# Health Insurance Claim Submission Form

Policyholder's Name

Policy Number

Date of Birth

Contact Number

Patient Name

Relationship to Policyholder

Patient Date of Birth

Hospital / Clinic Name

Date of Admission

Date of Discharge

Claim Amount

Diagnosis / Reason for Hospitalization

Treatment / Procedures Performed

Account Holder Name

Bank Name

Account Number

IFSC / Branch Code

Declaration I hereby declare that the information provided is true and

Date

Signature