Medical Claim Form

1. **Patient Information:**
   Name: Alice Johnson
   Date of Birth: 07/22/1990
   Gender: Female
   Address: 9876 Maple Lane, Chicago, IL 60601
   Phone: (312) 555-7890
   Email: alice.johnson@email.com
   Insurance ID: DEF7894561

2. **Policyholder Information (if different from patient):**
   Name: Robert Johnson
   Relationship to Patient: Spouse
   Insurance Provider: ABC Health Insurance
   Policy Number: ABC1239876
   Group Number: G567890

3. **Medical Provider Information:**
   Facility Name: Chicago Medical Center
   Address: 3456 Birch Street, Chicago, IL 60602
   Phone: (312) 555-1234
   Attending Physician: Dr. Emily Carter
   Physician License No: MD567890

4. **Treatment Details:**
   Date of Service: 05/18/2024
   Diagnosis: Migraine (G43.9)
   Procedures Performed: MRI Scan, Blood Test, Neurological Consultation
   Procedure Codes: 70551, 85025, 99214
   Total Amount Billed: $1,200.00
   Amount Paid by Insurance: $800.00
   Amount Due by Patient: $400.00

5. **Payment and Reimbursement Details:**
   Payment Method: Bank Transfer
   Reimbursement Requested: Yes
   Preferred Payment Method: Check
   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: 05/20/2024
   Insurance Representative Approval: _____
   Date: 05/25/2024