redefining / standards

Policy Number(s)

Critical Illness 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:

◯ ELI

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 regarding his/her illness? ◯ Yes ◯ No

If "Yes", please provide details below:

Date when you first attended the patient

Chief complaints of the patient

4. Particulars of the Illness:

What illness is the patient suffering from?

Date of diagnosis of the Patient's Illness:

Did you inform the patient regarding the illness? ◯ Yes ◯ No **If "Yes" when?**

Complete diagnosis: (including staging/classification if any, etc.)

State the test(s) or work up(s) conducted and a brief description of their results (i.e. X-ray, ECG, Biopsy, CT-Scan etc.)

Details of treatment/management: (including surgery if any, etc.)

Prognosis:

Aside from you, did other physicians attend to the patient regarding his/her illness?

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

Name:

Contact Details:

5. Details of your past consultations on the patient:

Date (yyyy/mm/dd)	Diagnosis	Treatment

6. Declarations:

I hereby certify that I have personally examined and/or 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.: