Manulife

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ATTENDING PHYSICIAN'S STATEMENT (Health Insurance)

NAME OF PATIENT (Last Name),	(First Name),	(Middle Name) ☐ Do not know/ not applicable
ATTENDING PHYSICIAN'S NAME	ADDRESS	

This section must be completed by a qualified and registered physician at the expense of the patient.

The above name is insured with us against the happening of contingent events associated with his/her health. A claim has been submitted in connection with HEALTH INSURANCE. To enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

Please countersign on any corrections or erasures. Please attach any required documents upon submission of this form. In this form, the "Company" means The Manufacturers Life Insurance Co. (Phils.), Inc.

GENERAL INFORMATION

Are you the patient's usual medical doctor?
☐ Yes ☐ No

If yes, over what period do your records extend to?
Start Date (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐ End Date (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

When did the patient first consult you for this condition? (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

Please state symptoms presented and date symptoms first appeared.

SYMPTOMS PRESENTED AT FIRST CONSULTATION	DATE SYMPTOMS FIRST STARTED (MM/DD/YYYY)
	☐☐/☐☐/☐☐☐☐
	☐☐/☐☐/☐☐☐☐
	☐☐/☐☐/☐☐☐☐

What/ Who is the source of this information? _____

In your opinion, what were the likely durations of the patient's symptoms? Please provide reasons:

_____

_____

Did the patient consult any other doctors for these symptoms before he/she consulted you? ☐ Yes ☐ No ☐ I do not know If yes, please provide the details below.

NAME OF DOCTOR	NAME AND ADDRESS OF HOSPITAL/CLINIC

Please provide the details below when he/she consulted you.

DATES ATTENDED	COMPLAINTS & PHYSICAL EXAMINATION FINDINGS	DURATION OF ILLNESS	DIAGNOSIS	DESCRIBE TREATMENT/PROCEDURE

Was the service of an ambulance used for the patient's hospital confinement? ☐ Yes ☐ No ☐ Not applicable

If yes, this must be supported by an official receipt for use of ambulance

Was the patient admitted in the hospital? ☐ Yes ☐ No ☐ Not Applicable	If yes, please state name and address of hospital

Complaint(s)	Date of Admission (MM/DD/YYYY) Time Admitted	Date of Discharge (MM/DD/YYYY) Time Discharged
	☐☐/☐☐/☐☐☐☐ _____	☐☐/☐☐/☐☐☐☐ _____

Was the patient given care at the ICU? ☐ Yes ☐ No

If yes, please state dates of ICU confinement (must be supported with a hospital billing statement): From_____ to _____ No. of Days _____

Final Diagnosis	Prognosis

Were there prescription drugs during the patient's hospital confinement? ☐ Yes ☐ No

If yes, this must be supported with the details/copy of drugs prescribed in the hospital billing statement.

Is there any Surgical Procedure Performed? ☐ Yes ☐ No

If yes, please describe the Surgical procedure performed in details including Pathology Result and copy of Operation Room Record.

Please state Name of Surgeon _____ Date when surgery was performed: (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

Was treatment as an outpatient required for the following?

			If yes, please provide details/manner of treatment
Kidney Dialysis	☐ Yes	☐ No	
Stroke Treatment	☐ Yes	☐ No	
Cancer Treatment	☐ Yes	☐ No	

To the best of my knowledge, do you consider him/her to be TOTALLY DISABLED (unable to work)?

☐ Yes ☐ No

If yes, please provide period of Total Disability From ☐☐/☐☐/☐☐☐☐ (MM/DD/YYYY) To ☐☐/☐☐/☐☐☐☐ (MM/DD/YYYY)

Or give approximate date when he/she would be able to return to work (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐ (MM/DD/YYYY)

Please provide any other information that have a bearing to this claim.

ATTENDING PHYSICIAN'S CERTIFICATION AND SIGNATURE

I hereby certify that the above statements are true and complete to the best of my knowledge and belief.

Name of Attending Physician (Please print)	Degree/Specialty
Signature	**Date Signed**
PRC Number/PIR Number	**Contact Number(s)**

To the Attending Physician: You may use additional sheets if more space is needed for the above information requested. You may also submit this form directly to any Manulife Office Nationwide.