AmMetLife Insurance Berhad (15743-P)
(Formerly known as AmLife Insurance Berhad) Licensed Insurer
Level 19, Menara AmMetLife, No. 1, Jalan Lumut, 50400 Kuala Lumpur
1300 88 8800 +603 2171 3000 customercare@ammetlife.com
Type AML<space>message send to 33911 ammetlife.com

AmMetLife

HOSPITALISATION CLAIM – ATTENDING PHYSICIAN'S STATEMENT

Part 2 (to be completed by the attending physician at Life Assured's expense)

1. Patient 's Name*

2. NRIC No.*
(Old) (New) - -

3. i. Admission No.
iii. Discharge Date/Time
ii. Admission Date/Time

4. The date on which you first saw the patient for this illness/injury/condition.

5. Was the patient referred to your hospital by any other doctor? If yes, please indicate his / her name and address.

6. What were symptoms the patient complained when he/she first saw you?

7. i. According to the patient, how long has he/she been experiencing these symptoms?
ii. How long do you feel these symptoms have lasted?

8. Has the patient previously received any treatment for the above symptoms? If so, please furnish name, address of doctors and dates of consultation.

9. Have any investigation, test or procedure been performed? If so, please furnish a certified true copy of the result.

10. i. What was your diagnosis?.
ii. Did you inform the patient of the diagnosis?. If so, when?

* Obligatory / *Wajib*

11. Nature of medical treatment given

12. For surgery:
   i. What was your diagnosis?

   ii. Date of surgery performed

   iii. Nature of operation performed

13. Any possibility of patient having a relapse?

14. Has the patient previously been treated or hospitalized in this or any other hospital for this or any other diseases?, Please state.

Date	Disease / Illness	Hospital / Clinic

15. For female only
   i. Was the patient pregnant at the time of hospitalisation? If so, for how many months?

   Ii. Was illness caused directly or indirectly by pregnancy/child birth/caesarean section/abortion/miscarriage and all complications arising from there?

Declaration

I hereby certify that the answers above are full, complete and true to the best of my knowledge.

Name of Physician : ______________________

Telephone no : ______________________

Qualification/Rank : ______________________

Date : ______________________

Signature &
Clinic / Hospital : ______________________
Stamp