Surgical Reimbursement Claim Form

Hospital Name: _____ **Hospital Code:** _____

Form Reference Number: _____ **Date of Submission:** ____ / ____ / _____

Patient Information			
Patient Name	_____	**Patient ID**	_____
Gender	Male [ ] Female [ ] Other [ ]	**DOB (dd/mm/yyyy)**	____ / ____ / _____
Insurance Provider	_____		
Policy Number	_____		

Surgery Details			
Surgery Name/Procedure	_____		
Date of Surgery	____ / ____ / _____	**Surgery Code (if any)**	_____
Consulting Surgeon	_____		
Duration of Hospital Stay	From ____ / ____ / _____ To ____ / ____ / _____		

Expense Details			
Description	**Date**	**Amount (INR)**	**Remarks**
Surgery Charges	____ / ____ / _____	_____	_____
Consultation Fees	____ / ____ / _____	_____	_____
Room Charges	____ / ____ / _____	_____	_____
Medicines	____ / ____ / _____	_____	_____
Other (specify)	____ / ____ / _____	_____	_____
Total Claim Amount		**Rs. _____**	

Bank Details for Reimbursement	
Account Holder Name	_____
Account Number	_____
Bank Name & Branch	_____
IFSC Code	_____

Declaration: I hereby certify that the above information is true and accurate to the best of my knowledge. All

relevant documents and bills are attached.

Patient/Guardian Signature: _____ **Date:** ____ / ____ / _____
Hospital Authority Signature: _____ **Stamp:** _____

This **surgical reimbursement claim form** sample provides hospitals with a standardized template to efficiently document and process patient surgery expenses. It ensures accurate submission of claims for timely insurance reimbursement. Utilizing this form helps streamline administrative workflows and reduce errors in hospital billing.