Policy Number(s)

Medical Indemnity Claim Form
(Attending Physician's Statement)

Important Notes:

1. This form is to be accomplished by the Attending Physician.
2. Please write legibly in BLOCK LETTERS. Do not sign on a blank form.
3. Please shade the circle to indicate your choice(s).

FOR OFFICE USE ONLY

Date Received:

Time Received:

Receiving Dept./Office:

FOR DISTRIBUTOR'S USE ONLY

FE/Advisor's code:

FE/Advisor's name:

FE/Advisor's mobile number:

1. Claim Types:

◯ Hospitalization

2. General Information:

Full Name of the Patient:

Date of Birth: (yyyy/mm/dd)

3. Your Association with the patient:

Are you related to the patient? ◯Yes ◯No **If "Yes", please provide details below:**

Relationship:

No. of years you have known the patient

Are you the attending physician of the patient prior/during his/her medical consultaion?

◯ Yes ◯ No **If "Yes", please provide details below:**

Date when you first attended the patient

Chief complaints of the patient

4. Particulars of Medical Consultation:

What illness/condition is the patient suffering from?

Date of Consultation:

If Medical consultation is due to illness, please provide details below:

Symptoms/Complaints for Consultation:

Date Symptoms Discovered:

Date of First Consultation:

If Medical consultation is due to accident, please provide details below:

Details of injury(ies) sustained:

Date & time of accident:

Place of accident:

Please state below details of your Diagnosis and the Medical Treatment/Management given to the Patient:

Complete diagnosis:

Treatment/management:

Prognosis:

Has the insured been hospitalized? ◯ Yes ◯ No **If "Yes", please provide details below:**

Date of Admission:

Date of Discharge:

Name of the Hospital:

Contact Details:

Aside from you, did other physicians attend the patient during his/her confinement?

◯ Yes ◯ No. **If "yes", please provide details below:**

Name:

Contact Details:

Please state all tests performed during the consultation and/or confinement of the patient:

5. Declarations And Authorizations:

I hereby certify that I have personally examined and treated the Patient in connection to the above condition and that the facts as given above present my opinion of his/her condition. I declare and agree to make the declaration on this claim form.

Name of Physician:

Signature:

Place of Signing:

Date of Signing: (yyyy/mm/dd)

Field of Specialization:

License No:

Clinic Address:

Mobile No.:

Clinic Tel. No.: