Hospital Claim Form Sample

Download our **hospital claim form sample** designed to simplify the reimbursement process. This form includes an itemized bill attachment section to ensure all medical expenses are clearly documented. Submitting a complete and detailed claim accelerates verification and payment.

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1. Patient Information

Full Name		**Gender**	
Date of Birth		**Contact Number**	
Address			
Policy Number		**Insurance Provider**	

2. Hospitalization Details

Hospital Name		**Hospital Address**	
Admission Date		**Discharge Date**	
Reason for Hospitalization			

3. Claim Details

Total Claimed Amount			
Bank Name		**Account Number**	
IFSC Code		**Payee Name**	

4. Declaration

I hereby declare that the information provided above is true and complete to the best of my knowledge.

Signature of Claimant		**Date**	

5. Itemized Bill Attachment

Please attach a detailed and itemized bill from the hospital. Each charge must be listed separately with corresponding amounts. Example below:

Date	Description of Service/Item	Quantity	Rate	Total Amount
2024-03-10	Consultation Fee	1	$100	$100
2024-03-11	Room Charges	2 days	$200	$400
2024-03-12	Laboratory Tests	3	$50	$150
2024-03-12	Medicines	1 lot	$75	$75
			Total	**$725**

Attach all supporting bills, prescriptions, and reports as required by your insurance provider.