HOSPITALIZATION CLAIM FOR PAYMENT

EMPLOYEE'S COMPENSATION

PART I - HOSPITAL TO FILL IN ALL ITEMS

Hospital	Address		PMC No.
Patient/Employee	Date Admitted	Date Discharged	Date of Death

	Hospital Charges (Ward Services)	BC	Actual
Diagnosis	A. Rm Bd & Special Charges _____ days at P _____		
Final Diagnosis	B. Surgical		
GSIS No. / Sex ☐ M ☐ F / Age	C. Medicines		

Address of Employee

Employer

Address of Employer

For GSIS Use *(Signature Verified by)*

Remarks

CERTIFICATION

I hereby certify that the services claimed are duly recorded in the patient's chart and the information given this form including the attached copy of the patient statement of actual charges is correct.

Printed name of Hospital	Authorized Representative
Official Capacity	
Signature of Authorized Representative	Date signed

PART II - DOCTOR TO FILL IN ALL ITEMS

Do not Fill

Code No.

Brief Clinical History of the Case *(For clarification, use reverse side hereof)*

For services rendered always state the nature of service, surgical operation performed, if any, and date of each.		CHARGES	
		E.C.	Actual
A. Name of Attending Physician/Surgeon	Address		
Signature PMA No. TIN	Date signed	P	P
Services Rendered			
B. Name of Attending Physician/Surgeon	Address		
Signature PMA No. TIN	Date signed	P	P
Services Rendered/Operation Performed			
C. Name of Anesthesiologist	Address		
Signature PMA No. TIN	Date signed	P	P
Services Rendered			

MEDICAL EVALUATION REPORT (For GSIS use only)

Nature of Degree of Sickness/Sickness

Noted: _____

Signature: _____

Designation: _____

Date: _____

NOTICE: Any one who falsifies essential information, requested by this or a related form may, upon conviction be subject to fine and imprisonment under the law. All data required on this form are necessary for adjudication of the claim. The GSIS will adjudicate any claim where forms are not properly or completely accomplished.

PART III - ATTENDING PHYSICIAN'S CERTIFICATION (Fill in All Items)

Name of Employee	Treatment Period (exact date) From: ______________ To: ______________
History of present illness: (Give exact date, if possible and include signs and symptoms up to the time of this report	Pertinent P.E. Findings & Laboratory procedures: Past history (only those relevant to present illness)
Final Diagnosis:	
Was the injury or illness directly caused by the employee's duties?	
Degree of disability ( ) Temporary total ( ) Permanent total ( ) Permanent partial	Was patient working at the time of illness?
______________________ M.D. Signature over printed name PMA No. ____________ BIR TIN: ________ Lic. No. ____________ Date Issued ________	Medical Evaluation Report: (for GSIS use only)