



**ASIANLIFE**  
& GENERAL ASSURANCE CORPORATION

G/F - 3/F Morning Star Center, 347 Sen. Gil. Puyat Ave., Makati City  
Tel. No.: (632) 890-1758 \* Fax No.: (632) 895-8524 \* website: www.asianlife.com.ph

T.I.N. 000-169-096-000-NON VAT

## OUT-PATIENT CLAIM FORM

Name of Employee: \_\_\_\_\_ Date of Consultation: \_\_\_\_\_  
Name of Patient: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_  
Policyholder: \_\_\_\_\_

**To be accomplished by the attending Physician:**

Complaints: \_\_\_\_\_  
Recommendation - Laboratory Examination: \_\_\_\_\_  
- Prescribed Medicines: \_\_\_\_\_  
Final Diagnosis: \_\_\_\_\_

\_\_\_\_\_  
ATTENDING PHYSICIAN'S SIGNATURE  
OVER PRINTED NAME

\_\_\_\_\_  
OFFICE ADDRESS & TELEPHONE NO.  
LICENSE NO. \_\_\_\_\_

\_\_\_\_\_  
EMPLOYEE'S SIGNATURE

\_\_\_\_\_  
EMPLOYER'S SIGNATURE (HRD)

\* PLEASE MAKE CHECK PAYABLE TO

(To be filled up by the Insurance Broker or Company HRD Head)

**Note: Please attach this form to the ORIGINAL Doctor's Prescription and Official Receipts.**