VIDAL HEALTH
THIRD PARTY ADMINISTRATOR
Formerly TTK HEALTHCARE TPA PRIVATE LIMITED

Vidal Health TPA Pvt Ltd

युनाइटेड इंडिया
UNITED INDIA

IBA Domicilary Treatment Claim Reimbursement Statement

Name of the Bank/Branch :		**Policy No :**	
Name of the Insured :		**Vidal ID Card No :**	
Employee Id :		**Designation :**	
Name of the Claiment :		**Date of Submission :**	
Relationship :		**Period :**	

S.No	Bill Date	Description	Name of the Pharmacy/Lab	Prescribed Doctor/ Hospital Name	Name of the Domicilary Treatment	Amount Claimed	Remarks
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

Signature of the Insured

Total Amount Claimed :

Note : This form should be attached along with Claim Form A