Medical Claim Reimbursement Form

Patient Information

Name: _____

Date of Birth: _____

Policy Number: _____

Contact Number: _____

Claim Details

Medical Service Provided: _____

Date of Treatment: _____

Healthcare Provider: _____

Total Amount: $_____

Reimbursement Request

Amount to be Reimbursed: $_____

Supporting Documentation Checklist

[ ] Original Receipts

[ ] Prescription Copies

[ ] Doctor's Note

[ ] Insurance Claim Form

Approval Section (Office Use Only)

Approved Amount: $_____

Approver Name: _____

Approver Signature: _____

Date: _____