GROUP MEDICAL INSURANCE CLAIM FORM

Singapore Life Ltd.
Group Life & Health Claims
4 Shenton Way, #01-01 SGX Centre 2
Singapore 068807
Tel: 6827 8030
Company Registration No. 1968424199K

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 extend of Injury DRG Code ☐☐☐☐ ICD Code ☐☐☐☐ ICD Code ☐☐☐☐ Date of Diagnosis:_____	05) Date of surgical procedure or treatment rendered : _____ 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 procedure 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 a) Physician _____ b) Surgeon _____ c) Anesthetist _____
09) Is the condition/treatment related to: a) Pregnancy or childbirth b) Abortion or Miscarriage c) Infertility or Sub-fertility Condition d) Congenital Anomaly e) Genetic or Chromosomal Disorder f) Mental or Psychiatric Condition g) Cosmetic Surgery h) Is the surgery for correction of short sightedness? i) Is the surgery for dental purposes?	Yes / If "Yes", please elaborate. / No a) ☐ _____ ☐ b) ☐ _____ ☐ c) ☐ _____ ☐ d) ☐ _____ ☐ e) ☐ _____ ☐ f) ☐ _____ ☐ g) ☐ _____ ☐ h) ☐ _____ ☐ i) ☐ _____ ☐
Medical History	
10) Please provide the name and address of referring doctor if patient was referred to you.	15) If there is no symptoms presented, what has prompted the patient to see you?
11) When did the patient first consult you for this condition?	16) Please specify the approximate date of discovery of the illness or injury
12) Nature and Date of Treatment rendered	17) How long has the illness / injury existed prior to consulting you?
13) What were the symptoms/complaints prior to consulting you?	18) Has the patient ever had the same or similar condition / symptom? ☐ Yes ☐ No ☐ Not to my knowledge
14) Please indicate the nature of Symptoms and date Symptoms first started	19) Doctors previously consulted by the patient for the above condition. Name of Doctors: _____ First Consultation:_____ Name of Clinic: _____ Address: _____
20) Is the patient still under your care for this condition? ☐ Yes ☐ No If Yes, please state the estimated duration that patient needs to follow up with you.	If No, please give termination date of service 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