Filled Surgical Claim Form Sample

This **filled surgical claim form sample** provides a clear example of how to accurately document medical details for insurance processing. It includes patient information, surgical procedures performed, and itemized medical expenses to ensure efficient claim approval. Using this sample can help streamline the submission process and reduce errors.

1. Patient Information

Policy Number	ABC123456789
Patient Name	Jane Doe
Date of Birth	1987-11-23
Contact Number	(555) 123-4567
Address	456 Elm Street, Springfield, IL 62704

2. Hospital and Admission Details

Hospital Name	Springfield General Hospital
Hospital Address	100 General Rd, Springfield, IL 62704
Date of Admission	2024-03-10
Date of Discharge	2024-03-14
Type of Room	Private Ward

3. Surgical Information

Date of Surgery	2024-03-11
Type of Surgery	Laparoscopic Appendectomy
Name of Surgeon	Dr. Emily Carter
Anesthesiologist	Dr. Trent Rivera
Diagnosis	Acute Appendicitis
Procedure Details	Removal of inflamed appendix using minimally invasive laparoscopic technique.

4. Itemized Medical Expenses

Description	Date	Amount (USD)
Room Charges (4 days)	2024-03-10 to 2024-03-14	1,200
Surgical Charges	2024-03-11	2,500
Anesthetist Charges	2024-03-11	600
Operation Theatre Charges	2024-03-11	800
Medicines & Consumables	2024-03-10 to 2024-03-14	400
Diagnostic Tests	2024-03-10	250
	Total	**5,750**

5. Bank Details for Reimbursement

Account Holder's Name	Jane Doe
Bank Name	Springfield Federal Bank

Account Number	004567891234
IFSC Code	SFB0001234

6. Declaration

I hereby declare that the information provided above is true and correct to the best of my knowledge. I authorize the insurer to verify the details with the hospital, if required.

Signature: _____ **Date:** 2024-03-15