

# MEDICAL INSURANCE CLAIM FORM

### Patient Information

Name	
Date of Birth	
Phone	
Address	

### Insurance Information

Insurance Company	
Policy Number	
Policy Holder Name	
Relationship to Patient	

### Medical Service Information

Date of Service	
Doctor / Clinic Name	
Reason for Visit	
Treatment Provided	
Total Charges	
Amount Paid	

### Authorization

I confirm that the information provided is correct.

Signature:

Date:

