

HOSPITALIZATION CLAIM FORM

PART III

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Name of Patient	Birthdate	Age	Cert. No.
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Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospitalized at
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Is this hospital/clinic registered With the Bureau of Medical Services <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, does it have a permit to operate as Hospital/Clinic and to admit in-patients <input type="checkbox"/> Yes <input type="checkbox"/> No
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Registration/Permit No. Date Issued	Issued by
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Dates of Confinement Admitted on : _____ at _____ AM/PM	Discharged on : _____ at _____ AM/PM
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COMPLETE AND FINAL DIAGNOSIS (If injured, give dates and place of accident)

SHORT HISTORY OF ILLNESS OR DISABILITY

Did Disability or illness arise out of and in the course of the patient's employment? Yes No

If so, explain briefly

Is disability due to Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give approximate date of first day of last menstruation
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COMPLETE IF X-RAY OR LABORATORY SERVICES WERE PERFORMED (If with previous, please indicate also)

Type of Examination	Date	Where Performed	Fee Charged	Findings
Previous consultation/treatment as out/in patient prior to this confinement				
		PLACE	DATES	DIAGNOSIS
		Office		
		Home		
		Hospital		

TO BE COMPLETED IF SURGERY WAS PERFORMED: Nature of Surgical Operation/Obstetrical procedure performed

Date Performed	Where Performed	If performed in Hospital check whether as <input type="checkbox"/> In Patient <input type="checkbox"/> Out Patient
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Name of Surgeon	Fees Charged:
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Name of Anesthesiologist	Fees Charged:
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OTHER DOCTORS WHO ATTENDED TO YOUR PATIENT:

NAME	SPECIALTY	PROCEDURES	FEES	DATE OF ATTENDANCE
1.				
2.				
3.				

The patient has been continuously disabled (unable to work)	FROM	TO
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When should your patient be able to work?

REMARKS

I HEREBY CERTIFY that the foregoing answers have been taken from the medical/hospital records of the above-named patient. They are full, complete, correct and true.

I am a graduate of _____ in the year _____.

Name of Attending Physician (Please Print)	Signature of Attending Physician
Address	Date Signed:
Telephone No. _____	License No. _____