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MEDICAL ALLOWANCE CLAIM FORM

BORANG TUNTUTAN ELAUN HOSPITAL

ATTENDING PHYSICIAN'S STATEMENT

KENYATAAN DOKTOR YANG MERAWAT

Part 2 (To be completed by the attending physician at participant's expense)

Certificate No.		Present Occupation	
Name of Patient			
Gender	Male / Female	NRIC / Passport	

1.	**Hospitalisation Details**			
(a)	Admission Date and Time	Date	Time	am / pm
(b)	Discharge Date and Time	Date	Time	am / pm
(c)	i. Was there any ward leave given to the patient? If yes, kindly provide us the date and time of the leave. ii. Please furnish us a certified true copy of the proof for the ward leave if available. If there is no proof, please indicate the reason.	☐ Yes Date	☐ No Time	 am / pm

2.	**Diagnosis Details**	
(a)	Final Diagnosis	
(b)	Date of first diagnosed and by which doctor	
(c)	Date when the patient first consulted you	
(d)	Underlying cause and pathology of the diagnosis	
(e)	How do you confirm the diagnosis? Please enclose a copy of the report(s).	
(f)	Since when the symptoms presented	
(g)	Type of symptoms presented	

3.	Referral Doctor	
(a)	Name and address of the referral doctor(s)	
(b)	Name and address of other doctors who attended to the patient for the diagnosis	

4.	Treatment Details	
(a)	Type of treatment given for the diagnosis	
(b)	Date and type of surgery performed for the diagnosis	Date Surgery performed
(c)	Planned surgery/ treatment to be performed	

5.	If the condition is due to an accident	
(a)	Date and time of accident	Date Time am / pm
(b)	Full circumstances of accident	
(c)	Were there any external and visible injuries seen as a result of the accident? If yes, please describe the nature and extent of injuries including site and other characteristic features.	☐ Yes ☐ No Details:
(d)	In your opinion, is it certain that these injuries resulted directly from the accident? Please elaborate.	☐ Yes ☐ No Details:

6.	Inpatient treatment rendered to patient for Outpatient treatment or daycare case	
(a)	Based on your professional opinion, if the treatment can be rendered to patient on outpatient basis or day care basis, please provide us the justification for his/her inpatient treatment or this admission.	

7.	**For surgery or procedure:** ☐ Major ☐ Minor	
(a)	Indication and Nature of surgery or procedure performed	
(b)	Name of surgeon(s)	
(c)	MMA OPCS code / PHFSR Code	
(d)	Date(s) of surgery or procedure performed	

8.	**Is the patient's condition related to the below? (Please tick in the relevant box if there is any.)**		
	Cosmetic / plastic surgery, routine health screening		Congenital / hereditary conditions
	Intoxication, illegal drugs, AIDS, ARC, HIV, related disease		Dental Treatment
	Psychotic / mental disorder / nervous / sleep disorder		Self-inflicted injury
	Hazardous sports / unlawful act		Strike / Riot / Insurrection
	Pregnancy, Childbirth, Sterilisation, Infertility		Others

9.	Any possibility of having relapse?	☐ Yes ☐ No

10.	**Has the patient been treated or hospitalised this or any other illness? If yes, please provide additional information as per the table below.**		
Dates	Illness(s)	Details of treatments / Hospitalisation	Doctors'/Hospital Names

11.	For Female only	
Was the patient pregnant at the time of hospitalisation?	☐ Yes _____ months	☐ No

12.	If this admission is unusually longer than usual period of stay, please provide us your professional opinion and findings to justify the lengthy period of stay.

13.	Additional information relating to this patient and all medical examination/ tests results that you can provide us the details and let us have the certified true copy of the documents for us to access the claim

I hereby certify that I have personally examined and treated the Covered Person for his/ her injuries/ illness described above and that the facts as stated above represent my medical opinion of his/her condition.

Name & Address (Official Stamp)

_____

Signature of Attending Physician

_____

Qualification _____

_____

Date _____

Contact No.

_____