Covid-19 Medical Reimbursement Claim Form (Sample)

The **Covid-19 medical reimbursement claim form** sample provides a structured template to facilitate the submission of medical expenses related to Covid-19 treatment. This form ensures accurate documentation and smooth processing of indemnity claims by healthcare providers or insurance companies. Utilizing this standardized format helps claimants receive timely reimbursements with minimal delays.

1. Claimant Information

Full Name:

Policy/Employee No:

Contact Number/Email:

Address:

2. Patient Details

Patient Name:

Relation to Claimant:

Date of Birth:

Diagnosis (Covid-19 Confirmation):

3. Hospital/Clinic Details

Hospital/Clinic Name:

Date of Admission:

Date of Discharge:

4. Claimed Expenses

Sl. No.	Expense Type	Bill/Invoice Number	Date	Amount (INR/USD)

1	e.g., Hospitalization			
2				
3				

Total Amount Claimed:

5. Bank Account Details (for Reimbursement)

Account Holder Name:

Bank Name:

Account Number:

IFSC/SWIFT Code:

6. Declaration

I hereby declare that all information provided above is true and correct to the best of my knowledge. I am attaching all relevant documents/bills for your verification and processing.

Signature:

(Type name for digital submission)

Date:

Submit Claim