Health Insurance Claim Form

1. Patient Information

Full Name

Date of Birth

Gender

Select

Contact Number

Address

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2. Insurance Details

Insurance Company

Policy Number

Group Number (if any)

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3. Claim Information

Date(s) of Service

e.g. 2024-04-05 to 2024-04-07

Provider Name

Description of Services

Amount Claimed

4. Additional Information

Do you have other health insurance?

Select

Comments / Notes

5. Declaration

☐ I hereby declare that the above information is true and correct.

Signature

Type or sign name

Date