Medical Expense Claims Form for Accident Insurance

1. Policyholder Details

Full Name

Policy Number

Address

Contact Number

Email

2. Patient Information

Patient Name

Date of Birth

Relationship to Policyholder

3. Accident Details

Date of Accident

Time

Place of Accident

Description of Accident

4. Medical Treatment Details

Hospital/Clinic Name

Treating Doctor

Date Admitted

Date Discharged

Nature of Injury/Treatment Details

5. Medical Expenses Claimed

Date	Type of Expense	Provider	Amount	Receipt Number
		Total		

6. Other Insurance Details (if any)

Other Insurer Name

Policy Number

Claim Amount

7. Declaration

I hereby declare that all information given above is true and complete to the best of my knowledge. I consent to the insurer obtaining further medical information if necessary for the assessment of this claim.

Signature of Policyholder

Date