Medical Claim Form Sample

This **medical claim form** sample is designed to simplify the health insurance reimbursement process by providing a clear and organized template. It ensures accurate documentation of medical expenses, facilitating quicker approval and payment from insurers. Using this form helps policyholders efficiently claim their entitled benefits with minimal hassle.

Section 1: Policyholder Details

Full Name	_____
Policy Number	_____
Email Address	_____
Contact Number	_____
Mailing Address	_____

Section 2: Patient Information

Patient Name	_____
Date of Birth	_____ / _____ / _____
Relationship to Policyholder	☐ Self ☐ Spouse ☐ Child ☐ Other

Section 3: Claim Details

Date of Treatment	_____ / _____ / _____
Name of Hospital/Clinic	_____
Doctor's Name	_____
Diagnosis/Reason for Treatment	_____
Treatment Description	_____
Total Amount Claimed	â‚¹_____

Section 4: Payment Information

Account Holder Name	_____
Bank Name	_____
Account Number	_____
IFSC Code	_____

Section 5: Declaration & Signature

I hereby declare that the information provided above is true and correct to the best of my knowledge. I have attached all supporting documents for the claim.

Signature	_____	**Date**	_____ / _____ / _____

Checklist of Required Documents

- Original medical bills and receipts
- Doctor's prescription

- Discharge summary (for hospitalization)
- Copy of policy document
- Investigation/lab reports (if applicable)
- Other supporting documents

For insurance office use only