Filled Hospital Claim Form Sample for Insurance Reimbursement

Download a **filled hospital claim form sample** to understand the correct procedure for insurance reimbursement. This sample helps ensure all necessary details are accurately provided, speeding up the claim process. Use it as a reference to avoid common mistakes and delays.

Sample Filled Hospital Claim Form

1. Policy Number	GH1234567890
2. Name of Insured	John Doe
3. Address	123 Main Street, Springfield, State, 12345
4. Contact Number	+1 555-123-4567
5. Name of Hospital	Springfield General Hospital
6. Hospital Address	456 Health Ave, Springfield, State, 12345
7. Date of Admission	2024-04-10
8. Date of Discharge	2024-04-15
9. Reason for Hospitalization	Acute Appendicitis
10. Treatment Details	Laparoscopic appendectomy performed
11. Total Hospital Bill Amount (Attach Bills)	$4,500.00
12. Amount Claimed	$4,500.00
13. Bank Details for Reimbursement	Bank Name: Springfield Bank Account Holder: John Doe Account Number: 9876543210 IFSC/SWIFT: SPRING123
14. Declaration & Signature	I hereby declare that the information provided is true to the best of my knowledge. *Signature: John Doe* *Date: 2024-04-16*

Note: Please attach the original hospital bills, discharge summary, doctor's prescription, and identity proof while submitting your claim to expedite reimbursement.

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