Health Insurance Proof of Loss Documentation

Policyholder Information

| Name |
|--------------------------------------------------------------------|
| |
| Policy Number |
| |
| Date of Birth |
| |
| Phone Number |
| |
| • • • • |
| Address |
| |
| |
| Claim Information |
| Patient Name |
| |
| Date of Loss |
| |
| |
| Description of Loss/Illness |
| |
| |
| Provider Name |
| |
| Amount Claimed |
| |
| Other Insurance Coverage |
| |
| |
| Supporting Decumentation |
| Supporting Documentation |
| List of attached documents (e.g. bills, receipts, medical reports) |
| |
| |
| |
| |
| Declaration and Signature |
| |
| |
| |
| |

| Signature o | f Policyholder |
|-------------|----------------|
|-------------|----------------|

Date