Medical Claim Form
Required Information

Patient Information

Full Name	_____
Date of Birth	____ / ____ / _____
Gender	□ Male □ Female □ Other
Contact Number	_____
Address	_____
Policy/Member ID	_____

Insurance Information

Insurance Provider	_____
Policy Number	_____
Group Number (if applicable)	_____
Policyholder Name	_____
Relationship to Patient	□ Self □ Spouse □ Child □ Other

Provider Information

Provider/Facility Name	_____
Provider Address	_____
Provider Phone	_____
NPI/Provider ID	_____

Claim Details

Date(s) of Service	____ / ____ / _____ to ____ / ____ / _____
Diagnosis/ICD Code(s)	_____
Treatment/Procedure Codes	_____
Amount Claimed	_____
Paid By Other Insurance?	□ Yes □ No If yes, amount: _____
Supporting Documents Attached	□ Invoice(s) □ Prescription(s) □ Discharge Summary □ Other: _____

Declaration & Authorization

Signature of Patient/Policyholder _____

Date ____ / ____ / _____

Important Notes

- Ensure all required fields are accurately completed to prevent processing delays.
- Attach all necessary supporting documents (e.g., receipts, medical reports, prescriptions).
- Sign and date the declaration/authorization section before submission.
- Incomplete or incorrect forms may result in rejection or delay of your claim.
- Keep copies of all documents submitted for your records.