Health Benefit Claim Form

A. Patient Information

Full Name

Date of Birth

Insurance/Policy ID

Contact Number

Address

B. Treatment Details

Date of Consultation/Treatment

Diagnosis/Reason for Treatment

Treatment Rendered

Amount Claimed

C. Doctor's Certification (to be completed by Attending Physician)

Physician's Name

Medical License No.

Clinic/Hospital Address

Date

Signature

(Sign over printed name)

D. Claimant's Declaration

I hereby certify that the above information is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.

Claimant's Name

Signature

(Sign over printed name)

Date

Submit Claim