Accident, Inpatient Medical or Critical Illnesses Treatment Fees Claim Form (AI/PA/IPD/CI)

Allianz AYUDHYA

C 30010001

National Identification Number ☐-☐☐☐☐-☐☐☐☐☐-☐☐-☐

Insurance Policy Number _____

my allianz

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Convenient and Speedy

- ☑ Requesting claim via online
- ☑ Receiving benefit via bank account
- ☑ Changing Address

Would you like this document to be returned to you? ☐ No ☐ Yes

Please return it to
- ☐ Address of the Insured specified in this form
- ☐ Agent specified in this form
- ☐ Others, please specify _____

Name of Sender _____ Tel _____ Date _____

Name of Agent/Agency Leader/Broker _____ Code _____ Tel _____

1. Name-Surname of the Insured _____ Date/Month/Year of birth _____ Age _____ Year (s)

   Gender ☐ Male ☐ Female Current Address: Name of Housing Estate/Condominium _____ No. _____ Moo _____ Alley _____ Street _____

   Sub-district/Tambon _____ District/Amphur _____ Province _____ Postal Code _____

   Home Phone/Mobile Phone _____ E-mail Address _____

   Other insurance company (ies) (if any, please specify) _____ Policy (ies) of other insurance company (ies) _____

   Occupation and job description _____

2. In case of illness(es), please specify the Insured's symptoms _____

   Period of the symptom(s) prior to the current medical treatment _____

   Name of the medical facility (ies) receiving medical treatment prior to the current medical treatment _____

   Date of medical treatment _____

3. In case of accident: Date of the accident _____ Time _____ Location _____

   Please provide the specific details of the accident _____

   _____

   Detals of wounds, size and location _____

   Current symptoms _____

   Date of the latest medical treatment _____ Name of the medical facility _____

I hereby certify that the above information is true and correct, and. I also understand that if any above information is untruthful or incomplete, it may make effect to the claim for accidental compensation, inpatient medical treatment fee, and the renewal of this insurance contract.

Signature _____ Insured

( )

Date _____

**In case the Insured is a juvenile, his/her legal guardian shall sign this form instead and specify the relationship with the Insured.

Statement of Intent

I agree to authorize physician(s), medical personnel, hospital(s) or all medical facilities to disclose my health history, medical treatment history, diagnosis or any other my relevant information, and send the copies of those documents to the Company. I also agree to authorize the Company to store, compile, use, improving and disclose my personal information both domestically and internationally in order to consider and process my claim and comply with the insurance contract. Moreover, the copy of this statement shall have the same enforcement with its original.

Signature _____ Insured

( )

Date _____

Physician's Report

Physician issuing this report must be the physician having the Doctor of Medicine degree and license in the practice of medicine. In case there is any fee, the insured shall take responsibility for such fee.

Patient's Name…… ID Card No | | | | | | | | | | | | | |

Sex : ☐ Male ☐ Female H.N.# …… A.N.# …… X.N.# ……

Consultation Date……(OPD case) or Admission Date ……Time …… Discharge Date ……Time……

For illness :

1. Date you first saw this patient for this illness ?.....
2. Chief complaint and duration of symptoms ……
3. In your opinion, how long should these symptoms persist for this illness……

For Injury:

1. Date & Time of injury……Date & Time you first saw this patient……
2. Cause of injury……
3. (Did you smell alcohol from the patient) ได้กลิ่นสุราจากผู้ป่วยหรือไม่ ☐ No ☐ Yes ☐ Not known

   Level of consciousness ☐ Normal ☐ Confusion ☐ Drowsiness ☐ Semi-coma ☐ Coma

   (Did the patient take any medication,drugs?) ผู้ป่วยกินยามาหรือไม่ ☐ No ☐ Yes (ชื่อ/ชนิด ของยา.....) ☐ Not known

Pertinent Clinical findings (Symptoms & Signs) / nature of wound and injured organs……

……

……

Past History / Underlying diseases……

Investigations……

……

Diagnosis 1. …… ICD10 …… Diagnosis 2. …… ICD10 ……

Diagnosis 3. …… ICD10 …… Diagnosis 4. …… ICD10 ……

Treatment……

……

Surgery/Operation…… ICD-9CM or 10TM…… Date performed……

Anesthesia type : ☐ GA ☐ LA …… Pathology report……

Result / Complications……

Is the illness related to alcohol , drug abuse or addiction ? ☐ No ☐ Yes ……

For Female : Was the patient pregnant at the time of treatment? ☐ No ☐ Yes ……wks (LMP……)

Was the treatment related to infertility ? ☐ No ☐ Yes ……

HIV test ☐ Not done ☐ Done Result .....

Has the patient ever been treated by other doctors before? ☐ No ☐ Yes, please give name and address……

……

Was the injury/illness contributed to or influenced by any of the following (e.g. Pre-existing weakness or extened period of disability)?

a) Physical defects/congenital anomaly ☐ No ☐ Yes

b) Unfavorable past medical history ☐ No ☐ Yes

c) Degenerative change (s) ☐ No ☐ Yes

d) A family history that increased the probability or severity of this disease ☐ No ☐ Yes

e) Doctor's advice to have periodic **" Medical Screening "** for this disease of increased risk ? ☐ No ☐ Yes

If the answer is **" yes "** , please specify ……

Other past medical history :

Date	Sign & Symptom	Diagnosis	Treatment	Doctor / Hospital's Name

Other comments about the injury / illness……

……

I, hereby certify that I have personally examined and treated the insured in connection to the above disability and that the facts are in my opinion as given above.

Name of physician…… Specialty…… License No……

Hospital Name…… Address…… Telephone No……

Signature…… Date ……

(……)

Remark: Whoever, in the pursuance of work in the medicine, makes the false certification or document by the manner likely to cause injury to the other persons or people, that person commits the offence according to the Panel Code and shall be imprisoned not out of two years or fined not out of four thousand Baht or both, and shall compensate for a civil penalty.