

ATTENDING PHYSICIAN'S STATEMENT – Hospital Income & Medical/ Surgical Expense Reimbursement Benefit

(Instruction : This form shall be accomplished by each and every attending physician on the injury sustained by the insured)

The person whose name appears below is insured with us against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with his/her insurance policy. To enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

A. General Data of the Patient

Name of the Patient	Date of Birth
Are you the patient's regular physician?	How long has the patient been under your care?

B. Hospitalization/Consultation Details

Name & Address of the Hospital /Clinic			
Date of Admission/Consultation	Ward/Room No :	Date of Discharge	
Chief Complaints / Concurrent Conditions			
Laboratory / Diagnostic Procedures conducted			
Date	Laboratory Test	Diagnostic Procedure	Results
Treatment / Medications Given		Diagnosis	
Cause of Hospitalization: <input type="checkbox"/> Illness <input type="checkbox"/> Accident		Date & Time of Accident Place of Accident	
Extent of Injury : <i>Please specify below (specify which particular part of the body)</i>			

NAME OF THE PATIENT : _____

Name, First Name, Middle Name

Is consultation/treatment on injury/ailment is related or due to <input type="checkbox"/> <i>Pregnancy, infertility, sub-fertility or childbirth? If for pregnancy, what was the approximate date of commencement?</i> <input type="checkbox"/> <i>self-inflicted injury or sexually transmitted disease? Please specify</i> <input type="checkbox"/> <i>congenital anomaly, nervous or mental disorder? Please specify.</i> <input type="checkbox"/> <i>surgery for cosmetic reasons? Please specify</i> <input type="checkbox"/> <i>a job-related injury?</i> <input type="checkbox"/> <i>Infection or out of consequent upon or contributed to by Acquired Immune Deficiency Syndrome (AIDS)</i> <input type="checkbox"/> <i>Alcoholism or drug addiction</i> <input type="checkbox"/> <i>Mental or nervous disorders</i> <input type="checkbox"/> <i>By poison, gas or fumes voluntarily taken</i> <input type="checkbox"/> <i>Others, which are not specified above</i>	Please Specify			
Are you the one who duly recommended and approved the hospitalization? YES [<input type="checkbox"/>] NO [<input type="checkbox"/>]	If no, was it the patient's choice? If no, please provide name/s of the other physician/s			
Was surgical operation suggested? YES [<input type="checkbox"/>] NO [<input type="checkbox"/>] Was surgical operation performed? YES [<input type="checkbox"/>] NO [<input type="checkbox"/>] <i>If Yes, please indicate below</i>				
Date	Type of Operation	Name & Address of Hospital		
Was recovery uncomplicated and the period of hospitalization is normally expected for this type of case [<input type="checkbox"/>] YES [<input type="checkbox"/>] NO	If no, what factors hampered recovery and/or prolonged the period of hospitalization ?			
What is your prognosis? GOOD [<input type="checkbox"/>] POOR [<input type="checkbox"/>]				
Do you know of any medical problem/s the patient had in the past ? YES [<input type="checkbox"/>] NO [<input type="checkbox"/>] <i>if Yes pls provide details below</i>				
Date	Complaints/Symptoms	Diagnosis	Treatment	From - To
Rehabilitation / Physical Therapy Details :				
Date	Hospital/Institution	Type of Therapy	Duration	

DECLARATION

I hereby certify that the answers and information given above are full, complete and true.

AUTHORIZATION

I further authorize your Medical Director or any of his/her authorized representative or other person in your employ, to obtain or secure from me or any clinic, hospital or entity all the medical records of the above-named patient. A photographic copy of this authorization is valid as the original.

 Signature Over Printed Name of the
 Attending Physician

Date _____

License No :

Address :

