Medical Claim Form

Patient Information

- Patient Name: _____
- Date of Birth: _____
- Insurance Policy Number: _____

Medical Information

- Date of Treatment: _____
- Provider Name: _____
- Diagnosis: _____
- Treatment Provided: _____

Claim Information

- Total Amount Claimed: _____
- Itemized Bill Attached: [ ] Yes [ ] No

Authorization

By signing below, I authorize the release of any medical information necessary to process this claim.

- **Patient Signature:** _____