

# Mandatory Fields in Medical Expense Claim Documentation

| Field                        | Description  |
|------------------------------|--|
| Patient Full Name            | Name of the individual receiving medical treatment.                          |
| Policy/Employee Number       | Unique identification number for insurance or employer policies.             |
| Date of Service              | The date when the medical service was provided.                              |
| Provider Name & Address      | Name and address of the healthcare provider or facility.                     |
| Diagnosis                    | Reason for medical treatment (medical diagnosis or condition).               |
| Details of Services Rendered | Description of medical services (consultation, medication, procedure, etc.). |
| Amount Claimed               | Total amount claimed for the medical expenses.                               |
| Original Invoices/Receipts   | Submission of detailed original bills/receipts from the provider.            |
| Bank Account Details         | Bank name, branch, and account number for reimbursement (if required).       |
| Claimant Signature           | Signature of the person submitting the claim.                                |
| Date of Submission           | Date the claim form is submitted to the insurer/employer.                    |

## Important Notes

- Ensure all information provided is complete and accurate to avoid delays in processing.
- Attach copies of all supporting documents as required by your insurer or employer.
- Incomplete submissions may be rejected or require resubmission.
- Check your specific insurance policy for any additional mandatory fields or requirements.
- Maintain copies of all documents submitted for your own records.