HOSPITALISATION CLAIM - ATTENDING PHYSICIAN'S STATEMENT

Certificate No. | | | | | | | | | | New NRIC No. | | | | | | - | | - | | | |

Certificate No. | | | | | | | | | |

Name of Patient (Person Covered)

The above name is covered with GREAT EASTERN TAKAFUL BERHAD against the happening of certain contingent events associated with his / her health. A claim has been submitted for Hospitalisation benefit and to enable us to assess the claim, kindly complete this confidential report.
(For any fee incurred in completing this form, it will be borne by claimant)

DECLARATION: TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SPECIALIST

I hereby certify that :

☐ I am the patient's attending doctor, and I have personally examined and treated the patient for the illnesses and injuries sustained; OR

☐ This medical report has been prepared on behalf of the treating doctor based on medical records.

Name:

Signature and Official Stamp

TO BE COMPLETED FOR CLAIMS CAUSED BY ACCIDENT (NOT APPLICABLE FOR ILLNESS CONDITION)

1) Accident

a) Date and Time of Accident: ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) Time ☐☐ : ☐☐ AM/PM

b) Please describe how the accident occurred

c) Nature and extent of injury(ies) sustained
(please include mechanism of injury)

TO BE COMPLETED FOR CLAIMS CAUSED BY ACCIDENT OR ILLNESS

2) Are you the patient's regular doctor

☐ If "NO", please provide name of clinic/hospital with regular doctor's name

☐ If "YES", since when? ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

3) Blood Pressure / Temperature/ Pulse Rate

BP _____mmHg, Temperature _____ºC, Pulse _____beat per minute

4) Symptom(s) during FIRST consultation. (Please indicate what had prompted the Patient to see you.)

Symptom(s) complained by the Patient	Date of symptoms first presented and/or Duration of symptoms presented prior to first consultation	Based on your professional opinion, what is the duration of symptoms presented prior to first consultation?

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5) Diagnosis

a) Full and Exact Diagnosis?

b) Date patient FIRST consulted you for this illness — ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

c) Date the illness was FIRST diagnosed — ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

d) Date of diagnosis was first informed to patient — ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

e) Did the patient already know or was made aware of this diagnosis before the first consultation with you? ☐ No ☐ Yes If "Yes", pleave provide following:

i) Since when? (please indicate exact if possible) _____

ii) Name of doctor and clinic/ hospital illness diagnosed:

f) What is the underlying cause(s)/ pathology/ mechanism of injury/ medical comorbidities for the above diagnosis?

6) Hospitalisation Details

a) Name of Hospital

b) Date of Admission/Day Surgery — ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) Time ☐☐ : ☐☐ AM/PM

c) Date of Discharge — ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) Time ☐☐ : ☐☐ AM/PM

d) For surgery/procedure:

(i) Date(s) of surgery/procedure performed — ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

(ii) Indication and Nature of surgery/ procedure performed

(iii) Name of Surgeon(s)

(iv) MMA OPCS code/PHFSR code

7) Type of investigation, test or procedure done (Please tick and furnish us the details or certified true copy of result.)

☐ Laboratory ☐ Ultrasound ☐ X-ray ☐ EEG ☐ Echocardiogram ☐ Histopatholgy (HPE) ☐ Scope _____

☐ Urine FEME ☐ CT/MRI ☐ PET scan ☐ ECG ☐ Stress Test ☐ Others, Please specify: _____

8) Please state details of treatment given or planned to be performed (including follow up details)

Date of Consultation	Type of Treatment/Further Follow-up plan	Progression/ Prognosis of Illness (If there is any complications, please provide the details)

9) Has the patient consulted any other doctors for this condition(s)/symptom(s) before consulting you? ☐ No ☐ Yes
(If "Yes", please provide a copy of referral letter or memo if available)

Date of Consultation	Diagnosis/Reason for Consultation and Details	Name of Doctor, Clinic/Hospital and Address

10) Has patient consulted you or other doctors for any other diseases/complaints/pathologies as either an outpatient or inpatient?
☐ No ☐ Yes If "Yes", please provide details:-

Date of Consultation	Diagnosis/Reason for Consultation and Details	Name of Doctor, Clinic/Hospital and Address

11) Was the illness/condition caused directly or indirectly by the following condition(s). If yes, please tick the appropriate box.

☐ Pregnancy/Childbirth/Caeserean/Miscarriage/Prenatal/Postnatal/Sterilization/Infertility or any complication arising thereof

☐ Congenital Conditions or Deformities including Hereditary Conditions

☐ Drug abuse/Intoxication/influence of alcohol (please provide sample urine/blood test report)

☐ Nervous/Mental/Emotional/Sleeping Disorder/Alternative Therapy/Hormone Replacement Therapy

☐ Cosmetic surgery/Refractive errors correction/Dental Treatment

☐ AIDS/HIV/STD/VD

☐ Suicide/Attempted Suicide/Self-inflicted injuries/Violation of laws/Strike/Riot/Insurrection

☐ None of the above

12) Do provide us with any other additional information you would like to share with regards to this patient.

Note:
Please enclose copies of all reports that are available with you (including Histopathology examination(HPE)/Biopsy, Blood and Laboratory test results, Radiological report and any relevants reports). If not submitted, company reserves the right to defer for further verification.

DECLARATION: TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SPECIALIST

I, the undersigned, certify that I have examined the above Person Covered and all statements made and answers given are true and to the best of my knowledge and belief.

Signature and Official Stamp

Name:

Address:

Contact No:

Date: ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)