Hospital Claim Form Sample

1. Patient Information

Full Name

Date of Birth

Patient ID/Insurance No.

Address

Phone Number

2. Hospital Information

Hospital Name

Hospital Address

Admission Date

Discharge Date

3. Claim Details

Diagnosis/Description of Illness

Services Rendered

Claim Amount

4. Physician Certification

Physician's Certification: I hereby certify that the procedures and services listed above were medically necessary and performed as indicated.

Physician's Name

License Number

Date

Signature

5. Authorization

I hereby authorize release of information relating to this claim to the insurance company and certify that the above details are true and complete to the best of my knowledge.

Claimant Name

Signature

Date

Submit Claim