Health Insurance Claim Form

Section 1: Patient/Claimant Information

Patient/Claimant Name: (Last Name, First Name, Middle Initial) Smith, Alice, M Date of Birth: (MM/DD/YYYY) *07/12/1988*___ Gender: Male ☐ Female ☒ Other ☐ Patient/Claimant Address: City: _____ State: _____ Zip Code: _____ Patient/Claimant Phone Number: _____ Patient/Claimant Email Address: _____ Member ID/Policy Number: *ABC1234567*_____ Group Number (if applicable): _____ Primary Insurance Holder's Name (if different): _____ Primary Insurance Holder's Date of Birth (if different): _____ Relationship to Insured (if dependent): _____ Has the Patient/Claimant received any other services for this medical condition? Yes ☐ No ☒ If Yes, explain: _____ Does the Patient/Claimant have any other health insurance coverage? Yes ☐ No ☒ If Yes, please provide: Insurance Company: _____ Policy Number: _____ Group Number (if applicable): _____

Section 2: Provider Information

Provider/Facility Name: *Family Practice Clinic*_____ Provider/Facility NPI/Tax ID: *987654321*_____ Provider/Facility Address: City: _____ State: _____ Zip Code: _____ Provider/Facility Phone Number: _____ Provider Type: (Doctor, Hospital, Lab, Other) *Doctor*_____ Specialty (if applicable): _____

Section 3: Service Details

Date(s) of Service: From: *02/27/2024*__ To: 02/27/2024____ Location of Service: (e.g., Office, Hospital, Lab) *Office*_____ Description of Service(s) or Procedure(s): (Brief Description) *Doctor's Visit*_____ ICD-10 Diagnosis Code(s): _____ CPT/HCPCS Procedure Code(s): _____ Is this claim related to an accident or employment? Yes ☐ No ☒ *If Yes, please explain:_____ Did the service require Pre-Authorization? Yes ☐ No ☒ *If Yes, provide Authorization Number: _____ Is the Provider In-Network? Yes ☐ No ☒ (Note: This would require additional knowledge)

Attach copies of itemized bills, medical records, if needed (Refer to section 5 in Claim Guide)

Section 4: Authorization

I certify that the information provided is accurate and complete to the best of my knowledge. I authorize the release of my medical information to [Your Health Insurance Company Name] for the purpose of processing this claim. I authorize payments of medical benefits to the health care provider or as appropriate. Signature of Patient/Claimant (or Authorized Representative): *(Signature)*_____ Date: 02/29/2024_____ Printed Name of Signer: Alice M. Smith_____ Relationship to Patient/Claimant (if not the patient/claimant): *Self*_