Insular Life

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Hospital's Certification

(I-Shield Claim Form II)

INSTRUCTIONS: This form is to be accomplished by the following:
Part 1 - Authorized Officer of the hospital and must be submitted with the official Statement of Account, Official Receipts covering hospital charges incurred during confinement; the patient's Hospital Records such as Admitting History, Clinical History and Physical Examination, Discharge Clinical Summary, Hospital Chart, Clinical Chart Records, or their equivalent
Part II – Attending Surgeon, if surgery was performed and must be submitted together with the Official Receipt covering surgical fee.

Part I To be completed by the hospital's Authorized Representative

Name of Patient: ____________________
Surname Given Name Suffix (Sr., Jr., etc.)

Date of Birth:	Age:	Sex:	Marital Status:

Nature of Injury:	Diagnosis:

Complete Name/s of Attending Physician/s:
______ ______ ______
______ ______ ______

Dates of Confinement:	Period of Confinement:
Admitted on:	Room & Board
Month / Day / Year / Time	¤ Regular Rooms From: Month / Day / Year To: Month / Day / Year
Discharged on:	¤ ICU From: Month / Day / Year To: Month / Day / Year
Month / Day / Year / Time	

Name of Hospital:

Address of Hospital:

No. Name of Street/ Highway Town/Municipality City/Province Country Zip Code

Contact Nos.:	Email address:

Is the hospital registered with the Bureau of Health, Facilities and Services, Department of Health, Phils? ____Yes ____No

If Yes, please indicate : Registration/Permit No. ________________Date Issued: ________________Issued By: ________________

If Not, does it have the permit to operate as hospital,/clinic and to admit in-patient? ____Yes _____No

I HEREBY CERTIFY that the foregoing answers have been taken from the hospital records of the above-named patient. They are true, correct and complete.

______________________	______________	______________
Printed Named & Signature of Hospital's Authorized Representative	**Official Title**	**Date Signed**

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Part II To be completed by the Attending Surgeon, if any surgical operation was performed.

Name of Patient: ____________ Last Name / First Name / Middle Name	Age:	Sex:
Complete Diagnosis:	Short History of Injury:	
Is the patient under your professional care at present? ____Yes _____No		
Nature of Operation Performed:		
Date Performed:	Where Performed?	
Name of Surgeon:	Fees Charged: P	
Name of Anesthesiologist:	Fees Charged: P	

ATTENDING SURGEON'S DECLARATION

I HEREBY CERTIFY that the foregoing answers in Part II above are true, correct and complete.

______________________	______________________
Signature of Attending	**Date**
Area of Specialty	**Area of Practice**
License No.	**Date Issued**