Hospital Cash Benefit Claim Form

To be completed by Attending Physician

Policy Number

1. Information of the insured

Name of Insured (Title, First Name, Middle Name, Last Name)

2. Attending physician's statement

To enable us to evaluate the claim for Hospital Cash Benefit, this section must be completed by the Attending Physician providing complete and detailed answers to the following questions:

Association with the Patient

1. Are you the regular physician of the patient? ☐ Yes ☐ No
2. Are you related to the patient? If Yes, please state relationship: ☐ Yes ☐ No ______
3. How long have you known the patient? ______

General Information

1. Confinement Details

a. Regular Confinement:	b. ICU Confinement:
a1. Date Admitted and Discharged:	b1. Date Admitted and Discharged:
c. Name of Hospital:	

2. What are the chief complaints of the patient?

3. Please provide details for the following:

a. When did you first attend the patient for his present condition?
b. What are the signs/symptomps experienced by the patient?
c. Date when signs/symptoms were first experienced?
d. How long do you believe the signs/symptoms had been present when you were first consulted?
e. Describe the underlying cause of patient's condition.

4. To the best of your knowledge, does the patient had any other illness or impairments? ☐ Yes ☐ No

If Yes, state what are these illnesses/impairments and when were these experience.

a. Nature of illness, disease or impairments	b. Inclusive dates of illness	c. If confined or treated, Name of Clinic/Hospital

5. Please provide other consultations you had with the patient.

a. Inclusive Dates	b. For what reason have you attended the patient

6. What was your final and complete diagnosis? (Please include any complications and stage of illness)

3. Attending physician's affirmation

This is to certify that the above statements are true and complete to the best of my knowledge and belief. I allow FWD to collect and store my personal data specified below to process this Claim Form and contact me for any clarification regarding the statements I provided in this Form.

______ Attending Physician's Signature over Printed Name

______ Date Signed

______ Complete Clinic/Hospital Address

______ Telephone number / Mobile Number

Lic No: ______

PTR No: ______

______ Field of Specialization

______ Email Address

Please do not sign on blank form