

## **52** Cutpatient (OPD) Claim Form for Accident, Illness

Hospital Name.....  $\hfill\square$  Group Insurance

1. Name Summer (disperd minimider)	For the Insured Person		
Mobile priors runther:	1. Name-Surname (Insured member) Sex: ☐ mal	e 🗌 female National identity number:	
Current and allow sociots, medical combes, other insurance company   No   Yes Company;   No   Yes Yes Company;   No   Yes	Date of birth:	ns Occupation:	
2. Inserance policy number:    Insurance policy number:   Insurance policy	Mobile phone number:Landline:	E-mail:	
Do you hold other insurance policies underwritten by another insurance company. ☐ No ☐ Yes Company. Yes	Current address:		
Tearning policy number	2. Insurance policy number:	Certificate number (if any):	
Beasons for making this claim   Dieses   For Now long have you suffered from the illness before receiving medical treatment?   Date of treatment	Do you hold other insurance policies underwritten by another insurance company? $\square$ No	□ Yes Company:	
Illiness Symptoms   Date of the injun;	Insurance policy number:		
Illiness Symptoms   Date of the injun;	3. Reasons for making this claim		
James   Date of the medical confer where you were treated before this investment:	_	suffered from this illness before receiving medical treatment?	
	<del> , </del>	-	
States of the injuly.  Network of wounds(s), size, and the injured body part(s)  Network of wounds(s), size, and the injured body part(s)  Network of wounds(s), size, and the injured body part(s)  Network of the state of this accident? □ No. I have not been treated □ ves, I have been breated at:  □ partial: Symptoms:  Teatment:  □ Date of treatment: □ Date of tre	•		
Nature of wound(s), size, and the injured body part(s):    Lake you be man beard for this accident?   Mo, I have not been treated   Yes, I have been treated at:   Date of treatment:	<del></del>		
Have you been treated for this accident? □ No, 1 have not been treated at: □ Date of treatment. □ Date of D			
Light   Symptoms:			
	•		
I, hereby, consent and allow doctors, medical centres, other insurance companies or any relevant persons who have acquired my personal information to the Company, the Company is the insurance agents, or the Company is prospected history with over available or will be available to disclose and release such information to the Company, the Company is the insurance agents, or the Company is presentatives in order to apply for an insurance policy, in order to apply for an insurance policy, and in the benefit thereof, or deciding with the misurance policy in any manner.  In the event of a claim of indemnification through a hospital, I, hereby, consent and allow the Company to pay the medical fees to the medical centres from which I have received the reastment as if the Company has legally indemnification of such expenses under the terms and conditions of the insurance policy. Nevertheless, I will directly and insurance policy and interest of cellang with the insurance policy and interest of acquired the insurance policy. Nevertheless, I will directly and presented the reastment as if the Company has legally indemnification of such expenses under the terms and conditions of the insurance policy. Nevertheless, I will directly and presented in the company in payment of any outstanding medical frees which are not evered by the insurance policy. Nevertheless, I will directly and presented in the Company that is sufficient to the company of payment of any outstanding medical fees within a micro-decidence with the properties of the insurance policy. Nevertheless, I will directly and present payment of any outstanding flower the switch are not becomed to the medical centres on my behalf within (Sewen) days from the date of the notice by the Company. I also agree that the Company reserves the rights to be assurance to the medical centre on my behalf within (Sewen) days from the date of the notice by the Company.  Additionally, the copy of this Letter of Consent shall be binding as same as the original.  I, hereby, (uly day ak	□ <u>Dental</u> : Symptoms:	Date of treatment:	
records, disability, sexual behaviour, biometric data, genetic data, and my past or future medical history which were available or will be available to disclose and release such information to the Company, the Company's Efferishment agents, or the Company's presentatives in order to apply for an insurance agents, or the Company to collect, use, disclose and release suph of the final property of the final property of the final property of the company to collect, use, disclose and release my personal information, health, medical records, disability, sexual behaviour, biometric and its representatives for the purpose of applying for an insurance policy, indemnifying the insurance policy in any manner.  