Medical Insurance Claim Form

Insured Person Details

Full Name: _____

Policy Number: _____

Date of Birth: _____

Contact Number: _____

Hospital and Treatment Details

Hospital Name: _____

Date of Admission: _____

Date of Discharge: _____

Reason for Admission: _____

Treatment Provided: _____

Billing Summary

Service	Date	Amount	Notes

Supporting Documents Submitted

☐ **Medical Bills**

☐ **Discharge Summary**

☐ **Prescriptions**

☐ **Other: _____**

Declaration

☐ **I declare that the information provided is true and consent to the insurer verifying all details provided.**

Insured Name: _____

Signature: _____

Date: _____