

# 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 Office Home Hospital	DATES	DIAGNOSIS

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 \_\_\_\_\_

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. _____