CERTIFICATE FROM HOSPITAL (Rider)

edelweiss life insurance

Without prejudice

Important points:

- This form needs to be completed by the Hospital Authorities where the Life Assured was either admitted or treated
- 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: D D M M Y Y Y Y Time ___ ___ : ___ ___ (In 24 Hrs format)	Date of discharge: D D M M Y Y Y Y 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 D D M M Y Y Y Y to D D M M Y Y Y Y
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

1. Definitive discharge diagnosis: _____	Date of diagnosis: D D M M Y Y Y Y
2. Symptoms insured presented with, related to current illness (please specify separately if multiple symptoms)	1) _____ 2) _____ 3) _____
3. Duration of the said symptoms (please specify separately if multiple symptoms)	1) _____ 2) _____ 3) _____
4. Investigations done and their findings:	
5. Treatment given during the course of hospitalization:	
6. 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 If Yes, please give details:_____
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 ☐ Temporary ☐ Total ☐ Partial
2. If due to illness, please provide the following: Name of the illness: _____ Date of diagnosis of illness: D D M M Y Y Y Y	If due to Accident, please provide the following: Date of Accident: D D M M Y Y Y Y Nature of Accident: RTA/ RSA Domestic Others If Others pls specify: _____ _____
Give cause of Injury/Accident:	☐ Self Inflicted ☐ Road side / Road Traffic Accident ☐ Under effect of Substance Abuse (incl. Alcohol)
If Injury due to substance Abuse /Alcohol Consumption, Test conducted to establish this: (If yes, attach reports) If Medicolegal: Reported to Police:	☐ Yes ☐ No ☐ Yes ☐ No ☐ 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
4. Progress	☐ Partially Improved ☐ Unimproved ☐ Fully recovered
5. Treatment given during the course of hospitalization	
6. If discharged condition at the time of discharge (multiple options can be ✓)	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
Please describe in detail any complications, RELATED to injury that may have occurred after discharge;	
Please describe in detail any complications, NOT RELATED to injury that may have occurred after discharge and worsened clinical condition	

Past history of the insured

1. Was the patient suffering from any illnesses in the past?

Nature of illness	Yes/No		Duration
Hypertension	Y	N	
Diabetes	Y	N	
Tuberculosis	Y	N	
Kidney disease	Y	N	
Liver disease	Y	N	
Heart disease	Y	N	
Cancer	Y	N	
Asthma/COPD	Y	N	
Others	Please Specify: _____ _____		

2. Did the patient have habits like	Habits	Yes/No		Duration	Quantity consumed
	Consumption of alcohol	Y	N		
	Smoking	Y	N		
	Tobacco	Y	N		
	Drugs	Y	N		
	Drugs of abuse consumption	Y	N		
3. Did the patient undergo any surgery/biopsy/endoscopy in the past and or during current hospitalization	☐ Yes ☐ No If yes, provide the following details: Name of the surgery: _____ Indication for Surgery: _____ In case any biopsy done, finding of HP report: _____ Final Diagnosis arrived at: _____ Name of the hospital where the surgery was performed: _____ Date on which surgery was performed: D D M M Y Y Y Y				
4. Who reported the above mentioned history					

Expense Incurred Details

Details of Fee charged and mode of payment:	Amount:	Mode of Payment:
Whether paid ☐ all at discharge or ☐ Advance payment (s) with final settlement at discharge		☐ Cheque ☐ Cash ☐ DD ☐ Medical Insurance ☐ Others If other, please specify _____

If the patient availed the benefit of any Mediclaim insurance policy for the purpose of making payment please provide details ☐ Cashless ☐ Reimbursement ☐ Group ☐ Individual	Name of the Insurer	Sum Assured	Amount of claim received	Date of claim

Prior admission details

Had the patient been admitted or treated by you or your hospital earlier?		☐ Yes ☐ No (If yes, provide the following)	
Dates		Reason for seeking treatment	Treatment given
From	To		

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 in-patients, 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
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: _____ Date: _____

Doctor registration no. & contact no.

_____

_____

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

_____

_____

Hospital Seal