IMA's
Karnataka State Health Scheme

OFFICE USE	
CLAIM NO.	
DATE	

CLAIM FORM
(READ INSTRUCTIONS IN PAGE 3 BEFORE FILLING)

1) NAME OF CLAIMANT : AGE : SEX :

2) BRANCH : SCHEME ENROLMENT NO :

3) DATE OF JOINING THE SCHEME : RENEWAL DATE :

4) ADDRESS - PERMANENT : FOR COMMUNICATI :

5) PHONE : RESIDENCE : OFFICE : MOB :

6) DETAILS OF PREVIOUS CLAIMS - IF ANY (IN THE CURRENT MEMBERSHIP YEAR)

DATE : AMOUNT CLAIMED : AMOUNT RECEIVED :

7) DETAILS OF PRESENT CLAIM :

DATE OF 1) ADMISSION : 2) DISCHARGE : 3) NO. OF DAYS IN HOSPITAL :

8) DIAGNOSIS :

9) DETAILS OF HOSPITAL (S) TREATED :

NAME OF HOSPITAL/S :

ADDRESS :

1) 2) 3)

PHONE :

11) NAME(S) OF DOCTOR(S) TREATED :

12) CLAIM DETAILS :

(A) ROOM RENT + TAX [IF ANY] : (B) WATER & ELECTRICITY / HOUSEKEEPING ETC :

(C) NURSING CHARGES : (D) PROCEDURE CHARGES :

TOTAL AMOUNT CLAIMED :

13) DETAILS OF DOCUMENTS SUBMITTED :

14) STATUS OF IMA MEMBERSHIP : LIFE MEMBER ☐

ANNUAL MEMBER : RENEWED ☐ NOT RENEWED ☐

AFFIDAVIT :

I,. .....DO HEREBY DECLARE THAT THE DETAILS SUBMITTED ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND IS THE BONAFIDE RECORD OF THE CHARGES INCURRED DURING MY/MY CHILD'S TREATMENT.

PLACE : SIGNATURE :

DATE : NAME :

(IN THE ABOVE COLUMN THE CLAIMANT WHETHER MEMBER, SPOUSE, PARENT OR CHILD (ABOVE 18 YRS) HAVE TO SIGN.)

FOR OFFICE USE

STATUS OF SCHEME MEMBERSHIP : VALID ☐ NOT RENEWED ☐

DATE OF ENROLMENT : LAST RENEWED ON : NEXT RENEWAL :

MEMBERSHIP YEAR :

TOTAL CLAIMS RECEIVED DURING PRESENT MEMBERSHIP YEAR : DETAILS

NO.	DATE	AMOUNT	NO.	DATE	AMOUNT
1			5		
2			6		
3			7		
4			8		

TOTAL RS._____

BALANCE AMOUNT IN PRESENT MEMBERSHIP YEAR : Rs.

STATUS OF IMA MEMBERSHIP (AFTER HQ VERIFICATION) :

TOTAL AMOUNT CLAIMED :

DEDUCTIONS :

CALCULATION :

ELIGIBLE AMOUNT AFTER DEDUCTION :

UPPER LIMIT OF THE CLAIM :

PAYMENT ALLOTTED RS. :

(IN WORDS) RUPEES :

SIGNATURE OF SCHEME SECRETARY / TREASURER

CLAIMING PROCEDURE - INSTRUCTIONS

1. Please fill in the name, address and diagnosis in block letters
2. Row (6) Current year: Calculated yearly starting from the date and month of joining.
3. Row (13): Originals of discharge summary and all bills should be presented.
4. If you want to get the originals back, send photocopies of the required documents.
5. Originals will be returned once the scrutiny is over. If you want to get originals back immediately, put the originals in a self addressed envelope with adequate stamp for speed post, and keep along with the copies. Originals will be send back soon after verification.
6. In any case, originals will not be returned if the photocopies of the documents are not attached along with.
7. OP Treatments will not be reimbursed unless accepted as day care procedure. Routine investigations as part of health check up will not be reimbursed.
8. Claim application will be rejected if your IMA membership is not up to date at the time of treatment.
9. Claim application will be considered only if the scheme membership is renewed properly and effective at the time of treatment.
11. Bills should reach the office within 2 months [60 days] of the discharge date/ bill date.
12. In case of conditions in which no IP treatment is mandatory for reimbursement, bills should reach the office within 2 months of purchase/ treatment/investigation.
13. In any case, bills older than 2 months will not be accepted.
14. Total amount of bills should be more than 5000/-
15. The reimbursement may take up to 3 months from the receipt of the application in the scheme office.
16. The duly filled form with documents should be sent to the address given below

Contact Address : **Dr. Jambunath Gouda, Chairman, KSHS, Kottureshwara MRI Scan Centre, Beside Little Heart School, Opp LIC Office, Hosalli Road Gangavathi-583227. Contact No : 8618744511, 9448145035**

If you have any query / doubt regarding the claim procedure, feel free to call

Dr.Jambunath Gouda	Dr.Madhusudhan K.N	Dr.Hanumanthappa.A
Chairman	Secretary	Treasurer
9448145035	9448140003	9945605974