PNB MetLife India Insurance Company Limited
Registered office: Unit No. 701, 702 & 703, 7th Floor, West Wing, Raheja Towers, 26/27 M G Road, Bangalore -560001, Karnataka. IRDA of India Registration number 117.
CI No. U66010KA2001PLC028883, Call us Toll-free at 1-800-425-6969, Website: www.pnbmetlife.com, Email: indiaservice@pnbmetlife.co.in or write to us at 1st Floor, Techniplex -1, Techniplex Complex, Off Veer Savarkar Flyover, Goregaon (West), Mumbai – 400062. Phone: +91-22-41790000, Fax: +91-22-41790203

HOSPITAL CERTIFICATE

(TO BE FILLED IN BY THE ATTENDING PHYSICIAN)

Patient Details:

Name of the Patient: _____

Age: _____ (Please Tick box) Sex: Male ☐ Female ☐

Address of the Patient: _____

_____ Telephone No: _____

Name & Address of the Physician: (As Applicable): _____

_____ Telephone No: _____

Name & Address of the Hospital: (As Applicable): _____

_____ Telephone No: _____

Hospital Inpatient No / MRD No: _____

Particulars of Complaints and Symptoms:

1. Reason for Hospitalization:_____
2. Date of first diagnosis/surgery: __ __ / __ __ / __ __ __ __ (DD/MM/YYYY)
3. Date and time of admission: __ __ / __ __ / __ __ __ __ (DD/MM/YYYY) __ __ : __ __ (in 24 Hrs format)
4. Date and time of Discharge: __ __ / __ __ / __ __ __ __ (DD/MM/YYYY) __ __ : __ __ (in 24 Hrs format)
5. Exact diagnosis (es)/condition(s) :_____
6. Date of first Consultation (prior to hospitalization) __ __ / __ __ / __ __ __ __ (DD/MM/YYYY)
7. Was the Patient admitted to ICU? Yes ☐ No ☐ If "Yes" Please specify below details:

- Date and time of Admission into ICU: __ __ / __ __ / __ __ __ __ (DD/MM/YYYY) __ __ : __ __ (in 24 Hrs format)
- Date & time of Discharge from ICU: __ __ / __ __ / __ __ __ __ (DD/MM/YYYY) __ __ : __ __ (in 24 Hrs format)

8. A) With what complaints was the patient admitted for?_____

   B) Since when was the patient suffering from the said complaint?_____
9. Please give previous medical history of the patient:_____
10. Is the ailment a complication of pre-existing disease or condition? If 'Yes' please give details._____
11. Is the present ailment attributable to the influence of alcohol or intoxicating drugs?_____
12. Exact cause of Illness: (if others Please specify)

    Congenital ☐ Accidental ☐ Pre-existing ☐ Disability ☐ Others ☐ : _____
13. ICD 10 Code:_____ Details of Procedure/s done: _____
14. Additional Remarks by Attending physician/ Surgeon: _____

    _____
15. Nature of identity proof submitted by patient: _____

HOSPITAL CERTIFICATE

16.

Sr. no	Hospital Details	To be filled by Physician/Hospital
a.	Hospital Registration number	
b.	No. of inpatient beds in the hospital (including ICU)	
c.	No. of fully equipped operation theatres in the hospital	
d.	No. of qualified nurses in the Hospital	
e.	No. of fully qualified doctors the hospital have round the clock	

17. Details of Doctor's / Surgeons treated or advised the patient.

Name of the Doctor / Surgeon	Contact Details

Declaration:

By The Hospital

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. We hereby authenticate the identity of the above person who underwent treatment at this hospital.

Doctor's name & Qualification:_____

Doctor's Signature: _____ Date: _____

Address & Seal: _____
(To be attested with Hospital Seal)

Note: All the questions are mandatory.