Typical Subsets in Medical Reimbursement Form Templates

1. Personal and Policy Details

Field	Description
Patient Name	Full legal name of the person seeking reimbursement
Date of Birth	Patientâ€™s date of birth
Policy Number	Insurance identification or member number
Contact Details	Phone number, email, and address

2. Treatment & Provider Details

Field	Description
Provider Name	Name of hospital/clinic/doctor
Provider Contact	Address or phone number of provider
Treatment Dates	Start and end date of treatment
Diagnosis	Illness or medical condition treated

3. Expense Details

Type of Expense	Date	Amount (USD)
Consultation Fee	YYYY-MM-DD	___
Medicine/Prescription	YYYY-MM-DD	___
Procedure/Test	YYYY-MM-DD	___
Others	YYYY-MM-DD	___
Total Claimed		**___**

4. Bank Details for Reimbursement

Bank Name	_____
Account Holder Name	_____
Account Number	_____

IFSC / SWIFT Code	_____

5. Declaration & Signature

Declaration
I hereby declare that the information provided above is true and complete to the best of my knowledge. I agree to provide any supporting documents on request. Signature: _____ Date: _____

Important Notes

- Ensure all mandatory fields are filled and all documents are attached.
- Incomplete or incorrect forms may delay claim processing.
- Attach original bills, prescriptions, and payment receipts where applicable.
- Claims should be submitted within the stipulated time period as per policy.