Allianz

Allianz Life Insurance Malaysia Berhad 198301008983 (104248-X)
(Licensed under the Financial Services Act 2013 and regulated by Bank Negara Malaysia)

Medical Report (Hospitalisation Claim)

To be completed by a legally qualified and registered doctor at the life assured's expenses

Policy No. : _____

Personal Details Of Patient			
Name of Patient:		Age:	
New NRIC / Passport No.:		Sex:	☐ Male ☐ Female

Hospitalisation Details					
1.	Admission / Daycare Surgery Date: D D / M M / Y Y Y Y	2.	Discharge Date: D D / M M / Y Y Y Y	3.	Admission No.:
4.	If hospitalisation was due to accident, please furnish: (a) Date of accident: D D / M M / Y Y Y Y Time of accident (AM/PM): _____ (b) Nature of accident: _____				
5.	Date which you first saw the patient for this illness / condition / injury: D D / M M / Y Y Y Y				
6.	Was the patient referred to you by any other doctor?	☐ No ☐ Yes			
7.	What were the symptoms that the patient complained when he/she first saw you?				
8.	According to patient, how long had he/she been experiencing these symptoms?				
9.	Based on your professional expertise, how long do you feel these symptoms had existed prior to first consultation with you?				
10.	Had patient previously consulted another doctor for the same or similar symptoms as above? If yes, please state the name and address of doctors and date of consultation.	☐ No ☐ Yes			

11.	Any investigation, imaging, laboratory test or procedure been performed? If yes, please furnish a certified true copy of the results.	☐ No ☐ Yes	
12.	(a) What was your diagnosis?		
	(b) What was the underlying cause?		
	(c) Did you inform the patient of the diagnosis? If yes, since when?	☐ No ☐ Yes	☐☐ ☐☐ ☐☐☐☐
	(d) Any relevant past history which could have contributed to the above diagnosis? If yes, please elaborate.	☐ No ☐ Yes	
13.	Is the illness / condition / treatment caused directly or indirectly, wholly or partly by any one of the following? Please tick [✓] whichever applicable: ☐ Nervous / Mental / Emotional / Sleeping Disorder ☐ AIDS / STD / VD / HIV ☐ Congenital / Hereditary diseases ☐ Influence of Drugs / Alcohol ☐ Self-inflicted injuries / Violation of laws / Strike / Riots ☐ Cosmetic reason / Dental care / Refractive errors correction ☐ Pregnancy / Childbirth / Infertility / Caesarean section / Miscarriage ☐ None of the above		
14.	Can the condition be managed on outpatient basis? If no, please provide reason for admission.	☐ No ☐ Yes	
15.	Nature of medical treatment given:		

16.	For surgery / procedure:	
	(a) Nature of surgery / procedure performed	
	(b) Name of surgeon(s)	
	(c) Name of anaesthesiologist(s)	
	(d) Date of surgery / procedure	D D / M M / Y Y Y Y
	(e) MMA OPCS code / PHFSR code	
17.	Were there any complications developed during hospitalisation? If yes, please elaborate.	☐ No ☐ Yes
18.	Any possibility of patient having a relapse?	☐ No ☐ Yes
19.	**For female only.** Was the patient pregnant at the time of hospitalisation?	☐ No ☐ Yes _____ month(s)
	(a) Was the illness caused directly or indirectly by pregnancy / childbirth / caesarean section / abortion / miscarriage and all complications arising therefrom?	☐ No ☐ Yes
	(b) If yes, please elaborate.	

Other Information

20. Did the patient suffer from any of the following illnesses?
Please tick [✓] whichever applicable and provide onset date.

- ☐ Hypertension, since
- ☐ Hyperlipidaemia, since
- ☐ Diabetes Mellitus, since
- ☐ Cardiovascular Disease, since
  Please specify the diagnosis:

  _____
- ☐ Others, please specify: _____

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21. Based on your records or from your personal knowledge, please state in details of all illnesses, accidents, surgical operations or diseases from which the patient had suffered or had been treated in this or any other clinic or hospital.

Date (DD/MM/YYYY)	**Diagnosis**	**Details of treatment**	**Doctors' name & clinic / hospital name and address**

22. Please provide details of patient's past medical and/or surgical history, family history, lifestyle (e.g. smoker, drinker, etc.) and any other information which you feel may be helpful in the assessment of patient's medical claim.

Declaration

I hereby certify that I have personally examined and treated the patient for his/her illness/condition/injury described and the facts stated above represent my medical opinion of his/her condition. I declare that I have not withheld any material information or fact. The above information is full, complete and true as per record from the hospital/clinic. I further understand that my report may form part of the evidence in any medico legal assessment.

Signature and Official Stamp of Attending Doctor

Hospital / Clinic Official Stamp

Name of Attending Doctor :

Qualification / Specialty :

Date (DD/MM/YYYY) :

Allianz Customer Service Centre
Allianz Arena, Ground Floor,
Block 2A, Plaza Sentral, Jalan Stesen Sentral 5,
Kuala Lumpur Sentral, 50470 Kuala Lumpur

Tel: 1 300 22 5542 /
1 300 88 2229*
Email: customer.service@allianz.com.my /
HSBC.customercare@allianz.com

Head Office
Level 29, Menara Allianz Sentral,
203, Jalan Tun Sambanthan,
Kuala Lumpur Sentral, 50470 Kuala Lumpur
Tel: +603 2264 1188
Fax:+603 2264 1199
allianz.com.my

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