FORTE INSURANCE
We build confidence

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Medical Claim Information

To be wholly completed by the medical practitioner

Patient name: _____ Address: _____
Date of hospitalization: _____ Date of discharge: _____
Diagnosis: _____

Condition requiring treatment

Underlying cause(s)

How long has the condition existed?

When were symptoms first apparent to the patient?

Address of referring doctor

Please detail pathology performed and attach the results

Date of first consultation with any practitioner for this condition

Has the patient suffered the condition previously?

Please provide dates of previous consultation/treatment

Please confirm the likely period of treatment

Please detail the medication/treatment prescribed or that will be prescribed

Was the treatment in respect of an acute exacerbation of a chronic condition?

Is this a routine check up? ○ Yes ○ No

I hereby declare that the abovementioned statements made by me are true and correct to the best of my knowledge and belief.

Physician name: _____ Tel: _____
Email: _____ Fax: _____
Address: _____
Signature and official stamp: _____ Date: _____