Health Insurance Claim Authorization Form

Policyholder Information

Full Name

Policy Number

Date of Birth

Phone Number

Address

Patient Information

Patient Name

Relationship to Policyholder

Date of Birth

Gender

Claim Details

Type of Claim

Date(s) of Service

Healthcare Provider/Facility

Diagnosis / Reason for Claim

Claim Amount

Authorization

I authorize the release of any medical information necessary to process this claim. I certify the statements above are true and complete.

Signature of Policyholder

Date