Hospital Maternity Claim Form

1. Patient (Mother) Information			
Full Name:		Date of Birth:	
Insurance Policy No.:		Contact Number:	
Admission Date:		Discharge Date:	

2. Baby Delivery Details			
Baby's Name (if assigned):		Sex of Baby:	Select
Date of Birth:		Time of Birth:	
Birth Weight (kg):		Length (cm):	

3. Delivery Method & Observations			
Type of Delivery:	☐ Normal ☐ Cesarean Section ☐ Other		
Complications (if any):			
APGAR Score:		NICU Required:	Select

4. Attending Physician/Doctor Details			
Doctor's Name:		Registration No.:	
Signature:		Date:	

Submit Claim