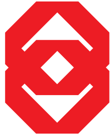

ក្រុមហ៊ុនធានារ៉ាប់រង កម្ពុឡុនប៉ាក់

CAMPU LONPAC INSURANCE 柬埔寨大众伦平保险

SECTION ONE - HOSPITAL & SURGICAL INSURANCE CLAIMS FORM

Our Claim No : ____________________

SECTION 1 - To be completed by the Insured / Claimant (IN BLOCK LETTERS)

Name of Insured

Policy No.

Claimant (other than the Insured)

Claimant is:

☐ Self ☐ Spouse

☐ Child

ID Card. No./Passport No.(if applicable)

Birth Date

☐ (dd) ☐ (mm) ☐ (yy)

Age

☐

Sex

☐ Male ☐ Female

Race

Marital Status

Occupation

Employer

Tel. No.

Employer 's Address

Type of Claim

☐ Hospitalisation

☐ Outpatient

☐ Accident
Circumstances of Accident

If Claim payable, make cheque(s) to
☐ Employer
☐ Employee

Details of other insurance policies, Workmen's Compensation and others:-

Policy Type	Insurance Company	Policy No.

AUTHORISATION TO PHYSICIAN, HOSPITAL OR CLINIC TO RELEASE INFORMATION

I hereby authorise any physician, medical practitioner, hospital or clinic by whom or where I have/my ward has been observed or treated, to give full particulars about my/ward 's health including my/ward 's whole medical history in respect of this hospitalisation/surgery, to the above insurance company.

....
Signature of Patient

....
Signature of Insured/Claimant
(Company stamp where applicable)

....
Date

....
Date

CAMPU LONPAC INSURANCE PLC.
7th Floor, Campu Bank Building, No. 23, Street 114, Phnom Penh, Kingdom of Cambodia. P.O Box 1556
Tel : +855 23 966 966 / 998 200 / 986 279 Fax : +855 23 986 308 / 986 273 E-mail : enquiries@campulonpac.com.kh Website : www.campulonpac.com.kh

SECTION TWO - MEDICAL REPORT

SECTION II - To be completed by the Attending Doctor (IN BLOCK LETTERS) **Ref. No:**

Name of Hospital and Address

Name of Patient

Date and Time of Admission

☐ (dd) ☐ (mm) ☐ (yy) ☐ (hrs)

Date and Time of Discharge

☐ (dd) ☐ (mm) ☐ (yy) ☐ (hrs)

Name of Referring Doctor and Address

Admitting Doctor	Attending Doctors	Speciality

1a. Diagnosis/ICD Coding

1b. Cause and Pathology (if applicable) of the above diagnosis

2a. When did patient first consult you for this condition?

☐ (dd) ☐ (mm) ☐ (yy)

2b. Was the patient previously treated for this condition?

No Yes, give details and when

☐ (dd) ☐ (mm) ☐ (yy)

....

....

....

2c. How long in your professional opinion has the condition existed?

☐ (dd) ☐ (mm) ☐ (yy)

4a. Please ✓ Nature of Treatment and Investigation:

☐ OPERATION ☐ PHYSIOTHERAPY
☐ DIETARY COUNSELLING ☐ MEDICATIONS
☐ X-RAY ☐ BLOOD TESTS
☐ OTHERS, give details...

....

....

4b. If more than one procedure was involved, please state Type of Procedures performed:

	TYPE	DATE	NAME OF DOCTOR
i.			
ii.			
iii.			

4c. Other medical conditions present?

....

Since (dd mm yy)...

Since (dd mm yy)...

....

Since (dd mm yy)...

3. Any possibility of a relapse?

5. Was the condition

congenital nervous mental

6. Was the patient pregnant at the time of hospitalisation? (For Females Only)

7. If the hospitalisation was due to accident, please indiciate date/time of accident:

☐ (dd) ☐ (mm) ☐ (yy) ☐ (hrs)

8. Discharge/Follow-up instructions

....

Signature and Name of Attending Doctor Hospital Stamp Date