

Medical Claim Form: Detailed Breakdown

1. Patient Information

Full Name

Date of Birth

Gender



Contact Number

Email Address

Policy/Member ID

2. Insurance Information

Insurance Company

Group Number

Plan Type

3. Provider Details

Provider Name

Provider NPI/ID

Contact Number

Address**4. Claim & Treatment Details****Date of Service****Diagnosis Code (ICD-10)****Procedure Code (CPT/HCPCS)****Description of Service****Amount Charged****5. Payment & Authorization****Amount Paid by Patient****Signature of Patient****Date****Signature of Provider****Date****Important Notes**

- Ensure all fields are accurately filled to avoid processing delays.
- Submit supporting documents such as medical bills, prescriptions, and receipts.
- Retain a copy of the completed form for your records.
- Inaccurate or incomplete information may result in claim denial.
- Verify policy coverage and authorization requirements before submitting the claim.

