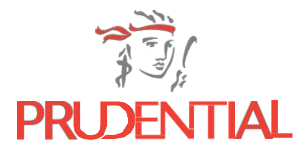
INFECTIOUS DISEASE BENEFIT CLAIM (GROUP)- DOCTOR'S STATEMENT

Note: This form is to be completed at the patient's expense by the Attending Physician/ Surgeon who treated the patient.



Patient's Personal Details

Name

Policy Number

NRIC/Old IC/Passport/Birth Cert/Other

Date of Birth

Gender

☐ Male ☐ Female

SECTION A : Medical History of The Patient

1. Please select the infectious disease the patient is suffering from:

☐ Measles

☐ Dengue Fever

☐ Malaria

☐ Typhoid

☐ Covid -19

2. Are you the patient's regular / family doctor?

☐ YES ☐ NO

If Yes, please state the date of the patient's first visit to you / your clinic.

Day Month Year

3. Date the patient first consulted you for this condition.

Day Month Year

4. The presenting signs and symptoms during the first consultation with you.

5. The date when the patient first noticed the presenting signs and symptoms.

Day Month Year

6. In your opinion, how long has the presenting signs and symptoms lasted prior to the first consultation with you?

Day Month Year

7. Date ofdiagnosis.

Day Month Year

8. Date when the patient was informed of the diagnosis.

Day Month Year

9. Please state all investigations or tests which had been performed on the patient.

Date (DD/MM/YYYY)	Test / Laboratory / Procedure	Investigation Outcome / Test Result

10. . Was the patient hospitalised for the above condition?

☐ YES ☐ NO

If Yes, please provide hospitalisation details:

i. Admission Date & Time:

ii. Discharged Date & Time:

11. Please state details and nature of the treatment / medication given to the patient.

Date (DD/MM/YYYY)	Treatment / Medication

SECTION B : Attending Doctor's Declaration

I hereby certify that:

☐ I am the patient's attending doctor and I have personally examined and treated the patient for the illnesses / injuries sustained; OR

☐ I have personally perused the patient's medical records;

and that the facts as stated above are all true to the best of my knowledge and information that I have perused.

If you are not the attending doctor, please state:

The Attending Doctor's Name & Speciality:

The reason(s) for completing this document on behalf of the Attending Doctor:

Signature : Date :

Name :

Professional Qualification :

MMC / Registration Number :

Name & Address of Hospital / Clinic :

Official Stamp of the Doctor :