Health Insurance Accident Claim Form Sample

Filling out a **health insurance accident claim form** accurately ensures prompt processing and reimbursement for medical expenses incurred during accidents. This sample form provides a clear template to report details such as the nature of the accident, treatment received, and policy information. Utilizing the correct format helps avoid delays and facilitates efficient communication with insurance providers.

A. Policy Holder Information

Policy Number:

Policy Holder's Name:

Contact Number:

Address:

B. Patient Information

Patient's Name:

Date of Birth:

Relationship to Policy Holder:

--Select--

C. Accident Details

Date of Accident:

Time of Accident:

Location of Accident:

Description of Accident:

D. Treatment Details

Hospital/Clinic Name:

Attending Physician Name:

Dates of Treatment:

From - To

Diagnosis:

Total Claimed Expense (in USD):

E. Other Insurance

Is patient covered by any other insurance?

--Select--

If yes, provide details:

F. Declaration & Consent

I hereby declare that the information provided above is true and correct to the best of my knowledge. I authorize the insurance provider to obtain and verify medical and other relevant information pertaining to this claim.

Signature:

Date:

Submit Claim

Note: Attach copies of all medical bills, prescriptions, police reports (if applicable), and proof of payment with this form.