Medical Insurance Claim Statement

Policy Holder Information

Full Name:	John Doe
Policy Number:	ABC123456789
Date of Birth:	12 Jan 1985
Contact Number:	+1 234 567 8901
Address:	123 Main St, Springfield, USA

Patient Information

Name:	Jane Doe
Relationship to Policy Holder:	Daughter
Date of Birth:	28 Sep 2012

Hospital & Treatment Details

Hospital Name:	Springfield Medical Center
Admission Date:	02 Feb 2024
Discharge Date:	05 Feb 2024
Diagnosis:	Viral Fever
Treatment Provided:	IV Fluids, Medication, Monitoring
Attending Physician:	Dr. Samantha Smith

Claim Summary

Description	Amount (USD)
Hospital Charges	1,200.00
Medical Fees	450.00
Medicines	200.00
Other Expenses	100.00
Total Claim Amount	**1,950.00**

Bank Details for Claim Settlement

Bank Name:	National Bank
Account Holder Name:	John Doe
Account Number:	9876543210

IFSC/SWIFT Code:	NATB0012345

Declaration

I hereby declare that the information provided above is true and correct to the best of my knowledge and belief. I agree to provide any further documentation if required.

Signature _____ **Date** _____

Important Notes

- Ensure all details and attached documents are accurate and complete before submission.
- Retain copies of all medical and expense documents for your records.
- Claims are subject to verification as per the policy terms and insurerâ€™s discretion.
- Incomplete or false information may lead to claim rejection or delays.
- Contact your insurer for guidance if you are unsure about any section of the claim form.