AVIVA

AVIVA LTD
Group Life & Health Claims
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## SECTION 2 : MEDICAL REPORT (TO BE COMPLETED BY ATTENDING PHYSICIAN / SURGEON)

For admission to Private Hospital or Hospital outside Singapore, claimant must arrange to have this section completed by the Attending Physician when submitting a claim.

### Patient Information

| Policy No: | Name of Company: | |
|---|---|---|
| Name of Patient: | NRIC/Passport No: | Admission Period: |

| Nature of Illness | Nature of Treatment / Surgery |
|---|---|
| 01) Final Diagnosis (Based on ICD 10) of illness or extent of Injury<br>DRG Code ☐☐☐☐ ICD Code ☐☐☐☐ ICD Code ☐☐☐☐<br>Date of Diagnosis: ____________ | 05) Date of surgical procedures or treatment rendered : ____________<br>Operation Code ☐☐☐☐ Operation Table ☐☐ |
| 02) Given the aetiology of the condition, please state the estimated date of such condition would be in existence. | 06) Describe the surgical procedures or treatment rendered. If no surgery was performed, please state treatment / medication given |
| 03) What is the cause of illness / injury? | 07) If excision was performed, please indicate the size of the lesion / tumor. (Please attach a copy of the Histology Report) |
| 04) What is the anatomy of this illness? | 08) Name of<br>a) Physician ____________<br>b) Surgeon ____________<br>c) Anesthetist ____________ |

| 09) Is the condition/treatment related to: | | Yes | If 'Yes", please elaborate. | No |
|---|---|---|---|---|
| a) Pregnancy or childbirth | a) | ☐ | ____________ | ☐ |
| b) Abortion or Miscarriage | b) | ☐ | ____________ | ☐ |
| c) Infertility or Sub-fertility Condition | c) | ☐ | ____________ | ☐ |
| d) Congenital Anomaly | d) | ☐ | ____________ | ☐ |
| e) Genetic or Chromosomal Disorder | e) | ☐ | ____________ | ☐ |
| f) Mental or Psychiatric Condition | f) | ☐ | ____________ | ☐ |
| g) Cosmetic Surgery | g) | ☐ | ____________ | ☐ |
| h) Is the surgery for correction of short sightedness? | h) | ☐ | ____________ | ☐ |
| i) Is the surgery for dental purposes? | i) | ☐ | ____________ | ☐ |

### Medical History

| | |
|---|---|
| 10) Please provide the name and address of referring doctor if patient was referred to you. | 11) When did the patient first consult you for this condition? |
| 12) Nature and Date of Treatment rendered | 13) What were the symptoms/complaints prior to consulting you? |
| 14) Please indicate the nature of Symptoms and date Symptoms first started | 15) If there is no symptom presented, what has prompted the patient to see you? |
| 16) Please specify the approximate date of discovery of the illness or injury | 17) How long has the illness / injury existed prior to consulting you? |
| 18) Has the patient ever had the same or similar condition / symptom?<br>☐ Yes ☐ No ☐ Not to my knowledge | 19) Doctors previously consulted by the patient for the above condition.<br>Name of Doctor: ____________<br>First Consultation: ____________<br>Name of Clinic: ____________<br>Address: ____________ |

### Follow-up Treatment

| | |
|---|---|
| 20) Is the patient still under your care for this condition? ☐ Yes ☐ No<br>If yes, please state the estimated duration that patient needs to follow-up with you. | If "No", please give date service was terminated and furnish name and address of doctor if the patient has been referred to another doctor for follow-up |

____________
Signature of Physician / Surgeon

____________
Date

____________
Name / Designation

____________
Name and Address of Clinic / Hospital & Stamp