

HOSPITAL TREATMENT CERTIFICATE - CI

Critical Illness Claim under Policy No.	:	<input type="text"/>
on the life of (Full Name of the Life Assured)	:	<input type="text"/>

Following information should be furnished as per the hospital records.

1) a) Full Name of the Life Assured	:	<input type="text"/>
	:	<input type="text"/>
b) Age	:	<input type="text"/> Years
c) Occupation	:	<input type="text"/>
d) Address	:	<input type="text"/>
	:	<input type="text"/>
	:	<input type="text"/>
e) Identification Mark (if any)	:	<input type="text"/>
2) a) Date of Admission	:	<input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y
b) Time of Admission	:	<input type="text"/> -- <input type="text"/>
c) Admission Number	:	<input type="text"/>
3) Nature and duration of illness as reported at the time of admission.	:	<input type="text"/>
	:	<input type="text"/>
4) If the patient was referred to you, please state the name & address of the hospital/doctor concerned.	:	<input type="text"/>
	:	<input type="text"/>
	:	<input type="text"/>
	:	<input type="text"/>
	:	<input type="text"/>
5) a) History of illness reported at the time of admission	:	<input type="text"/>
	:	<input type="text"/>
b) Who reported the history to you?	:	<input type="text"/>
	:	<input type="text"/>
c) Who recorded the above history?	:	<input type="text"/>
	:	<input type="text"/>
6) What were the investigations done/advised to be done at the hospital? (if so please attach copies).	:	<input type="text"/>
	:	<input type="text"/>
7) What was the diagnosis arrived at in the hospital?	:	<input type="text"/>
	:	<input type="text"/>
8) Was there any other illness/disease prior to or co-existed with the ailment reported at the time of admission into the hospital? Give brief particulars of it.	:	<input type="text"/>
	:	<input type="text"/>
	:	<input type="text"/>
	:	<input type="text"/>

9) Date of his/her discharge from the hospital :

10) Condition at the time of discharge :

11) Follow-up treatment advised :

12) What is the prognosis? :

13) Was he/she treated in the hospital on any previous occasion? If yes, please state details. :

Certified that the above information is correct as per records of the hospital.

Date :

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 :



Bharat Ki Udaan, Bandhan Se.



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