Employer-Provided Health Benefit Claim Form

This **employer-provided health benefit claim form** sample template simplifies the submission process for employees seeking health reimbursements. It includes essential fields for personal information, medical details, and claimant signatures, ensuring accurate and efficient claim processing.

Employee Information

Employee Name:

Employee ID:

Department/Unit:

Contact Number/Email:

Patient Information (if different from employee)

Patient Name:

Relationship to Employee:

Medical Details

Healthcare Provider/Clinic Name:

Date of Service:

Description of Treatment/Service:

Diagnosis (if available):

Claim Details

Date	Service/Item	Amount Claimed (USD)	Receipt Attached

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			☐

Bank Details for Reimbursement

Bank Name:

Account Holder Name:

Account Number:

Declaration and Signature

I hereby certify that the information provided above is accurate and complete to the best of my knowledge. I authorize the employer to process this health benefit claim and reimburse the eligible amount as per company policy.

Claimant's Signature:

(Type full name)

Date:

Submit Claim