

Health Claim Form Sample

Download our **health claim form sample** with easy-to-follow instructions to simplify your insurance filing process. This form template ensures accurate and efficient submission of your healthcare expenses. Follow the step-by-step guide to avoid errors and expedite your claim approval.

Instructions:

1. Complete all fields in **Section A** with your personal information.
2. Provide patient and treatment details in **Section B**.
3. Attach all supporting documents, such as medical receipts and doctors' notes.
4. Read and sign the declaration in **Section C**.
5. Submit the completed form and attachments to your insurance provider via email or postal mail.

Note: Incomplete forms may cause delays in processing your claim.

Section A: Personal Information

| | |
|----------------|----------------------|
| Full Name | <input type="text"/> |
| Date of Birth | <input type="text"/> |
| Policy Number | <input type="text"/> |
| Contact Number | <input type="text"/> |
| Email Address | <input type="text"/> |
| Address | <input type="text"/> |

Section B: Claim Information

| | |
|---------------------------|--|
| Patient Name | <input type="text"/> |
| Date(s) of Treatment | <input type="text"/> |
| Nature of Illness/Injury | <input type="text"/> |
| Healthcare Provider | <input type="text"/> |
| Total Amount Claimed | <input type="text"/> USD |
| Payment Receipt Attached? | <input type="radio"/> Yes <input type="radio"/> No |
| Doctor's Note Attached? | <input type="radio"/> Yes <input type="radio"/> No |

Section C: Declaration

I declare that the information given above is true and complete to the best of my knowledge. I agree to provide any further information if requested.

Signature: _____ Date: _____