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MATERNITY CLAIM FORM

All sections on this form must be filled in completely

POLICY DATA

Policy No.	
Policy Holder	
Insured	
Address	
Telephone No.	

PATIENT DATA

Patient Name	
Patient ID Card No.	
Patient passport No. (if any)	
Hospitalized at	
Date of Treatment	
Doctor Name	

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

I hereby authorize any Physicians, Clinics, Hospitals, Public Health Centers, Insurance Companies, Legal Entities, Individuals or other Organizations that have any records or information on the insured and health of the insured whether the insured is still alive or dead to give them to PT International Services Pacific Cross or its authorized institution. A copy of this statement should be as valid and legal as the original.

Place & Date

Name & Signature

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DOCTOR'S CERTIFICATE

All sections on this form must be filled in completely

1.	Patient Name	
2.	Medical Record No.	
3.	Date of Birth	
4.	Sex	
5.	Date of Treatment	to
6.	Anamneses; Medical History	
7.	Date of first occurance of the symptom and complaint of pain	
8.	Date of first consultation for the disease	
9.	Name and Address of referral Doctor	
10.	Types and results of Physical examination, lab, X-ray, CT scan Anatomic Pathology Report (APR), etc	
11.	Final diagnosis or presumptive diagnosis	
12.	Date of first diagnose	
13.	Type of surgery (if performed)	
14.	Medical Therapy	
15.	Was the condition caused by or in any way associated with conditions mentioned below	

a.	The influence of drugs or alcohol intake	Yes ☐	No ☐
b.	HIV/ PHS/ AIDS	Yes ☐	No ☐
c.	Infertility or sterilization	Yes ☐	No ☐
d.	Cosmetic or plastic surgery	Yes ☐	No ☐
e.	Psychiatric and mental disorder	Yes ☐	No ☐
f.	Congenital deformities or anomalies and hereditary	Yes ☐	No ☐

g.	Suicide, insanity or self-inflicted injury	Yes ☐	No ☐
h.	Dental	Yes ☐	No ☐
i.	Geriatric	Yes ☐	No ☐
j.	Menstruation and hormonal disorders	Yes ☐	No ☐
k.	Pregnancy syndrome, delivery and complication	Yes ☐	No ☐

As the treating Doctor of the above-mentioned patient, I hereby state that I have read and answered the questions in this form clearly and completely.

Doctor name	
Address	
Place and date	
Signature of doctor and stamp of hospital or doctor	