Medical Insurance Claim Form

Patient Information

Patient Name: _____

Date of Birth: _____

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: _____

Description of Service/Procedure: _____

Diagnosis Code (ICD-10): _____

Procedure Code (CPT): _____

Cost Breakdown

Consultation Fee: _____

Procedures/Services: _____

Medications: _____

Other Charges (specify): _____

Total Amount Claimed: _____

Supporting Documents

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: _____