

Hospitalization Claim Follow-Up Document

Patient Information

Patient Name	<input type="text" value="Full Name"/>
Patient ID / Policy No.	<input type="text" value="ID or Policy Number"/>
Date of Birth	<input type="text"/>
Contact Number	<input type="text" value="Phone Number"/>
Email Address	<input type="text" value="Email"/>

Claim Details

Claim Reference No.	<input type="text" value="Claim Number"/>
Date of Admission	<input type="text"/>
Date of Discharge	<input type="text"/>
Hospital Name	<input type="text" value="Hospital Name"/>
Hospital Address	<input type="text" value="Address"/>

Follow-Up Status

Date	Mode of Follow-Up	Status/Remarks
<input type="text"/>	<input type="text" value="Phone/Email/Visit"/>	<input type="text" value="Status or Remarks"/>
<input type="text"/>	<input type="text" value="Phone/Email/Visit"/>	<input type="text" value="Status or Remarks"/>

Additional Notes

<input type="text" value="Enter any additional notes"/>

Followed-up By	<input type="text" value="Name"/>
Date	<input type="text"/>