HOSPITAL TREATMENT CERTIFICATE – NON-ACCIDENTAL DEATH CLAIM

Claim under policy no _____ on the life of (Full Name of the Deceased) _____

Following information should be based on Hospital Records

1) a) Name :

b) Age : ____ Years

c) Occupation :

d) Address :

e) Identification mark (if any) :

2) a) Date of Admission : D D M M Y Y Y Y b) Time

c) Admission number :

3) Nature and Duration of illness reported at the time of Admission :

4) If the patient was referred to you, please state the

: Name & Address of the Hospital/ Doctor concerned.

5) a) History of illness reported at the time of admission
b) Who reported the history? :
c) Please give details of doctor who recorded the history

6) Please provide details and dates of the investigations and tests conducted during the stay in the hospital. (if so please attach copies)

D D M M Y Y Y Y

7) What was the diagnosis arrived at in the Hospital?

8) Please give details of the treatment rendered to the deceased. Attach separate sheets if required

9) Were there any other illness/ disease prior to or which coexisted with the ailment at the time of admission into the hospital. Give brief particulars of it. :

10) Date of his/her discharge from Hospital : D D M M Y Y Y Y

11) Condition at the time of discharge: _____

12) Was he/she treated in the hospital on any previous occasion for the last illness or any other illness? If yes, please give details _____

Certified that the above information is correct as per records of the Hospital

Date : D D M M Y Y Y Y Signature: _____

Name of the Doctor : _____

Code No : _____ Qualification and designation : _____

_____

Name of the Hospital: _____

Postal Address of the Hospital: _____

_____

Telephone Number (with STD code) : _____ _____

Hospital Seal/ Stamp _____