BDO life®

Attending Physician's Statement - Hospital Income Benefit Claim

Note: This section must be completed by a qualified and registered physician. Costs, if any, shall be shouldered by the Claimant.

1. PATIENT'S INFORMATION

a. Name : _____
Last Name First Name Middle Name

b. Address : _____

c. Date of Birth : _____ Place of Birth : _____ Age: _____ Status: _____

2. DETAILS OF HOSPITALIZATION

a. Date of first consultation _____ Patient's complaint(s) _____

b. Symptoms experienced _____ Date symptoms first experienced _____

c. Name and Address of Hospital _____

_____

d. Inclusive Dates of Confinement: From: _____To: _____ No. of days at the ICU: _____
(must be supported by hospital bill)

e. Please provide brief history of patient's illness/injury _____

_____

_____

f. Did the patient consult any other physician/s for this illness/injury before she consulted you? _____ If yes, please provide details below.

Date of Attendance	Name of Physician	Medical Institution and Address	Diagnosis/Treatment/ Procedure

g. If Surgical Procedure was performed, please narrate in detail the procedure and provide a copy of the Operation Room Record and Pathology Report.

_____

h. Final Diagnosis/ses/Prognosis/ses _____

_____

I hereby certify that the above statements are true, correct and complete to the best of my knowledge and according to records in my possession, if any.

Executed at _____ this _____ day of _____20_____.

_____	_____
Signature Over Printed Name of Physician	Specialty
_____	_____
Address	Contact Number (s)
_____	_____
PRC Number	PTR Number