NOTIFICATION OF CLAIMS

All sections must be completed

A. PARTICULARS OF THE CLAIMANT

Patient's Name _____

Insurance Policy Number _____

Insurance PolicyHolder_____

B. AUTHORIZATION

I hereby authorize any hospital or physician or third party who has attended me to furnish to Pacific Cross Health Insurance PCL (or its representative) and Pacific Cross Health Insurance PCL (or its representative) to review any and all information requested with respect to any illnesses or accident, medical history, consultations, prescriptions, or treatments, copies of all hospital or medical records and the records of any governmental agency with which a report of any such accident or illness is lodged. I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____

Date Signed (Patient; or Parent if a minor)

C. STATEMENT BY THE CLAIMANT (By Parent when claimant is a minor)

1. If as a result of an Accident:

1 (a) When did the accident occur?_____

Give a brief description of the circumstances:_____

_____

_____

_____

1 (b) Which part (s) of body injured?_____

_____

2. If as a result of an illness:

When did the symptom first appear?_____

D. DECLARATION

I, the undersigned, hereby declare that the particulars stated on this form are true in every respect. I have supplied full information on all particulars relevant to this claim, and the amounts claimed herein are lawfully due to me under the terms, conditions and exceptions of the above numbered account.

_____

Signature of Person Insured

Pacific Cross Health Insurance PCL, 152 Chartered Square Building, 21st Floor, Room 21-01, North Sathorn Road, Silom, Bangrak, Bangkok 10500

Tel: 0-2401-9189 Fax: 0-2401-9187

Patient's Name _____HN_____ Admit Date _____ Discharged Date_____

E. ATTENDING PHYSICIAN'S REPORT

(1)

1(a) What was the diagnosis you have made to the conditions of the patient and when was it made?_____

_____

1(b) If confinement in a hospital was required, state diagnosis of condition in respect of which hospitalization was required? _____

_____

1(c)

(i) When did the symptom first appear?_____

(ii) When did patient first consult you on this condition?_____

(iii) To the best of your knowledge, has the patient ever had similar conditions or symptoms relating thereto or hospitalized for the same disorders? If "YES", please give dates and details._____

_____

_____

(iv) To your knowledge, had patient previously consulted any other doctors for these symptoms? If "YES", please give names and address of the doctors:_____

_____

1(d) Was the symptom a secondary condition to some other illness (es)? If "YES", please give details.

_____

_____

_____

1(e) Was the condition caused by or in anyway associated with the conditions mentioned below:

(i) the influence of drugs or alcohol intake?	YES ( )	NO ( )
(ii) AIDS?	YES ( )	NO ( )
(iii) infertility or sterilization?	YES ( )	NO ( )
(iv) cosmetic or plastic surgery?	YES ( )	NO ( )
(v) psychiatric and mental disorder?	YES ( )	NO ( )
(vi) congenital deformities or anomalies?	YES ( )	NO ( )
(vii) suicide, insanity or self-inflicted injury?	YES ( )	NO ( )

1(f) Are any of the conditions treated due to (please tick):

(i) accident	YES ( )	NO ( )
(ii) sickness or injury due to patient's employment	YES ( )	NO ( )
(iii) pregnancy	YES ( )	NO ( )

If "YES", state approximate date of commencement of pregnancy_____

(2)

2 (a) What type of treatment was given to the patient? _____

_____

_____

2 (b) For surgical related conditions:

(i) Name and nature of surgical or obstetrical procedures: _____

_____

(ii) Date(s) of procedure (s):_____

2 (c) Discharge summary report and details of any further treatment and/or follow up treatment recommended:

_____

_____

_____

(3) Is it possible to provide this treatment on an outpatient basis? If "YES", please give reasons of performing this treatment on an inpatient basis._____

_____

_____

(…….)

Signature of Attending Physician with Stamp