Health Insurance Claim Form

Sample Document â€“ Medical Billing

1. Patient Information

Full Name

Date of Birth

Gender Select

Address

Phone

Insurance Policy #

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2. Insured Person Information (If different from patient)

Name

Relationship to Patient

Date of Birth

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3. Provider Information

Provider Name

Provider NPI #

Phone

Provider Address

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4. Claim Details

Diagnosis / Reason for Visit

Date(s) of Service YYYY-MM-DD to YYYY-MM

Amount Claimed USD

Procedures / Services Rendered

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5. Other Insurance Coverage

Is patient covered by another health plan?
Yes No

If Yes, Plan Name

Other Insurance Policy #

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6. Signature & Authorization

Signature of Patient or Authorized Person

Date

Authorization to Pay Provider Directly
I authorize payment of medical benefits directly to the provider.
