Completed Medical Claim Form Sample

Review this **completed medical claim form sample** to understand the necessary details for employee benefits processing. It clearly outlines the required information to facilitate a smooth and timely reimbursement. Use it as a reliable guide to ensure accuracy in your claims submission.

A. Employee Information

Employee Name	John A. Smith
Employee ID / Group No.	EMP123456 / G56789
Date of Birth	1985-08-15
Contact Number	(555) 123-4567
Address	123 Elm Street, Springfield, NY 10001
Email	john.smith@email.com

B. Patient Information (if different from Employee)

Patient Name	Emma J. Smith
Date of Birth	2014-11-23
Relationship to Employee	Daughter

C. Provider & Service Information

Provider Name	Springfield Medical Clinic
Date(s) of Service	2024-04-18
Type of Service	Office Visit â€“ General Pediatrics
Provider Address	789 Main Ave, Springfield, NY 10001
Diagnosis / Reason for Visit	Flu symptoms, persistent cough
Service Amount	$120.00
Amount Paid by Employee	$120.00
Method of Payment	Credit Card

D. Attachments & Declaration

- Original itemized receipt attached
- Copy of prescription (if applicable)
- Employee signature: **John A. Smith**
- Date: **2024-04-22**

E. For Office Use Only

Claim Number	MC20240418745
Date Received	2024-04-23
Status	Processed
Reimbursement Amount	$120.00

Comments	Approved. Full reimbursement per plan guidelines.