

Attending Physician's Statement Hospitalization / Medical Reimbursement Claim

NOTE: Fill out with block letters.

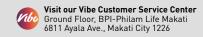
Put 🐧 on the tick boxes representing options.

Please use reverse side for answers requiring additional information but not indicated on this questionnaire.

Identify your answers with the corresponding numbers.

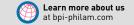
PATIENT'S INFORMATION			
Name:			
Date of Birth: mm/dd/yyyy Gender: Male Female	Are you related to the patient? Yes No If yes, please state relationship.		
DIAGNOSIS (to be filled up only by a licensed Physician)			
1. Nature of Complaint: Accident Sickness			
 What is your diagnosis? Please provide details. (Please attach corresponding medical document for diagnosis or use back sheet if necessary). 			
3. What are its contributory causes?			





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IF THE COMPLAINT IS DUE TO AN ACCIDENT, PLEASE COMPLETE THIS SECTION 4. Nature of accident ☐ Road Traffic Accident ☐ Accidents caused by Machinery ☐ Hit by a Heavy Object / Person ☐ Pricked by a Sharp Object ☐ Fire, Explosion, Hot Substance □ Accidental Fall ☐ Attacked / Bitten by Insect / Animal ☐ Cut by Substance / Device ■ Natural Disaster / Environmental □ Others Please specify: ☐ AM 5. Date and time of accident □ РМ mm / dd / yyyy hh/mm 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? No ☐ AM a. Date and time of first consultation □ PM mm / dd / yyyy hh/mm For Hospital Confinement 9. Was the patient hospitalized? 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 hh/mm mm / dd / yyyy hh/mm mm / dd / yyyy





mm / dd / yyyy

hh/mm



mm / dd / yyyy

hh/mm

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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?				
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	/wwy 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		







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DETAILS OF THE	TREATMENT (whether accident of	r sickness) Continuation		
Please answer with a YES or 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 DE	CLARATION			
I, a graduate of	Physician's Name in Full: La	nst Name, First Name, Middle Name Medical College		
in the year	with License No.			
hereby truthfully co	ertify that the answers given abo	ove are full, complete and true. Witnessed by:		
Physician's Signature				
Date Signed:		Printed name and signature of witness		
	mm / dd / yyyy			
Place Signed:				
Mobile Number:	(cover vereneral)			
	(09XX-XXXXXXX)			
Clinic Address:				
Clinic Hours:				

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