CERTIFICATE FROM HOSPITAL (Rider)

Edelweiss Tokio life
Insurance se badhkar hai ***aapki zaroorat***

Without prejudice

Important points:

- This form needs to be completed by the Hospital Authorities where the Life Assured was either admitted or treated
- If the Life Assured has been admitted in two different hospitals the form is to be filled up per hospital
- Medical records such as Discharge Summary, Inpatient / Outpatient records, Operation notes, Progress records to be provided along with this form

Policy No.: _____ Date: D D M M Y Y Y Y

Name of the patient: _____ Inpatient No./MRD No.: _____

Details of the hospital

1. Indoor patient no.: _____	
2. Date of Admission: D D M M Y Y Y Y Time ___ ___ : ___ ___ (In 24 Hrs format)	Date of discharge: D D M M Y Y Y Y Time ___ ___ : ___ ___ (In 24 Hrs format)
3. Was the patient admitted to ICU?	☐ Yes ☐ No (If yes, Please provide us with the following) Days of admission in ICU: _____ (No. of days) From D D M M Y Y Y Y to D D M M Y Y Y Y
4. Was the patient referred by any doctor/hospital?	☐ Yes ☐ No (If yes, Please provide us with the following) Name & Address: _____ _____ Tel. No.: _____

Details of the illness suffered

1. Exact diagnosis: _____	Date of diagnosis: D D M M Y Y Y Y
2. Treatment given during the course of hospitalization	
3. If discharged condition at the time of discharge	
4. Symptoms suffered by the Insured related to current illness	
5. Duration of the said symptoms	

Provide details if claim for disability

1. Cause of disability	☐ Illness ☐ Accident
If due to illness, please provide the following: Name of the illness: _____ Date of diagnosis of illness: D D M M Y Y Y Y	If due to Accident, please provide the following: Date of Accident: D D M M Y Y Y Y Nature of Accident: ☐ Railway ☐ Road ☐ Others If Others pls specify: _____ _____
2. Nature of disability	☐ Permanent ☐ Temporary
4. Is the Life Assured capable of performing any occupation or engaging in activities for remuneration or profits?	☐ Yes ☐ No
5. Progress	☐ Improved ☐ Fully recovered ☐ Unimproved
6. Treatment given during the course of hospitalization	
7. If discharged condition at the time of discharge	

Past history of the insured

1. Was the patient suffering from any illnesses in the past?	Nature of illness	Yes/No		Duration
	Hypertension	Y	N	
	Diabetes	Y	N	
	Tuberculosis	Y	N	
	Kidney disease	Y	N	
	Liver disease	Y	N	
	Heart disease	Y	N	
	Cancer	Y	N	
	Others	Please Specify: _____ _____		

2. Did the patient have habits like	Habits	Yes/No		Duration	Quantity consumed
	Consumption of alcohol	Y	N		
	Smoking	Y	N		
	Tobacco	Y	N		
	Drugs	Y	N		

3. Did the patient undergo any surgery in the past	☐ Yes ☐ No If yes, provide the following details: Name of the surgery: _____ Name of the hospital where the surgery was performed: _____ Date on which surgery was performed: D D M M Y Y Y Y
4. Who reported the above mentioned history	

Expense Incurred Details

Details of Fee charged and mode of payment:	Amount:	Mode of Payment:
		☐ Cheque ☐ Cash ☐ DD ☐ Mediclaim ☐ Others If other, please specify _____

If the patient availed the benefit of any Mediclaim insurance policy for the purpose of making payment please provide details	Name of the Insurer	Sum Assured	Amount of claim received	Date of claim

Prior admission details

Had the patient been admitted or treated by you or your hospital earlier?		☐ Yes ☐ No (If yes, provide the following)	
Dates		Reason for seeking treatment	Treatment given
From	To		

Declaration

We hereby declare that the details furnished in this form are true and correct to the best of our knowledge and belief and is as per the records of the hospital

Doctor's Name & Qualification: _____

Doctor's Signature: _____ Date: _____

Doctor registration no. & contact no.

_____

_____

Address & Seal (to be attested with hospital seal):

_____

_____

Hospital Seal