Health Insurance Claim Form PDF

Policyholder Information

Full Name: ____

Policy Number: ______________________________________

Date of Birth: ______________________________________

Contact Number: ____________________________________

Email Address: ______________________________________

Address: ____

Claim Details

Date of Illness/Accident: ______________________________

Place of Treatment: __________________________________

Name of Healthcare Provider: _________________________

Type of Treatment Received: __________________________

Total Claimed Amount: _______________________________

Medical Information

Diagnosis: ____

Prescribed Medication: _______________________________

Hospital Stay Duration (if applicable): __________________

Supporting Documents Submitted

☐ Medical Bills

☐ Doctor's Report

☐ Prescription Copies

☐ Other: ____

Declaration

☐ I certify that the information provided is accurate to the best of my knowledge.

☐ I authorize the insurer to verify details and process my claim.

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Policyholder Name: ___________________________________

Signature: ____

Date: ____

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