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.