**HOSPITAL INSURANCE ELIGIBILITY CONFIRMATION FORM**  
*For Insurance Reimbursement Purposes*

**Section 1: Patient Information**

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| --- | --- | --- | --- |
| **Full Name:** |  | | |
| **Date of Birth:** |  | **Gender:** | ☐ Male ☐ Female ☐ Other |
| **National ID:** |  | **Patient ID:** |  |
| **Phone Number:** |  | **Email Address:** |  |
| **Residential Address:** |  | | |

**Section 2: Treatment Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Hospital Name:** |  | | |
| **Hospital Address:** |  | | |
| **Date of Admission:** |  | **Date of Discharge:** |  |
| **Diagnosis:** |  | | |
| **Nature of Treatment/Procedure:** |  | | |
| **Treating Physician’s Name:** | |  | |
| **Registration/License #** | |  | |

**Section 3: Insurance Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Insurance Provider:** |  | | |
| **Policy Number:** |  |  |  |
| **Group/Corporate Plan Name: (if applicable)** | |  | |
| **Policyholder Name (if different from patient):** | |  | |
| **Relationship to Patient:** | | ☐ Self ☐ Parent ☐ Spouse ☐ Other: | |

**Section 4: Hospital Confirmation**

This is to certify that the patient named above was treated at our facility on the dates mentioned, and the information provided is accurate based on hospital records. The patient is eligible for submission of an insurance claim for reimbursement of medical expenses incurred.

|  |  |
| --- | --- |
| **Total Treatment Cost (Attach Invoice):** |  |
| **Hospital Representative Name:** |  |
| **Designation:** |  |
| **Signature Stamp & Date:** |  |

**Attachments Required:**

* Discharge Summary
* Medical Bills/Invoices
* Prescriptions and Reports
* Insurance Card Copy
* National ID Copy

**Declaration by Patient/Applicant**

I hereby declare that the above information is true and correct to the best of my knowledge. I understand that any false statement may result in denial of insurance reimbursement.

|  |  |
| --- | --- |
| **Signature of Patient/Applicant:** |  |
| **Date:** |  |