PACIFIC CROSS

MED-SURE

Notification of Claims
All sections must be completed

A. PARTICULARS OF THE CLAIMANT

Patient's Name (Insured Person's name)

Insurance Policy Number Valid Date from: To	Insurance Policy Holder Name

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:

1.1(a) When did the accident occur? : ……...

Give a brief description of the circumstances: ……

……...

……...

1.2(b) Which part(s) of body injured? ……...

……...

2. If as a result of an illness:

When did the symptom first appear? …….

3. First consultation date to the Treating Medical Officer: ……..

3.1 Provider name and address: ……

4. Require follow up treatment? If yes, please specify the follow update: ……...

……..…..

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

OUR CONTACT INFORMATION

บริษัท แปซิฟิค ครอส ประกันสุขภาพ จำกัด (มหาชน)
152 อาคารชาร์เตอร์สแควร์ ชั้น 21
ถนนสาทรเหนือ แขวงสีลม
เขตบางรัก กรุงเทพฯ 10500

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

Tax Number: 0107556000086
Tel: +662 401 9189
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Patient's Name	H/N	Admission Date : DD / MM / YYYY	Discharge Date : DD / MM / YYYY

E. ATTENDING PHYSICIAN'S REPORT

Section 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?

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

1(c)(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.

1(c)(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:

	YES	NO
(i) the influence of drugs or alcohol intake?		
(ii) AIDS?		
(iii) infertility or sterilization?		
(iv) cosmetic or plastic surgery?		

	YES	NO
(v) psychiatric and mental disorder?		
(vi) congenital abnormality or anomalies?		
(vii) suicide, insanity or self-inflicted injury?		

1(f) Are any of the conditions treated associated with below:

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

	YES	NO
(iii) pregnancy		
If "YES", state approximate date of commencement of pregnancy :		

Section 2

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

2(b) For surgical related conditions :

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

2(b)(ii) Procedure(s) date:

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

2(d) 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

OUR CONTACT INFORMATION

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