Health Insurance Claim Form

Claim ID: HIC-2025-07-18-003

Date of Submission: 2025-07-18

1. Policy Holder Information

1. **Full Name:** Sarah M. Chen
2. **Policy Number:** XYZ-789012345
3. **Date of Birth:** 1988-09-25
4. **Address:** Apt. 4B, 10 Main Street, New Harmony, State, 54321
5. **Contact Number:** (555) 789-0123
6. **Email:** sarah.chen@example.com

2. Incident Details

1. **Date of Incident/Symptom Onset:** 2025-07-05
2. **Type of Claim:** Medical - Illness (Respiratory)
3. **Brief Description of Incident/Condition:** Patient experienced a sudden onset of fever, cough, and fatigue. Symptoms worsened over several days, leading to a visit to a primary care physician.

3. Medical Provider Information

1. **Provider Name:** Dr. Emily White, Family Practice
2. **Provider Address:** 200 Health Plaza, New Harmony, State, 54321
3. **Provider Phone:** (555) 345-6789
4. **Diagnosis (as per provider):** Acute Bronchitis (ICD-10: J20.9)

4. ITEMIZED SERVICES & COSTS

Date of Service	Service Code	Description	Amount Claimed (₹)
2025-07-08	99213	Office Visit, New Patient	900
2025-07-08	87400	MRI Lumbar Spine	450

2025-07-08	97110	Therapeutic Exercise (1 unit)	300
2025-07-10	97110	Therapeutic Exercise (1 unit)	750
2025-07-10	J3420	Vitamin B12 Injection	600

5. Patient Declaration

I certify that the information provided in this claim is true and accurate to the best of my knowledge and belief. I understand that any false statements or misrepresentations may result in the denial of benefits, legal action, or criminal prosecution. I authorize the release of any medical information necessary to process this claim.

Signature: Sarah M. Chen **Date:** 2025-07-18