Health Insurance Claim Proof of Loss Form

1. Policyholder Information

Policy Number

Name of Insured

Date of Birth

Contact Number

Address

2. Patient Information (if different from Policyholder)

Patient Name

Relationship to Policyholder

Date of Birth

3. Claim Details

Date of Loss/Illness/Injury

Nature of Illness/Injury

Description of Incident

Diagnosis / ICD Code

4. Treatment & Provider Information

Name of Hospital/Provider

Date(s) of Treatment

Treatment/Services Rendered

5. Other Insurance Information

Is there any other insurance applying to this loss?

If yes, provide details

6. Claimant Declaration

Name

Signature

Date