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

End Stage liver failure evidenced by all of the following:-

i) Permanent jaundince
ii) Ascites
iii) Encephalopathy
iv) Portal hypertension

Wernicke's encephalopathy and liver failure secondary to alcohol or drug misuse is excluded.

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.

_____

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.

_____

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

_____

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.

_____

_____

10 What was your diagnosis ? Kindly advise date of diagnosis.

i Diagnosis : _____ Date : ☐☐☐☐☐☐ (DD/MM/YY)

ii Please describe full details of your patient condition.

_____

_____

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iii Was your patient jaundiced? ☐ Yes ☐ No

iv Was the jaundice permanent ? ☐ Yes ☐ No

v Did the patient have evidence of ascites ? ☐ Yes ☐ No

vi How was the extent of ascites confirmed ? ☐ Yes ☐ No

vii Had the patient suffered from encephalopathy ? ☐ Yes ☐ No

viii Had the patient suffered from Portal Hypertension ? ☐ Yes ☐ No

ix In your opinion, was the liver failure caused by alcohol or durgs misuse? ☐ Yes ☐ No

x Please furnish us full details (including dates) of investigation together with the results i.e. liver function tests, liver biopsy, scans etc. Please **enclosed a copy of the result.**

Dates	Type of test	Results

xi Please state treatment and medication including planned surgery i.e. liver transplant.

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

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.

15 Please state from your records the details of all illnesses, accidents, surgical operations or disease from which the deceased 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 :

Hospital/Clinic Stamp