Health Benefit Claim Form
Maternity Coverage

This **health benefit claim form** sample for maternity coverage provides a clear and organized template to submit medical expenses related to pregnancy and childbirth. It ensures accurate documentation and faster processing of your maternity insurance claims. Use this form to maximize your entitled health benefits efficiently.

1. Insured Member Information

Full Name:

Policy Number:

Date of Birth:

Contact Number:

Email Address:

2. Patient Details (if different from Insured Member)

Patient Name:

Relationship to Member: Select

Date of Birth:

3. Maternity Claim Details

Type of Claim: Select

Hospital Name:

Admission Date:

Discharge Date:

Attending Physician:

4. Expense Details

Date	Description of Service	Provider	Amount	Receipt/Invoice No.

Total Claimed Amount:

5. Declaration & Authorization

I hereby declare that the information provided above is true and correct to the best of my knowledge. I authorize the insurance company to obtain necessary medical information to process this claim.

Signature of Insured Member:

Date:

Submit Claim