PACIFIC CROSS
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OUTPATIENT CLAIM FORM

All sections on this form must be filled in completely

POLICY DATA

Policy Holder : ....

Employee Name : ....

Patient Name : ....

Address : ....

Telephone No : ....

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

MEDICAL INFORMATION

Name and address of doctor : ……………………………………………………………………

Date of Consultation : ……………………………………………………………………

Anamnese : ……………………………………………………………………

Medical History : ……………………………………………………………………

Final Diagnosis or
presumptive diagnosis : ……………………………………………………………………

Types and results of Physical
Examination lab, X-ray, CT Scan, Anatomic
Pathology Report (APR), etc) : ……………………………………………………………………

Medical therapy : ……………………………………………………………………

As a doctor handling the care of the above-mentioned patient, I hereby state that I have read and answered the questions on this form clearly and completely

Doctor Name : ……………………………………………………………………………………………….

Address : ……………………………………………………………………………………………….

Place and Date : ……………………………………………………………………………………………….

Signature of doctor and
stamp of hospital or doctor : ……………………………………………………………………………………………….