Health Insurance Claim Submission Form

1. Patient Information

Full Name

Date of Birth

Patient ID / Member Number

Phone Number

Address

2. Insurance Details

Policy Number

Group Number

Insurance Provider

3. Claim Details

Claim Type

Select

Claimed Amount (USD)

Date of Service

Healthcare Provider Name

Description of Services Received

4. Additional Information

List of Attached Documents (e.g., receipts, invoices)

Additional Notes

5. Declaration

☐ I hereby declare that the information provided is accurate and complete.

Date

Signature