Medical Insurance Claim Submission Template

Claim Submission Form

1. Patient Information

- Patient Name: _____
- Patient Date of Birth: _____
- Patient ID Number: _____
- Patient Address: _____
- Patient Phone Number: _____

2. Policyholder Information (if different)

- Policyholder Name: _____
- Policyholder Date of Birth: _____
- Policyholder ID Number: _____
- Policyholder Relationship to Patient: _____

3. Insurance Information

- Insurance Company Name: _____
- Policy Number: _____
- Group Number: _____
- Claims Address: _____

4. Claim Details

- Date of Service: _____
- Type of Service: _____
- Diagnosis Code(s): _____
- Procedure Code(s): _____
- Provider Name: _____
- Provider NPI Number: _____
- Total Charges: _____
- Amount Paid by Patient: _____

5. Additional Information

- Reason for Claim Submission: _____
- Attached Documents (check all that apply):
- [ ] Itemized Bill
- [ ] Medical Records
- [ ] Lab Results
- [ ] Referral Information
- [ ] Other: _____

6. Signature and Date

- Patient/Policyholder Signature: _____
- Date: _____

Instructions for Submission

- Please ensure all fields are completed accurately.
- Attach all required documents.
- Submit to the designated claims address for your insurance provider.
- Keep a copy of the submission for your records.

Contact Information for Follow-Up

- Customer Service Phone Number: _____
- Email Address: _____
