HEALTH INSURANCE CLAIM FORM

Form 1500

1. Patient Name: Bob Smith
2. Date of Birth: 1980-11-22
3. Address: 42 Pine Street, Seattle, WA
4. Diagnosis / Nature of Illness: Fractured Right Radius (Arm). Fell off a ladder while painting.
5. Date of Accident: 2025-03-10
6. Provider: Metro City Hospital
7. Total Charges: $1,300.00
8. Amount Paid: $1,300.00

I certify that the information above is true and correct.

Signature: _Bob Smith_
Date: 2025-03-12