Health Insurance Claim Form

1. POLICYHOLDER DETAILS

Policy Number

Name of Policyholder

Date of Birth

Address

Phone Number

Email

2. PATIENT INFORMATION

Name of Patient

Relationship to Policyholder Select

Date of Birth

Gender Select

3. HOSPITAL/CLINIC DETAILS

Name of Hospital/Clinic

Address

Date of Admission

Date of Discharge

Treatment/Diagnosis Details

4. CLAIM DETAILS

Claim Amount (in USD)

Description of Expenses

5. DECLARATION

I declare that the information given above is true and correct to the best of my knowledge.

Signature

Date