Pre-filled Health Benefit Claim Form Sample for Hospitalization

This **pre-filled health benefit claim form sample** for hospitalization simplifies the process of submitting your medical expenses for reimbursement. Designed to ensure accuracy and completeness, it helps speed up claim approvals. Using this sample form minimizes errors and saves valuable time during health insurance claims.

1. Policy Holder Details

Policy Number:	POL123456789
Name of Policy Holder:	John Doe
Contact Number:	+1 555-123-4567
Email Address:	john.doe@email.com

2. Patient Details

Patient Name:	Jane Doe
Date of Birth:	1990-04-15
Relation to Policy Holder:	Spouse
Patient ID (if any):	PAT789654

3. Hospitalization Details

Hospital Name:	City General Hospital
Hospital Address:	123 Health Ave, Metro City, ST 56789
Hospitalization Number:	HOSP2024060012
Admission Date:	2024-05-01
Discharge Date:	2024-05-07

4. Claim Details

Expense Type	Amount (USD)	Bill/Receipt No.
Room Charges	1,400.00	RC-1001
Doctor's Fees	600.00	DF-2001
Medicines	250.00	MD-3002
Diagnostic Tests	300.00	DT-4005
Other Charges	150.00	OC-5001
Total Claimed	**2,700.00**	

5. Bank Details (for Reimbursement)

Account Holder Name:	John Doe
Bank Name:	Metro State Bank

Account Number:	1234567890
IFSC/Swift Code:	MSBN0001234

6. Declaration & Signature

I hereby declare that the above information is true and correct to the best of my knowledge. I authorize the insurance company to process my claim based on the details provided.

Date:	2024-06-14
Signature:	John Doe