Medical Claim Form

1. Patient Information:

- Name: John Doe
- Date of Birth: 12/15/1985
- Gender: Male
- Address: 1234 Elm Street, Springfield, IL 62704
- Phone: (123) 456-7890
- Email: johndoe@email.com
- Insurance ID: ABC1234567

2. Policyholder Information (if different from patient):

- Name: Jane Doe
- Relationship to Patient: Spouse
- Insurance Provider: XYZ Health Insurance
- Policy Number: XYZ9876543
- Group Number: G123456

3. Medical Provider Information:

- Facility Name: Springfield General Hospital
- Address: 5678 Oak Avenue, Springfield, IL 62705
- Phone: (987) 654-3210
- Attending Physician: Dr. Michael Smith
- Physician License No: MD987654

4. Treatment Details:

- Date of Service: 03/10/2024
- Diagnosis: Acute Bronchitis (J20.9)
- Procedures Performed: Chest X-ray, Blood Test, Consultation
- Procedure Codes: 71010, 85025, 99213
- Total Amount Billed: $750.00
- Amount Paid by Insurance: $500.00
- Amount Due by Patient: $250.00

5. Payment and Reimbursement Details:

- Payment Method: Credit Card
- Reimbursement Requested: Yes
- Preferred Payment Method: Direct Deposit
- Bank Details: (Confidential)

6. Supporting Documents:

- Copy of Insurance Card
- Itemized Medical Bill
- Prescription (if applicable)

7. Declaration and Signature:
I hereby declare that the above information is true and accurate to the best of my knowledge. I authorize my insurance provider to process this claim.

Patient Signature: _____
Date: 03/15/2024

Insurance Representative Approval: _____
Date: 03/20/2024