Allianz

CRITICAL ILLNESS CLAIM FORM

ATTENDING PHYSICIAN'S STATEMENT

Agency/Agent's Code ________________
Policy No. ________________ Service No. ________________(Office use only)

1 This printed form is issued on receipt of notice of illness, and is no way an admission of liability.
2 This form is to be completed by the Attending Doctor at claimant's expenses.
3 For Critical Illness claim, the original or certified true copy of the investigation or histology reports must be attached to substantiate the claim.

DEFINITION

Motor Neurone Disease is defined as :

Confirmation by a Consultant Neurologist of a definite diagnosis of Motor Neurone Disease'

PERSONAL PARTICULAR

1 Name : ______________________________ I.C. No : ________________________

2 Occupation: ______________________________ Age/Sex : ________________________

3 Please give details of your patient's smoking habits, both past and present.

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4 Are you aware of any members of the patient's close family who have suffered from this or any similar condition ? If yes, please give details.

____

ILLNESS

5 Date you first saw the patient for this condition. ☐☐☐☐☐☐ (DD/MM/YY)

6 Was the patient referred to your clinic by any other doctor ? If yes, please indicate name and address of the referral doctor.

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7 What were the symptoms the patient complaint of when he/she first saw you ?

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8 According to the patient, how long had he/she been experiencing these symptom prior to consulting you?

____

9 In your professional opinion, how long would it take for the patient condition to develop ? Kindly advise reason if answer in Q(8) and Q(9) is different.

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____

10 What was your diagnosis ? Kindly advise date of firm diagnosis.
i Diagnosis : ______________________ Date : ☐☐☐☐☐☐ (DD/MM/YY)
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ii Please describe the exact details of your patient's condition.

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iii Has your patient suffered any previous episodes of this condition or any conditions leading to it or relating to it? If so, please give details.

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iv How long has your patient been experiencing these abnormalities and have they been present continuously?

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v Please describe the neurological abnormalities that your patient has experienced.

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vi Have any other investigatory tests or procedures been performed? If so, please give details.

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11 Have the patient previously received treatment for the above condition ? ☐ Yes ☐ No
If yes, please give details of treatment inclusive of date, name and address of the doctor.

Date	Doctor's name and address	Treatment

12 Please give any other information which you feel would be helpful in the assessment of your patient's claim

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GENERAL INFORMATION

13 Are you the patient's Usual Medical Attendant? If so, since when? ____________

14 If no, please give name and address of his/her Usual Medical Attendant if known to you.

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15 Please state from your records the details of all illnesses, accidents, surgical operations or disease from which the patient had suffered or had been treated at your clinic. (Please use additional sheet, if necessary.

Date of Consultation	Diagnosis	Treatment

I hereby certify that I have examined the above patient and that the injury/sickness stated above represent my medical opinion of the patient's condition.

____

Signature

Date :

Name of Doctor : ____________________

Qualification : ____________________

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Hospital/Clinic Stamp