



## AmAssurance

AmAssurance Berhad  
Penanggung Insurans Berlesen (15743-P)  
A member of the AmBank Group

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### HOSPITALISATION CLAIM – ATTENDING PHYSICIAN'S STATEMENT

#### Part 2 (to be completed by the attending physician at life assured's expense)

1.	Patient's name : _____	I.C. No : _____
2.	i. Admission No : _____	ii. Admission Date/Time : _____
		iii. Discharge Date/Time : _____
3.	If hospitalisation due to accident, please furnish	
	i. Date of accident _____	Time of accident _____
	ii. Nature of accident _____	
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 patient, how long had she/he been experiencing these symptoms? _____	
	ii. How long do you feel these symptoms had lasted? _____	
8.	Had patient previously received any treatment for 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? _____

11 Nature of medical treatment given

\_\_\_\_\_  
\_\_\_\_\_

12 For surgery:

i. Name of surgeon \_\_\_\_\_

iii. Nature of operation performed \_\_\_\_\_

ii. Date surgery performed \_\_\_\_\_

13 Any possibility of patient having relapse? \_\_\_\_\_

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

Date

Disease/Illness

Hospital/Clinic

15 For female only

i. Was the patient pregnant at 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 there from?  
\_\_\_\_\_

### Declaration

I hereby certify that the answers above are full, complete and true to the best

\_\_\_\_\_  
Signature

Date: \_\_\_\_\_

Name of Physician : \_\_\_\_\_

Clinic/Hospital Stamp:

Qualification : \_\_\_\_\_

Telephone no. : \_\_\_\_\_