In the event of a dain of indemnification through a hospital, I, hereby, consent and allow the Company to pay the medical fees to the medical centeres received the treatment as if the Company has logally indemnified med of such expenses under the terms and conditions of the insurance policy and personally make payment of any outstanding medical fees which are not covered by the insurance policy. Also, I fully appreciate that the Company reserves the rights to determine policy in any manner.  In the event of a dain of indemnification of such expenses under the terms and conditions of the insurance policy. Also, I fully appreciately the terms and canning found to the exempted under the insurance policy despite the Company's preliminary approval of my inaptient restment. In this case, I shall reimburse the Company of all expenses it has advanced to the medical expenses the or the other of the country and the company of all expenses it has advanced to the medical center on my behalf within 7 (execyt) days from the edited of the medical expenses to the formation of the insurance policy despite the Company of all expenses it has advanced to the medical expenses on my behalf within 7 (execyt) days from the edited of the expenses of the Company of all expenses it has advanced to the medical expenses on my behalf within 7 (e			
1. Visit date: Time: Vital signs: T: P: R: BP: 2. Chief complaint duration: 3. Present illness or cause of injury:  For Injury: Date of injury. Time:Place of injury:	records, disability, sexual behaviour, blometric data, genetic data, and my past or future medical history which were available or will be available to disclose and release such information to the Company, the Company's life insurance agents, or the Company's representatives in order to apply for an insurance policy, or claim the benefit thereof, or dealing with the insurance policy in any manner.  I, hereby, grant my consent to the Company to collect, use, disclose and release my personal information, health, medical records, disability, sexual behaviour, biometric data, genetic data, and my past or future medical history to the competent authorities or the reinsurers, relevant persons, the Company's life insurance agents, its personnel, and its representatives for the purpose of applying for an insurance policy, indemnifying the insured person thereunder, or for medical interest or dealing with the insurance policy in any manner.  In the event of a claim of indemnification through a hospital, I, hereby, consent and allow the Company to pay the medical fees to the medical centres from which I have received the treatment as if the Company has legally indemnified me of such expenses under the terms and conditions of the insurance policy. Nevertheless, I will directly and personally make payment of any outstanding medical fees which are not covered by the insurance policy. Also, I fully appreciate that the Company reserves the rights to indemnify according to the campaign of payment of the medical expenses through hospitals if the illness or accident which I am claiming found to be exempted under the insurance policy despite the Company's preliminary approval of my inpatient treatment. In this case, I shall reimburse the Company of all expenses it has advanced to the medical centre on my behalf within 7 (seven) days from the date of the notice by the Company.  Additionally, the copy of this Letter of Consent shall be binding as same as the original.  I, hereby, fully acknowledge and understand the content as well		
2. Chief complaint duration: 3. Present illness or cause of injury:  For Injury: Date of injury			
For Injury: Date of injury.  For Injury: Date of injury.  For Injury: Date of injury.  Time:			
For Injury: Date of injury	2. Chief complaint duration:		
For Injury: Date of injury. Time: Place of injury: Details of injury: Physical exam: Physical exam: Place of injury: Details of injury: Details of injury: Physical exam: Physical exam: Details of injury influenced by alcohol or drug addict: ( ) No ( ) Yes, please specify Previous treatment for this illness or injury influenced by alcohol or drug addict: ( ) No ( ) Yes, please specify Previous Pregnancy / Childbirth / Infertility / Caesarean section / Miscarriage Congenital / Hereditary disease Influence of Drugs / Alcohol Anacy / Mental / Emotional / Sleeping disorder Influence of Drugs / Alcohol Anacy / Alcohol Anacy / Anacy / Anacy / Alcohol / Alcohol Anacy / Alcohol / Alcohol / Anacy / Alcohol /	Present illness or cause of injury:		
4. Physical exam:    Congenital   Frevious treatment for this illness or injury (Date & Place):			
5. Previous treatment for this illness or injury (Date & Place):  6. The illness or injury influenced by alcohol or drug addict: () No () Yes, please specify  7. Is the illness related to: (please tick ☑ if yes)  □ Pregnancy / Childbirth / Infertility / Caesarean section / Miscarriage □ Nervous / Mental / Emotional / Sleeping disorder □ Cosmetic reason / Dental care / Refractive errors correction □ An accident; Date of accident: □ Influence of Drugs / Alcohol □ An accident; Date of accident: □ Investigation & Result (Lab, EKG, X − ray, etc.): □ Diagnosis: □ Treatment: □ Surgery/Operation: □ Anaesthesia Type: () General Anaesthesia () Spinal Anaesthesia () Others □ Pathological report: □ Invertigation in the facts are in my opinion as given above.  Physician's signature  Medical specialty: Medical specialty: Medical license no: Date:	For Injury: Date of injuryPla	ce of injury:Details of injury:	
