Claim Intimation Form

ApolloMunich HEALTH INSURANCE
www.apollomunichinsurance.com

1.	Apollo Munich Health Card Number :	
2.	Policy Number :	
3.	Name of Policyholder : (in whose name policy is issued)	First Name : Last Name :
4.	Name of person admitted :	First Name : Last Name :
5.	Date of Birth / Age :	(DD__ __ /MM __ __/YYYY __ __ __ __) _____Years
6.	Address :	City : State : Pin Code :
7.	Date of loss / Treatment / Event / Admission :	
8.	Unique ID of Provider, If any :	
9.	Provider Name :	
10.	Provider address in case of non network :	City : State : Pin Code :
11.	Provisional Diagnosis :	
12.	Treatment Planned :	
13.	Estimated Expenses :	Rs.
14.	Estimated length of stay (if it is an inpatient treatment) :	_____ Days
15.	Contact details, if changed :	
16.	Intimating Persons :	
17.	Admitting Doctor details :	

Date :

Place :

Signature of person suffering injury or legally authorized representative

We would be happy to assist you. For any help contact us at: E-mail : customerservice@apollomunichinsurance.com Toll Free : 1800-102-0333

AMHI/PR/H/0021