

MEDICAL INSURANCE CLAIM FORM

Claim ID: SYN_session_
Form Type: Synthetic Form
Generated Date: 2025-09-05 06:08:07

PATIENT INFORMATION

Patient Name: Aarav Mehta
Policy Number: POL-IN-987654
Date of Birth: N/A
Contact Number: N/A
Email: N/A

INSURANCE INFORMATION

Insurance Company: CareShield Health Insurance Co.
Coverage Amount: █1000000
Deductible: █N/A
Coplay Percentage: N/A%

MEDICAL INFORMATION

Hospital/Facility: Springfield General Hospital
Doctor Name:
Service Date: 2025-08-20
Admission Date: 2025-08-20
Discharge Date:
Total Amount: █169350.0
Diagnosis:
Room Type:

PROCEDURES/TREATMENTS

1. Appendectomy (Open)
2. Comprehensive Metabolic Panel
3. Complete Blood Count
4. Blood Draw (Venipuncture)
5. ECG with report
6. Room Rent - Semi Private
7. OT & Nursing Charges
8. Pharmacy & Consumables

BANK DETAILS

Account Holder Name: Aarav Mehta

Account Number:

IFSC Code:

Bank Name:

SIGNATURE

Patient/Policy Holder Signature: _____

Date: _____