



PASEGURUHAN NG MGA NAGLILINGKOD SA PAMAHALAAN
 (GOVERNMENT SERVICE INSURANCE SYSTEM)
 Financial Center, Pasay City, Metro Manila 1308

HOSPITALIZATION INSURANCE PLAN CLAIM FORM

Policy Number:	NAME: (Surname, Given Name, M.I.)	GSIS Number:
OFFICE: (Name and Address)	_____	_____
	<i>Signature of Claimant</i>	<i>Date</i>

TO BE FILLED-UP BY PHYSICIAN

BRIEF CLINICAL RECORD

NAME OF HOSPITAL:		ADDRESS:	
DATE OF ADMISSION:	DATE DISCHARGED:	DATE OF DEATH:	
CHIEF COMPLAINTS ON ADMISSION AND BRIEF CLINICAL HISTORY:		OPERATION/S PERFORMED, IF ANY:	
PERTINENT PHYSICAL FINDINGS:		MEDICINES ADMINISTERED:	
PERTINENT LABORATORY, X-RAY AND OTHER EXMINATIONS PERFORMED:		FINAL DIAGNOSIS:	

I hereby certify that the above statements are true and taken from the patient's/claimant's clinical chart during confinement in this hospital.

_____, M.D.
Attending Physician or Chief of Hospital,
Prof. License No.: _____

GSIS TO FILL IN ALL ITEMS BELOW

MEDICAL EVALUATION:

_____ Medical Evaluator

_____ Date