable to come to collect the Insurance Claim Form.
5. I.D. Proof of Authorized Person with residence address