Jeevan Sparsh Hospital & Imaging Centre
Third Party Administrator (TPA) Form

Patient Details

Patient Name:	
Age / Gender:	
Contact Number:	
Address:	

Admission Details

UHID No. (if any):	
Date of Admission:	
Department / Doctor:	
Diagnosis:	

Insurance Details

Insurance Company:	
TPA Name:	
Policy No.:	
Employee / Card Holder Name:	
Relationship with Patient:	

Claim Information

Type of Claim:	■ Cashless ■ Reimbursement
Estimated Hospitalization Expenses:	■
Claim Amount Requested:	■

Declaration

I hereby declare that the above information is true to the best of my knowledge. I authorize Jeevan Sparsh Hospital to share my medical details with the concerned TPA/Insurance company for processing my claim.

Patient / Attendant Signature:	
Date:	