Ceylinco Life Insurance Limited, Ceylinco Life Tower, 106 Havelock Road, Colombo 5 Co. Reg. No. PB5183 Tel:(011) 2461461 Email: service@ceylife.lk Web: www.ceylincolife.com

To be completed by the attending Medical Officer

Physician/ Surgeon

A. Patient Details

a. Name of the Patient :.....

b. NIC / Passport Number : .....

B. Admission Details

a. IP Registration Number : .....

b. Date and time of admission : .....

c. Date and time of discharge : .....

d. Type of admission : Emergency / Planned / Day care / Maternity

e. Status at discharge : Discharged to home / Another hospital / Deceased

f. Pre Authorization obtained : Yes / No

If yes: Pre Authorization Number .....

g. Total Claimed amount LKR : .....

h. Name of the hospital with address : .....

i. Hospital Registration number : .....

j. Number of Inpatient beds : .....

k. Facilities available in hospital

   a. OT : Yes / No

   b. ICU : Yes / No

   c. Others :

   .....

C. Details of Illness / Treatment / Surgery

a.

	ICD 10 Codes	Description
Primary Diagnosis		
Additional Diagnosis		
Co – Morbidities		
Co – Morbidities		

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	ICD 10 Codes PCS	**Description**
Procedure 1		
Procedure 2		
Details for the Procedures:		

(b) Is the condition / treatment related to:

i. Infertility/sub-fertility/pregnancy and related complications : Yes / No

ii. Genetic/chromosomal /congenital anomaly : Yes / No

iii. Mental or psychiatric condition : Yes / No

iv. Cosmetic procedure : Yes / No

v. Drug abuse, narcotics, alcohol and related complications : Yes / No

vi. Surgery for short slightness : Yes / No

vii. Surgery for dental purpose : Yes / No

(c) Other details

i. Name and address of referring doctor, if patient is referred to you? .....

.....

.....

ii. Nature of symptoms/complaints prior to consultation? .....

.....

.....

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iii. In your opinion, when do you think this ailment could have begun or been contracted?

.....

iv. Is the patent is suffering from any other ailment such as Diabetes, hypertension, Heart Disease etc?

.....

.....

I certify that I am General Practitioner/Consultant/Surgeon of the patient named above and that the information I have supplied is true and correct.

Name:.....

Qualification:.....

Reg. No.....

Signature and Official Stamp of
the Medical Officer/Consultant

Date: .....

Declaration by Hospital

We hereby declare that the information furnished in this medical certificate is true and correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, out right to claim shall be forfeited.

Date : _ _ / _ _ / _ _

Place:

Signature & seal of Hospital Authority