

Medical Insurance Claim Form

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ dd / mm / yyyy
Gender: _____ Address: _____
Phone Number: _____ Email: _____
Insurance Policy Number: _____ Group Number: _____

HEALTHCARE PROVIDER INFORMATION

Provider Name: _____ National Provider Identifier (NPI): _____
Address: _____ Phone Number: _____
Fax Number: _____ Email: _____

TREATMENT DETAILS

Date of Service: _____ dd / mm / yyyy

Description of Service/Procedure:

Diagnosis Code (ICD-10): _____ Procedure Code (CPT): _____

COST BREAKDOWN

Consultation Fee: _____ Procedures/Services: _____
Medications: _____ Other Charges (specify): _____
Total Amount Claimed: _____

PROVIDER CERTIFICATION

I certify that the information provided in this claim is true and accurate to the best of my knowledge. I understand that providing false information may result in the denial of the claim.

Signature: _____
Date: _____ dd / mm / yyyy