MEDICAL INSURANCE CLAIM FORM

Claim ID: SYN_session_

Form Type: Synthetic Form

Generated Date: 2025-09-05 13:19:52

PATIENT INFORMATION

Patient Name: Dhruv

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

Copay Percentage: N/A%

MEDICAL INFORMATION

Hospital/Facility: Springfield General Hospital

Doctor Name:

Service Date: 2025-09-15

Admission Date: 2025-09-15

Discharge Date:

Total Amount: ■845181.75

Diagnosis:

Room Type:

PROCEDURES/TREATMENTS

1. Critical Care - First Hour
2. Critical Care - Additional 30min blocks
3. Arterial Puncture for Blood Gas
4. Chest X Ray (2 views)
5. Comprehensive Metabolic Panel
6. Complete Blood Count with Differential
7. Prothrombin Time (PT/INR)
8. Partial Thromboplastin Time (PTT)
9. Creatinine, Blood
10. Uric Acid
11. Glucose, Blood
12. Sodium, Blood
13. Potassium, Blood
14. Chloride, Blood
15. CT Chest with Contrast
16. CT Abdomen/Pelvis with Contrast
17. Echocardiogram Complete
18. Abdominal Ultrasound Complete
19. Chest X Ray Single View
20. Continuous Positive Airway Pressure
21. Emergency Intubation
22. Ventilation Management per day
23. Aerosol/Vapor Inhalation Treatment
24. Hospital Visit - Intermediate
25. Thoracentesis with Imaging
26. Central Venous Catheter Insertion
27. Upper GI Endoscopy Diagnostic
28. Pulmonology Consultation
29. Nephrology Consultation
30. Critical Care Consultation
31. Cardiology Consultation

BANK DETAILS

Account Holder Name: Aarav Mehta

Account Number:

IFSC Code:

Bank Name:

SIGNATURE

Patient/Policy Holder Signature: _____

Date: _____