

Hospitalization Expense Statement for Accident Cases

Patient & Accident Details

Patient Name: _____

Age / Sex: _____

Hospital No: _____

Date of Admission: _____

Date of Discharge: _____

Claim/Reference No.: _____

Nature of Accident: _____

Date & Time of Accident: _____

Details of Hospitalization Expenses

S.No.	Particulars	Bill / Receipt No.	Date	Amount (â‚¹)
1.	Room Rent			
2.	Consultation / Doctor Fees			
3.	Surgical Charges			
4.	Medicines / Pharmacy			
5.	Diagnostic / Laboratory			
6.	Others (Specify)			
Total				

Declaration

I hereby declare that the above statements are true and correct to the best of my knowledge and belief.
I attach herewith all supporting documents/bills/receipts in original.

Patient / Claimant Signature
Date: _____

Hospital Authority Signature & Seal
Date: _____

