CERTIFICATE FROM HOSPITAL (Rider)



Without prejudice

Important points:

- This form needs to be completed by the Hospital Authorities where the Life Assured was either admitted or treated
- $\bullet \quad \text{If the Life Assured has been admitted in two different hospitals the form is to be filled up per hospital}\\$
- Medical records such as Death/Discharge Summary, Inpatient / Outpatient records, Operation notes, Progress records wherever applicable to be provided along with this form

Policy No.:	Date: D D M M Y Y Y Y
Name of the Patient:	Inpatient No./MRD No.:
Address:	Age:years
Details of the hospital	
1. Indoor patient no.:	
2. Date of Admission: DD MM YYYYY	Date of discharge: DD MM YYYY
Time : (In 24 Hrs format)	Time : (In 24 Hrs format)
3. Was the patient admitted to ICU?	Yes No (If yes, Please provide us with the following)
	Days of admission in ICU: (No. of days)
	From DDMMYYYY to DDMMYYYY
4. Was the patient referred by any doctor/hospital?	Yes No (If yes, Please provide us with the following)
	Name & Address:
	Tel. No.:
Details of the illness suffered	
Definitive discharge diagnosis:	Date of diagnosis: D D M M Y Y Y Y
2. Symptoms insured presented with, related to current illness	1)
(please specify separately if multiple symptoms)	2)
	3)
3. Duration of the said symptoms	1)
(please specify separately if multiple symptoms)	2)
	3)
4. Investigations done and their findings:	
Treatment given during the course of hospitalization:	
If discharged, clinical condition at the time of discharge:	Recovered & discharged/ Expired/ Referred/ LAMA/ DAMA
7. Is the ailment a complication of Pre-existing disease or condition?	Yes No
7. Is the difficulty of the existing disease of collution:	If Yes, please give details:
9. Is the present allment attributable to the inculones of cleakel or	
8. Is the present ailment attributable to the inculence of alcohol or intoxicating drugs?	Yes No
9. Cause of Illness (if others, please specify):	Congenital Accidental Pre-existing Disability
	Others

Provide details if claim for disability						
1. Cause, nature & extent of disability	Illness	Injury				
	Permanent	Permanent Temporary				
	Total	Total Partial				
2. If due to illness, please provide the following:	If due to Accident, p	If due to Accident, please provide the following:				
Name of the illness:	Date of Accident:	Date of Accident: DD MM YYYY				
Date of diagnosis of illness: DD MM YYYY	Nature of Accident:	Nature of Accident: RTA/ RSA Domestic Others				
	If Others pls specify	If Others pls specify:				
Give cause of Injury/Accident:	Self Inflicted	Self Inflicted				
	Road side / Roa	Road side / Road Traffic Accident				
	Under effect of	Under effect of Substance Abuse (incl. Alcohol)				
If Injury due to substance Abuse /Alcohol Consumption,						
Test conducted to establish this: (If yes, attach reports)	Yes No	Yes No				
If Medicolegal:	Yes No	Yes No				
Reported to Police:	Yes No					
FIR No:						
If not reported to police , specify reason:						
3. Is the Life Assured capable of performing any occupation or engaging in activities for remuneration or profits?	Yes No	Yes No				
4. Progress	Partially Improv	ved U	nimproved	Fully recovered		
5. Treatment given during the course of hospitalization						
 If discharged condition at the time of discharge (multiple options can be ✓) 	Recovered & discha	Recovered & discharged/ Expired/ Referred/ LAMA/ DAMA				
7. As per condition at discharged, what was the expected time of recovery?						
8. Has the insured followed all recommendations?	Yes No	Partly	У			
Please describe in detail any complications, RELATED to injury th	at may have occurred after di	scharge;				
Please describe in detail any complications, NOT RELATED to inju	ry that may have occurred aft	ter discharge a	and worsene	d clinical condition		
Past history of the insured						
Was the patient suffering from any illnesses in the past?	Nature of illness	Yes/No		Duration		
	Hypertension	Y	N			
	Diabetes	Υ	N			
	Tuberculosis	Y	N			
	Kidney disease	Y	N N			
	Liver disease	Y	N N			
	Heart disease	Y	N			
	Cancer	Y	N N			
		Y				
	Asthma/COPD		N			
	Others	Please Speci	ту:			

2. Did the patient have habits like		Habits		Vos	/No	Duration	Quantity consumed	
2. Did the patient have habits like						Duration	Quantity consumed	
			tion of alcohol	Y	N			
		Smoking		Y	N			
		Tobacco		Y	N			
		Drugs		Y	N			
		Drugs of a		Υ	N			
3. Did the patient undergo any surg	ery/biopsy/endoscopy	Yes No						
in the past and or during current	hospitalization	If yes, provide the following details:						
	Name of the surgery:							
		Indication for Surgery:						
		nosis arrived at						
						s performed:		
		Ivallie of	tile ilospital wild	ere trie sur	gery wa	s periorilleu.		
		Date on which surgery was performed: DD MM YYYY						
4. Who reported the above mention	ned history							
		I						
Expense Incurred Details								
Details of Fee charged and mode of p	payment:	Amount:	N	∕lode of Pa	yment:			
Whether paid				Cheque Cash DD				
all at discharge or				Medical Insurance Others				
Advance payment (s) with final s	settlement at discharge		If other, please specify					
	· ·	Strict, prease spessify						
If the nationt availed the henefit of a	ny Madiclaim insurance	Name o	f the Su	m Assured	Δn	nount of clain	n Date of claim	
If the patient availed the benefit of any Mediclaim insurance policy for the purpose of making payment		Insur		iii Assureu		received	Date of claim	
please provide details								
Cashless Reimbursement								
Group Individual								
Prior admission details								
Prior admission details Had the patient been admitted or tree	ated by you or your hospita	al earlier?	Yes	No (If y	es, prov	ide the follow	ring)	
Had the patient been admitted or tre	rated by you or your hospita	al earlier?	Yes Reason for se			ide the follow		
Had the patient been admitted or tre		al earlier?				1		
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Had the patient been admitted or tre	ites	al earlier?				1		

Declaration We hereby declare that the details furnished in this form are true and correct to the best of our knowledge and belief and is as per the records of the hospital Certification by Hospital Admitted, that 1. The Hospital is duly registered as a Hospital to provide treatment in India for the care and treatment of sick and injured persons as registered inpatients, fully equipped with facilities for diagnosis and major surgery which are under the constant supervision of one or more Registered $Medical \, Practitioners \, and \, which \, have \, 24-hour \, a \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, professional \, nursing \, services; \, and \, day \, full \, time \, profession$ 2. Maintains proper medical and patient records; and 3. The Hospital has on the following facility and resource (Please specify) Hospital Registration No No. of In-patient beds (including ICU) No. of fully equipped Operation Theatre in the Hospital No. of qualified nursing staff in Hospital round the clock No. of qualified medical practitioner (s) in charge round the clock Doctor's Name & Qualification: Doctor's Signature: Doctor registration no. & contact no.

Address & Seal (to be attested with hospital seal):

Hospital Seal