5. Previous treatment for this illness or injury (Date & Place):  6. The illness or injury influenced by alcohol or drug addict: ( ) No ( ) Yes, please specify  7. Is the illness related to: (please tick ☑ if yes)  □ Pregnancy / Childbirth / Infertility / Caesarean section / Miscarriage □ Nervous / Mental / Emotional / Sleeping disorder □ Cosmetic reason / Dental care / Refractive errors correction □ An accident; Date of accident: □ Time: □ None of above  8. Underlying condition: 9. Investigation & Result (Lab, EKG, X − ray, etc.): 10. Diagnosis: 11. Treatment: 11. Surgery/Operation: Anaesthesia Type: ( ) General Anaesthesia ( ) Spinal Anaesthesia ( ) Local Anaesthesia ( ) Others  12. Pathological report: 14. Investigation & Medical specialty: Medical specialty: Medical specialty: Medical license no:  Medical license no:  Medical license no:  Date:	4. Physical exam:		
6. The illness or injury influenced by alcohol or drug addict: ( ) No ( ) Yes, please specify  7. Is the illness related to: (please tick ☑ if yes)  □ Pregnancy / Childbirth / Infertility / Caesarean section / Miscarriage □ Nervous / Mental / Emotional / Sleeping disorder □ Cosmetic reason / Dental care / Refractive errors correction □ An accident; Date of accident:			
6. The illness or injury influenced by alcohol or drug addict: ( ) No ( ) Yes, please specify  7. Is the illness related to: (please tick ☑ if yes)  □ Pregnancy / Childbirth / Infertility / Caesarean section / Miscarriage □ Nervous / Mental / Emotional / Sleeping disorder □ Cosmetic reason / Dental care / Refractive errors correction □ An accident; Date of accident:	5. Previous treatment for this illness or injury (Date & Place):		
7. Is the illness related to: (please tick ☑ if yes)  □ Pregnancy / Childbirth / Infertility / Caesarean section / Miscarriage □ Nervous / Mental / Emotional / Sleeping disorder □ Cosmetic reason / Dental care / Refractive errors correction □ AIDS □ An accident; Date of accident:	• , , , , ,		
□ Pregnancy / Childbirth / Infertility / Caesarean section / Miscarriage □ Congenital / Hereditary disease □ Nervous / Mental / Emotional / Sleeping disorder □ Influence of Drugs / Alcohol □ AIDS □ An accident; Date of accident: □ Time: □ None of above		- specify	
Nervous / Mental / Emotional / Sleeping disorder   Influence of Drugs / Alcohol   Influenc	. , ,	<b>-</b> 0 21/11 12 15	
□ Cosmetic reason / Dental care / Refractive errors correction □ An accident; Date of accident:			
An accident; Date of accident: Time: None of above  8. Underlying condition: 9. Investigation & Result (Lab, EKG, X – ray, etc.): 10. Diagnosis: ICD10-TM: 11. Treatment: 11. Surgery/Operation: Date performed: ICD9-CM: Anaesthesia Type: () General Anaesthesia () Spinal Anaesthesia () Local Anaesthesia () Others 12. Pathological report: I hereby certify that I have personally examined and treated the insured in connection with the disability and that the facts are in my opinion as given above.  Physician's signature Medical specialty: Medical license no:  Tel no: Date:	□ Nervous / Mental / Emotional / Sleeping disorder	☐ Influence of Drugs / Alcohol	
8. Underlying condition: 9. Investigation & Result (Lab, EKG, X – ray, etc.): 10. Diagnosis: 11. Treatment: 11. Surgery/Operation: 12. Pathological report: 13. Pathological report: 14. In the personally examined and treated the insured in connection with the disability and that the facts are in my opinion as given above.  15. Physician's signature  Medical specialty:  Medical specialty:  Medical license no:  Date:  Date:	☐ Cosmetic reason / Dental care / Refractive errors correction	□ AIDS	
9. Investigation & Result (Lab, EKG, X – ray, etc.): 10. Diagnosis:	☐ An accident; Date of accident: Time:	None of above	
10. Diagnosis:	8. Underlying condition:		
10. Diagnosis:	9. Investigation & Result (Lab, EKG, X – ray, etc.):		
11. Treatment:	,		
11. Surgery/Operation:	-		
Anaesthesia Type: ( ) General Anaesthesia ( ) Spinal Anaesthesia ( ) Local Anaesthesia ( ) Others			
12. Pathological report:         I hereby certify that I have personally examined and treated the insured in connection with the disability and that the facts are in my opinion as given above.         Physician's signature       Medical specialty:       Medical license no:         ()       Tel no:       Date:			
Physician's signature         Medical specialty:         Medical license no:           ()         Tel no:         Date:	12. Pathological report:		
(	I hereby certify that I have personally examined and treated the insured in connection with the disability and that the facts are in my opinion as given above.		
	Physician's signature Medical sp	ecialty: Medical license no:	
Medical institute:  Address:	( Tel no:	Date:	
	Medical institute:		