



ATTENDING PHYSICIAN'S STATEMENT – ACCIDENTAL MEDICAL REIMBURSEMENT

Note: Kindly submit this form to Generali Life Assurance Philippines, Inc., (GLAPI) duly completed by a qualified and registered physician at the expense of the claimant.

PATIENT'S DETAILS

Last Name		First Name		Middle Name	
Address					
Date of Birth (MM/DD/YYYY)	Place of Birth			Age	Status
How long have you known the patient?					
When did the patient first consult you for the injury?					
What was the cause of the patient's injury? Please describe in detail.					
If Surgical Procedure was performed, please describe in detail and provide copy of the Operation Room Record.					

DETAILS OF HOSPITAL ADMISSION

Date admitted in the hospital	Date of Discharge	No. of Days
Final Diagnosis		
Date of diagnosis	What are the medications given and laboratory examinations requested?	
When is the patient expected to return to work?		

PLEASE GIVE DETAILS OF THE PATIENT'S PREVIOUS CONDITIONS FOR WHICH YOU ATTENDED PRIOR TO LAST ILLNESS/INJURY:

Date of Attendance	Diagnosis	Treatment/Procedure

Please enclose copies of specialist or hospital reports together with any tests or similar evidence to support the validity of the claim.

I HEREBY CERTIFY that the above statements are true and complete to the best of my knowledge and belief.

Dated at _____ this _____ day of _____, 20_____.

SIGNATURE OVER PRINTED NAME OF PHYSICIAN

QUALIFICATION

ADDRESS

CONTACT DETAILS