atlantic insurance

Policy No: ....

Claim No: ....
Code: ....

DOCTOR'S PROVISIONAL MEDICAL REPORT

FORM "A"

To be completed by the attending physician the day of the patient's admission

Name of Hospital/Clinic ....

Patient's Name ....

Company's Name (in case of collective policy) ....

Symptoms (in detail) ....

....

....

When did the symptoms appear: ....

When did the patient consult you: ....

Are you the patient's personal physician;..

Findings (in detail) ....

....

....

Preliminary Diagnosis: ....

Treatment plan (in detail, medication, examinations etc.) ....

....

....

Is the patient treated in ICU? (if yes explain why) ....

....

....

Approximate duration of treatment: ....

Date:............................ Doctor's Name:... Doctor's Sign.& Stamp:...

No claim will be accepted if Form "A" is not duly completed and submitted to Atlantic Ins. Co. Ltd. in due time.

FORM "B"

To be completed on the 3RD DAY of inpatient treatment OR PRIOR TO DISCHARGE (whichever is the earliest)

Final Diagnosis: ....

....

....

Patient's current symptoms and condition: ....

....

Is the patient treated in ICU? (if yes, explain why and for how long) ....

....

....

Treatment plan (in detail, medications, doses etc.) ....

....

....

Expected date of discharge: ....

Estimated cost of treatment: €..................................

Date:.......................... Doctor's Name:.. Doctor's Sign.& Stamp:...

Date:......................... Insured's Name:.. Insured's Signature:...

No claim will be accepted if Form "B" is not duly completed and submitted to Atlantic Insurance Co. Ltd. in due time.

atlantic insurance

Claim No: ....

Policy No: ....

Code: ....

DOCTOR'S FINAL REPORT
FORM "C"

NO CLAIM WILL BE PROCESSED IF THE PRESENT FORM AS WELL AS FORMS A & B ARE NOT SUBMITTED IN DUE TIME TO ATLANTIC INSURANCE CO. LTD. DULY COMPLETED.

ATLANTIC INSURANCE CO. LTD. WILL PAY MEDICAL AND PHARMACEUTICAL EXPENSES WHICH ARE COMMENSURATE WITH THE LEVEL OF FEES CHARGED BY MOST MEDICAL PRACTITIONERS AND/OR HOSPITALS IN THE COUNTRY WHERE THE EXPENSES WERE INCURRED.

Patient's Name ....

Company's Name (in case of collective policies) ....

Attending Physician's Name ....

Specialty ....

Date of Admission .... Date of Discharge ....

Diagnosis (please attach medical report) ....

ICU Treatment...days x €…................................ €..................

Inpatient Treatment...days x €…................................ €..................

Attending Physician's or Surgeon's fee.......................................days x €…................................ €..................
(please attach invoice)

Anaesthetist's Name...Fee €..................

Physiotherapist's Name...Fee €..................

Laboratory Investigations .... €..................
(please attach invoices and Lab results)

Ambulance Fee.. €..................

X-ray and Ultrasound Examination(s)... €..................
(please attach invoices and examination results)

Medication: (in detail) .... €..................

.... €..................

.... €..................

.... €..................

.... €..................

ECGs (please attach all ECGs) .... €..................

Other .... €..................
(please attach invoices and examination results)

After processing the claim all the relevant documents (Laboratory, ECGs etc.) will be returned

TOTAL: €..................

Please tick the appropriate box: Return all the documents to me ☐

Return all the documents to the patient ☐

Doctor's Signature& Stamp .... Insured's Signature...

Date .... Date ....