AIA Company Limited
Inpatient (IPD) Claim Form

C42500

Hospital Name..... ☐ Individual Insurance ☐ Group Insurance

Part A

For the Insured Person

1. Name-Surname (Insured member) ..... Sex: ☐ male ☐ female National identity number: __ __ __ __ __ __ __ __ __ __ __ __ __
   Date of birth: ..... Age: ..... Years .....Months Occupation: .....
   Mobile phone number: .....Landline: ..... E-mail: .....
   Current address:.....
2. Insurance policy number: .....Certificate number (if any): .....
   Do you hold other insurance policies underwritten by another insurance company? ☐ No ☐ Yes Company: .....
   Insurance policy number: .....
3. Reasons for making this claim
   ☐ Illness Symptoms: .....For how long have you suffered from this illness before receiving medical treatment?: .....
   Name of the medical centre where you were treated before this treatment: .....Date of treatment: .....
   ☐ Injury Date of the injury: ..... Time of occurrence: ..... Place of incident: .....
   Cause of the injury: .....
   Nature of wound(s), size, and the injured body part(s): .....
4. Have you been treated for this accident? ☐ No, I have not been treated ☐ Yes, I have been treated at: .....On: .....
   I have advanced the expenses or claimed the medical expenses through the hospital for the amount of: ..... Baht

LETTER OF CONSENT

I, hereby, consent and allow doctors, medical centres, other insurance companies or any relevant persons who have acquired my personal information, health, medical records, disability, sexual behaviour, biometric data, genetic data, and my past or future medical history which were available or will be available to disclose and release such information to the Company, the Company's life insurance agents, or the Company's representatives in order to apply for an insurance policy, or claim the benefit thereof, or dealing with the insurance policy in any manner.

I, hereby, grant my consent to the Company to collect, use, disclose and release my personal information, health, medical records, disability, sexual behaviour, biometric data, genetic data, and my past or future medical history to the competent authorities or the reinsurers, relevant persons, the Company's life insurance agents, its personnel, and its representatives for the purpose of applying for an insurance policy, indemnifying the insured person thereunder, or for medical interest or dealing with the insurance policy in any manner.

In the event of a claim of indemnification through a hospital, I, hereby, consent and allow the Company to pay the medical fees to the medical centres from which I have received the treatment as if the Company has legally indemnified me of such expenses under the terms and conditions of the insurance policy. Nevertheless, I will directly and personally make payment of any outstanding medical fees which are not covered by the insurance policy. Also, I fully appreciate that the Company reserves the rights to indemnify according to the campaign of payment of the medical expenses through hospitals if the illness or accident which I am claiming found to be exempted under the insurance policy despite the Company's preliminary approval of my inpatient treatment. In this case, I shall reimburse the Company of all expenses it has advanced to the medical centre on my behalf within 7 (seven) days from the date of the notice by the Company.

Additionally, the copy of this Letter of Consent shall be binding as same as the original.

I, hereby, fully acknowledge and understand the content as well as conditions and the practices of the Company. I also agree that they are in accordance with my intention. Therefore, I am thereby entirely bound without reservation.

NOTE: * If the insured person is a minor, his/her legal representative shall sign on his/her behalf and specify their relationship.
** If the fingerprint of the insured person is used instead of his/her signature, it must be certified by 2 (two) witnesses.

Insured person: ..... (.....) Date: ..... Witness: ..... (.....) Witness: ..... (.....)
Person giving consent: ..... Relationship: .....
As ☐ Father/Mother
☐ Legal representative of the insured (In case the insured is underage)

For Physician

1. Visit date: .....Time: ..... Vital signs: T: ..... P: ..... R:..... BP: .....
2. Chief complaint duration: .....
3. Present illness or cause of injury: .....
   .....
   .....
4. Physical exam: .....
   .....
5. Previous treatment for this illness or injury (Date & Place):
   .....
6. Is the illness related to: (please tick ☑ if yes)
   ☐ Pregnancy / Childbirth / Infertility / Caesarean section / Miscarriage
   ☐ Congenital / Hereditary disease
   ☐ Nervous / Mental / Emotional / Sleeping disorder
   ☐ Influence of Drugs / Alcohol
   ☐ Cosmetic reason / Dental care / Refractive errors correction
   ☐ AIDS
   ☐ An accident; Date of accident: ..... Time: .....
   ☐ None of above
7. Underlying condition: .....
8. Provisional diagnosis: .....
9. Can the condition be managed under Outpatient basis ☐Yes ☐No
   (If No please provide more information) .....
10. Reasons of admission.....
11. Treatment.....

Physician's name ..... Medical license No. ..... Specialty .....

(.....) Date .....

Part B

Medical certification

Patient's Name: .....Sex ☐ Male ☐ Female HN: .....AN: ..... Age .....year(s) .....month(s)

Admission Date: ..... Time: ..... Discharge Date: ..... Time: .....Consultation Date: .....

1. For Illness

a) Date you first saw this patient for this illness: .....

.....

.....

b) Chief complaint and duration of symptom(s):

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.....

2 For Injury

a) Date of injury..... Time: .....

b) Cause of injury.....

c) Details of injury .....

d) Did you smell alcohol from the patient?

( ) No ( ) Not known

( ) Yes**,** blood alcohol test (if any) = ... mg%

e) Level of consciousness ( ) Normal ( ) Confusion

( ) Drowsiness ( ) Semi-coma ( ) Coma

f) Estimated time for recovery .....

.....

3. Did the patient need to be admitted to hospital? ( ) No ( ) Yes, indication for admission.....

.....

4. Vital signs: T..... P..... R .....BP.....

5. Pertinent Clinical findings (Symptoms & Signs) .....

.....

6. Investigation & Result (Lab, EKG, X – ray, etc.) .....

.....

7. HIV Test ( ) No ( ) Yes, Result: ..... Date performed: .....

8. Underlying disease: .....

9. Diagnosis 1: .....ICD10-TM: .....

Diagnosis 2: ..... ICD10-TM: .....

Diagnosis 3: ..... ICD10-TM: .....

Discharge DRG	
Adjusted RW	

10. Treatment: .....

.....

11. Surgery/Operation: ..... ICD9-CM: ..... Date performed: .....

Anaesthesia Type: ( ) General Anaesthesia ( ) Spinal Anaesthesia ( ) Local Anaesthesia ( ) Others .....

12. Pathological report:.....

.....

13. Complications (if any): .....

14. Is the illness related to alcohol, drug abuse or addiction? ( ) No ( ) Yes, please specify.....

15. For Female: Is the patient pregnant? ( ) No ( ) Yes, gestational age.....weeks

Was the treatment related to infertility? ( ) No ( ) Yes, please specify .....

16. Has patient ever been treated by another doctor before? ( ) No ( ) Yes, please give name and address .....

17. Was the illness/injury contributed to or influenced by any of the following

a) Physical defects/congenital anomaly ( ) No ( ) Yes

b) Degenerative change(s) ( ) No ( ) Yes

18. Others past medical history

Date	Sign & Symptom	Diagnosis	Treatment	Physicians / Hospital

19. Other comments about the injury / illness .....

.....

I hereby certify that I have personally examined and treated the insured in connection with the disability and that the facts are in my opinion as given above.

Physician's signature ..... Medical specialty: ..... Medical license no: .....

(.....) Tel no: ..... Date: .....

Medical institute: ..... Address: .....

Remark: Doctor who issue this report must be a doctor who is licensed to practice medicine and correctly registered by the Medical Council