
INSURANCE CLAIM SUBMISSION FORM

All fields marked with (*) are required

INSTRUCTIONS: Please complete all sections of this form clearly and accurately. Attach all required supporting documentation. Incomplete forms may result in processing delays. For assistance, contact our claims department at 1-800-CLAIMS-1.

SECTION 1: CLAIMANT INFORMATION

Full Name (*): Sarah Johnson

Date of Birth (*): March 22, 1985

Social Security Number (*): XXX-XX-5678

Mailing Address (*): 1234 Maple Street, Springfield, IL 62701

Phone Number (*): (555) 123-4567

Email Address: sarah.johnson@email.com

SECTION 2: POLICY INFORMATION

Policy Number (*): POL-2024-15678

Group Number (if applicable): GRP-HEALTH-001

Policy Type (*):

- Health Insurance
- Life Insurance
- Motor/Auto Insurance
- Home/Property Insurance
- Other: _____

Policy Effective Date: January 1, 2024

Policyholder Name (if different from claimant): N/A - Same as claimant

SECTION 3: CLAIM DETAILS

Date of Incident/Service (*): January 10-13, 2024

Location of Incident/Service (*):

St. Mary's Regional Hospital
500 Medical Center Drive
Springfield, IL 62702

Claim Amount Requested (*): \$4,250.00

Detailed Description of Claim (*):

EMERGENCY APPENDECTOMY SURGERY AND HOSPITALIZATION

On January 10, 2024, at approximately 11:45 PM, I presented to St. Mary's Regional Hospital Emergency Department with severe abdominal pain. After examination and CT scan, I was diagnosed with acute appendicitis requiring emergency surgery.

I underwent emergency laparoscopic appendectomy performed by Dr. Patricia Anderson on January 11, 2024, at 2:45 AM. The surgery was successful with no complications.

I was hospitalized for 3 days (January 11-13, 2024) for post-operative monitoring and recovery. I was discharged on January 13, 2024, in stable condition with instructions for follow-up care.

MEDICAL DETAILS:

- Emergency Department Visit: January 10, 2024, 11:45 PM - 3:20 AM
- Diagnosis: Acute appendicitis
- Procedure: Emergency laparoscopic appendectomy
- Surgeon: Dr. Patricia Anderson, MD
- Hospital Stay: 3 days (January 11-13, 2024)
- Discharge Status: Stable condition, home care instructions provided

FINANCIAL SUMMARY:

- Total Hospital Charges: \$33,550.00
 - Insurance Coverage Requested: \$4,250.00 (deductible and co-insurance portion)
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SECTION 4: ADDITIONAL INFORMATION

Have you filed a claim for this incident with any other insurance company?

- Yes (Please provide details below)
 No

If yes, please provide details:

Is this claim related to an accident or injury?

- Work-related
 Auto accident
 Other accident
 Medical condition (non-accident)

SECTION 5: SUPPORTING DOCUMENTS CHECKLIST

Please attach all applicable documents:

- Hospital Admission Record
 Discharge Summary
 Itemized Hospital Bill/Invoice
 Emergency Department Records
 Diagnostic Test Results (CT Scan, Labs, etc.)
 Physician/Surgeon Notes
 Police Report (if applicable)
 Repair Estimates (for property claims)
 Photos/Evidence
 Other: _____

SUPPORTING DOCUMENTS INCLUDED WITH THIS SUBMISSION:

1. Hospital Admission Record (claim-1-hospital-admission.pdf)
2. Discharge Summary (claim-1-discharge-summary.pdf)
3. Itemized Hospital Bill (claim-1-itemized-bill.pdf)
4. Emergency Department Records (claim-1-emergency-room.pdf)
5. Diagnostic Test Results - CT Scan (claim-1-diagnostic-results.pdf)
6. Physician/Surgeon Operative Notes (claim-1-physician-notes.pdf)

Total Documents Attached: 6 files

SECTION 6: AUTHORIZATION AND SIGNATURE

I HEREBY CERTIFY THAT:

1. All information provided in this claim form is true, accurate, and complete to the best of my knowledge.
2. I authorize the release of any medical or other information necessary to process this claim.
3. I authorize payment of medical benefits directly to the healthcare provider(s) named in this claim.
4. I understand that any false or fraudulent claim may result in denial of benefits and potential legal action.

5. I have read and agree to the terms and conditions of my insurance policy.
6. I understand that submission of this claim does not guarantee approval or payment.

Signature of Claimant (*): Sarah Johnson

Date (*): February 15, 2024

Print Name: SARAH JOHNSON

OFFICE USE ONLY

Claim ID: _____

Date Received: _____

Received By: _____

Initial Review Date: _____

Assigned Adjuster: _____

Status: Approved Denied Pending Review More Info Needed

Notes:

CLAIMS DEPARTMENT CONTACT INFORMATION

Phone: 1-800-CLAIMS-1 (1-800-252-4671)

Fax: 1-800-555-0199

Email: claims@insurance.com

Website: www.insurance.com/claims

Mailing Address: Claims Department

Insurance Company
P.O. Box 12345
Claims Processing Center
Chicago, IL 60601

Business Hours: Monday - Friday, 8:00 AM - 6:00 PM CST

Emergency Claims: 24/7 Hotline: 1-800-HELP-NOW

PRIVACY NOTICE

Your privacy is important to us. All information provided will be kept confidential and used solely for the purpose of processing your insurance claim. We comply with all applicable federal and state privacy laws, including HIPAA regulations for health information.

END OF FORM

Form Version: 2024.1

Document Date: February 15, 2024

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