ATTENDING PHYSICIAN'S STATEMENT
HOSPITALIZATION / MEDICAL REIMBURSEMENT CLAIM

BPI AIA

NOTE: Fill out ☐ with block letters.
Put ☒ on the tick boxes representing options.
Please use reverse side for answers requiring additional information but not indicated on this questionnaire.
Identify your answers with the corresponding numbers.

PATIENT'S INFORMATION

Name:

Last Name	*First Name*	*Middle Name*

Da te of Birth:

mm / dd / yyyy

Are you related to the patient? ☐ Yes ☐ No
If yes, please state relationship.

Gender: ☐ Male ☐ Female

DIAGNOSIS *(to be filled up only by a licensed Physician)*

1. Nature of Complaint: ☐ Accident ☐ Sickness

2. What is your diagnosis? Please provide details.
(Please attach corresponding medical document for diagnosis or use back sheet if necessary).

3. What are its contributory causes?

IF THE COMPLAINT IS DUE TO AN ACCIDENT, PLEASE COMPLETE THIS SECTION

4. Nature of accident

- ☐ Road Traffic Accident
- ☐ Hit by a Heavy Object / Person
- ☐ Fire, Explosion, Hot Substance
- ☐ Attacked / Bitten by Insect / Animal
- ☐ Natural Disaster / Environmental
- ☐ Accidents caused by Machinery
- ☐ Pricked by a Sharp Object
- ☐ Accidental Fall
- ☐ Cut by Substance / Device
- ☐ Others

Please specify:

5. Date and time of accident — *mm / dd / yyyy* *hh / mm* ☐ AM ☐ PM

6. Place of accident

7. Describe the circumstances of the accident fully.

DETAILS OF THE TREATMENT *(whether accident or sickness)*

For Outpatient Treatment/Consultation

8. Did the patient undergo an outpatient treatment/consultation? ☐ Yes ☐ No

a. Date and time of first consultation — *mm / dd / yyyy* *hh / mm* ☐ AM ☐ PM

For Hospital Confinement

9. Was the patient hospitalized? ☐ Yes ☐ No

If yes, please give details.

Name of Hospital	Address (City and Province)	Date and Time of Admission	Date and Time of Discharge
		mm / dd / yyyy *hh / mm*	*mm / dd / yyyy* *hh / mm*
		mm / dd / yyyy *hh / mm*	*mm / dd / yyyy* *hh / mm*
		mm / dd / yyyy *hh / mm*	*mm / dd / yyyy* *hh / mm*

DETAILS OF THE TREATMENT *(whether accident or sickness) Continuation*

10. Was any part of the patient's body amputated or has lost its use? ☐ Yes ☐ No

If yes, state which body part.

11. Was surgery performed on the patient? ☐ Yes ☐ No

If yes, please provide the following details:

a. Type of surgery

b. Date of surgery *mm / dd / yyyy*

12. When was the patient first diagnosed with his/her illness? *mm / dd / yyyy*

a. From where did the condition originate?

13. Has the insured been treated by any other physician? ☐ Yes ☐ No

If yes, give their names and addresses.

Name of Physician	Address	Date	Nature of Disease
		mm / dd / yyyy	
		mm / dd / yyyy	
		mm / dd / yyyy	
		mm / dd / yyyy	

14. Is the patient disabled? ☐ Yes ☐ No

If yes, state duration of disability

From *mm / dd / yyyy* To *mm / dd / yyyy*

15. Is the patient diagnosed with Cancer? ☐ Yes ☐ No

If yes, please indicate the outpatient and chemotherapy treatments below:

Name of Doctor/Clinic	Address (City and Province)	Treatment Dates	Type of Treatment
		mm / dd / yyyy	
		mm / dd / yyyy	
		mm / dd / yyyy	
		mm / dd / yyyy	

DETAILS OF THE TREATMENT *(whether accident or sickness) Continuation*

Please answer with a YES or NO	YES	NO
16. Is the patient's condition a mental or nervous disorder?	☐	☐
17. Is the treatment related to pregnancy, miscarriage, abortion or childbirth?	☐	☐
18. Is the condition sustained from being intoxicated or under the influence of drugs?	☐	☐
19. Is the condition sustained from alcoholism or drug addiction?	☐	☐
20. Is the treatment for routine physical check-up, rest cure, or special nursing care?	☐	☐
21. Is the patient's condition congenital?	☐	☐
22. Is the treatment for cosmetic reasons, a dental treatment or an elective surgery?	☐	☐
23. Is the treatment for circumcision, sterilization, artificial insemination, sex transformation, or treatment of infertility?	☐	☐
24. Is the patient's condition AIDS-related or due to a sexually transmitted disease?	☐	☐

PHYSICIAN'S DECLARATION

I, _____
Physician's Name in Full: Last Name, First Name, Middle Name

a graduate of _____
Medical College

in the year _____ **with License No.** _____

hereby truthfully certify that the answers given above are full, complete and true.

_____
Physician's Signature

Witnessed by:

_____
Printed name and signature of witness

Date Signed: _____
mm / dd / yyyy

Place Signed: _____

Mobile Number: _____
(09XX-XXXXXXX)

Clinic Address: _____

Clinic Hours: _____