MEDICAL INSURANCE CLAIM FORM

Claim ID: STAR_HEALTH_session_

Form Type: Synthetic Form

Generated Date: 2025-09-05 06:58:07

PATIENT INFORMATION

Patient Name: aarav

Policy Number: POL-IN-987654

Date of Birth: N/A

Contact Number: N/A

Email: N/A

INSURANCE INFORMATION

Insurance Company:

Coverage Amount: ■

Deductible: ■N/A

Copay Percentage: N/A%

MEDICAL INFORMATION

Hospital/Facility: Springfield General Hospital

Doctor Name:

Service Date: 2025-08-20

Admission Date:

Discharge Date:

Total Amount: ■169350

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:

Account Number:

IFSC Code:

Bank Name:

SIGNATURE

Patient/Policy Holder Signature: _____

Date: _____