Detailed Health Benefit Claim Form

Instructions

1. Complete all applicable sections. Incomplete forms may result in delays or denial.
2. Attach required documents (e.g., itemized bills, receipts, prescriptions, referrals).
3. **Section 1-3** must be filled by the claimant or their authorized representative.
4. **Section 4** (Provider Information) must be completed by your treating provider.
5. Sign and date the certification at the end of the form.
6. Submit the completed form and attachments to your insurance provider via mail, email, or their online portal.

Section 1: Member Information

Full Name:

Member ID/Policy Number:

Date of Birth (YYYY-MM-DD):

Mailing Address:

Contact Number:

Section 2: Patient Information

Relationship to Member:

Select One

Patient Name (if not member):

Patient DOB (YYYY-MM-DD):

Section 3: Claim Details

Date(s) of Service:

e.g., 2024-05-30

Type of Service:

e.g., Consultation, X-ray, Surgery

Diagnosis/Condition:

Service/Expense Details:

Date	Service Rendered	Provider Name	Amount Charged	Amount Paid by Other Coverage	Amount Requested

Is the patient covered by another insurance?

Select One

Total Amount Requested:

Section 4: Provider Information (to be completed by provider if required)

Provider/Facility Name:

Provider ID/NPI Number:

Provider Phone:

Provider Address:

Section 5: Certification & Authorization

☐ I **certify that the above information is true and complete, and that the expenses claimed have been incurred for the medical care of the patient named in this form.**

Signature:

Type full name as signature

Date:

Submit Claim

Checklist

- All sections completed
- Supporting documents attached
- Signature and date provided

For questions, contact your insurance provider's member services or refer to your plan guidelines.