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.:**