Health Insurance Claim Form

Patient Information

Name: John Smith
Date of Birth: 01/01/1990
Gender: Male
Address: 123 Main Street, Bengaluru, Karnataka, India
Phone: 9876543210
Email: john.smith@example.com
Policy Number: ABCD123456789
Relationship to Policyholder: Self

Policyholder Information

Name: John Smith
Date of Birth: 01/01/1990
Gender: Male
Address: 123 Main Street, Bengaluru, Karnataka, India
Phone: 9876543210
Email: john.smith@example.com
Employer: XYZ Pvt Ltd
Occupation: Software Engineer

Claim Details

Date of Service: 15/09/2023
Type of Service: Outpatient Consultation
Diagnosis: Acute Bronchitis
Treatment: Antibiotics and Inhaler
Amount Claimed: Rs. 5000

Declaration

I hereby declare that the information given above is true and correct to the best of my knowledge and belief. I understand that any false or misleading information may result in the rejection of my claim or legal action by the insurance company. I authorize the insurance company to verify any details related to my claim from any source.

Signature of Patient/Policyholder:

John Smith

Date: 25/09/2023