PHILAM LIFE

CERTIFICATE OF ATTENDING PHYSICIAN

Hospitalization / Medical Reimbursement Claim

Kindly have this form accomplished by the attending physician.

1.	(a) Full Name of PATIENT First Middle Last		(b) Are you related to the patient? ☐ Yes ☐ No If yes, what is the relationship?
2.	Nature of complaint	☐ Accident ☐ Sickness	
3.	What is your Diagnosis? (Please Print)		
4.	What are its contributory causes?		

Accident Information

5.	Nature of Accident	☐ Road Traffic Accident ☐ Hit by a Heavy Object / Person ☐ Fire, Explosion, Hot Substance ☐ Attacked / Bitten by Insect / Animal ☐ Natural Disaster / Environmental			☐ Accidents caused by Machinery ☐ Pricked by a Sharp Object ☐ Accidental Fall ☐ Cut by Substance / Device	
		☐ Others	Please Specify:			
6.	Describe the circumstances of the accident fully and briefly					
7.	Date of Accident Place of Accident	Date and Time	mm	dd	yyyy	Time ☐ AM ☐ PM
		House No./Street/Bldg				
		Subdivision/Brgy/District				
		Town/City and Province				

Treatment Information (whether Accident or Sickness)

8.	Outpatient treatment / consultation	☐ Yes ☐ No				
		Date of 1st consultation	mm	dd	yyyy	Consultation Time, if availiable ☐ AM ☐ PM
9.	Hospital Confinement	☐ Yes ☐ No				
		Hospital Name				
		Admission Date	mm	dd	yyyy	Admission Time ☐ AM ☐ PM
		Discharge Date	mm	dd	yyyy	Discharge Time ☐ AM ☐ PM

10.	Was any body part amputated/have lost its use?	☐ Yes ☐ No			Specify body part that was amputated/have lost its use				
11.	(a) Was surgery done?	☐ Yes ☐ No			Type of Surgery				
	(b) Date of Surgery	mm	dd	yyyy					
12.	(a) When did the symptoms of the sickness begin?	mm	dd	yyyy	(b) When did the condition fiirst originate?	mm	dd	yyyy	

13.	Names and addresses of all doctors or hospitals who previously treated the patient:			
	Name	Address	Treatment Dates	Disease or Condition

14.	Is the patient disabled?	☐ Yes ☐ No						
		If yes, state duration of disability	from			to		
			mm	dd	yyyy	mm	dd	yyyy

15.	Is the patient diagnosed with Cancer?	☐ Yes ☐ No		
	If yes, please indicate the outpatient and chemotheraphy treatments below:			
	Name of Doctor/Clinic	Address	Treatment Dates	Type of treatment

16.	Is the patient's condition a mental or nervous disorder?	☐ Yes	☐ No
17.	Is the treatment related to pregnancy, miscarriage, abortion or childbirth?	☐ Yes	☐ No
18.	Is the condition sustained from being intoxicated or under the influence of drugs?	☐ Yes	☐ No
19.	Is the condition sustained from alcoholism or drug addiction?	☐ Yes	☐ No
20.	Is the treatment for routine physical check-up, rest cure, or special nursing care?	☐ Yes	☐ No
21.	Is the patient's condition congenital?	☐ Yes	☐ No
22.	Is the treatment for cosmetic reasons, a dental treatment or an elective surgery?	☐ Yes	☐ No
23.	Is the treatment for circumcision, sterilization, artificial insemination, sex transformation, or treatment of infertility?	☐ Yes	☐ No
24.	Is the patient's condition AIDS-related or due to a sexually transmitted disease?	☐ Yes	☐ No

25.	(a) Doctor's Full Name in print		(b) Doctor's Signature	
26.	Doctor's Clinic Address	House No./Street/Bldg		
		Subdivision/Brgy/District		
		Town/City and Province		
27.	(a) PRC License Number		(b) Date this form was accomplished	