Hospitalization Claim Document

Patient Details

Full Name: _____

Date of Birth: ____ / ____ / _____

Gender: _____

Contact Number: _____

Policy Number: _____

Hospital Details

Hospital Name: _____

Hospital Address: _____

Admission Date: ____ / ____ / _____

Discharge Date: ____ / ____ / _____

Diagnosis & Treatment

Diagnosis: _____

Treatment Details:

_____
_____
_____

Claimed Expenses

Item	Description	Amount (â‚¹)
Room Charges	_____	_____
Doctor Fees	_____	_____
Medicine	_____	_____
Surgery/Procedures	_____	_____
Other	_____	_____
	Total	_____

Declaration

I hereby declare that the details given above are true and correct to the best of my knowledge and belief.

Patient/Claimant Signature: _____

Date: ____ / ____ / _____