Medical Expense Claim Form

1. Claimant Information

Full Name

Date of Birth

Policy/Member Number

Contact Number

Address

2. Patient Information

Patient Name (If different from Claimant)

Relationship to Claimant

Select

3. Medical Expense Details

Date of Service

Healthcare Provider

Type of Service

Amount Claimed

4. Payment Information

Payee Name

Bank Account Number (if applicable)

Preferred Payment Method

Select

5. Declaration & Authorization

I hereby declare that the information provided above is true and correct to the best of my knowledge and that the expenses claimed are not reimbursed from any other source.

Claimant Signature

Date

Important Notes:

- Ensure all required fields are accurately completed to avoid processing delays.
- Attach original receipts and relevant supporting documents.
- Claims must be submitted within the prescribed time frame as per policy.
- Falsifying any information may result in claim rejection and policy termination.
- Retain copies of all documents submitted for your records.