Sample Filled Hospitalization Claim Form for Reimbursement

This sample filled hospitalization claim form demonstrates the proper way to complete your **hospitalization claim form** for reimbursement. It ensures all necessary details are accurately provided to facilitate a smooth and timely claim process. Use this example as a guide to avoid common errors and expedite your insurance settlement.

1. Policy Holder Details

Policy Number:	ABC123456789
Name of Policy Holder:	John Doe
Date of Birth:	15/04/1980
Address:	123 Green Lane, Springfield, IL 62704
Contact Number:	+1 555-678-2345
Email:	john.doe@email.com

2. Patient Details

Name of Patient:	John Doe
Relationship to Policy Holder:	Self
Patient ID (if any):	P456321
Gender:	Male
Age:	44

3. Hospitalization Details

Name of Hospital:	Springfield Community Hospital
Hospital Address:	456 Central Ave, Springfield, IL 62704
Date of Admission:	02/06/2024
Date of Discharge:	07/06/2024
Reason for Hospitalization:	Appendicitis
Nature of Treatment:	Appendectomy (Surgical Removal of Appendix)
Treating Doctor's Name:	Dr. Emily Carter

4. Claim Details

Total Expenses Incurred:	$6,850
Amount Claimed:	$6,500
Payment Mode for Reimbursement:	Bank Transfer

5. Bank Details (for Reimbursement)

Account Holder Name:	John Doe
Bank Name:	ABC National Bank
Branch:	Downtown Branch
Account Number:	01234567890
IFSC Code (or Routing Number):	ABC0987654

6. Declaration

I hereby declare that the information above is accurate and complete to the best of my knowledge. I authorize the insurance company to obtain necessary medical information from the hospital, if required.

Date:	10/06/2024
Signature:	John Doe