ATTENDING PHYSICIAN'S STATEMENT

PLEASE COMPLETE THIS FORM AND GIVE TO YOUR PATIENT

Name of Patient: _____ Age: _____

Address: _____

Name of Insured Person: _____

Address: _____

Date of visit or service	Diagnosis Describe complication (If any)	Type of visit (office or Hospital)	Visit fee $	Name of drug(s) prescribe or injection	Duration of drugs	Cost $ if supplied	Other services rendered	Cost $	Further service Recommended	Doctor's Signature

Describe procedure(s) performed

SURGICAL OPERATIONS

MATERNITY

Date of Pregnancy

Date: _____

Date: _____

Date: _____

Date: _____

Surgeon's Fees $_____

Amount paid by Insurance $_____

Assistant Surgeon's Fee $_____

Amount paid by Insurance $_____

Anesthetics Fee $_____

Amount paid by Insurance $_____

Obstetrics Fee $_____

Amount paid by Insurance $_____

Anesthetics Fee $_____

Amount paid by Insurance $_____

ASSIGNMENT OF CLAIM BENEFITS (Signed if payment has to be made other than to Member/Employee)

I hereby authorize payment of this claim benefits directly to the above-named physician otherwise payable to me, not exceeding the charges shown. I understand that I am financially responsible for charges not covered by this authorization.

SIGNATURE OF PATIENT:---------- **DATE:----------**

G.U.T. GROUP MEDICAL PLAN

P.O Box 452, Marine Villa, St. George
PHONE: 440-5988/3248 FAX: 444-5988
Email: medplan95@yahoo.com /medical.p2013@gmail.com

GENERAL CLAIM FORM

1. Member/Employee's Name _____
2. Relationship of patient to Member/ Employee: _____Date of Birth (of child)_____
3. Name of attending Physician: _____
4. When did symptoms of this aliment first appear or accident happen? _____
5. Have you ever had this ailment before?_____ if yes state when and describe _____

   _____
6. Did your sickness or injury arise out of your employment? ____if yes state when and describe

   _____
7. Is spouse employed? _____ if yes name of employer _____
8. Are you or any of your dependents covered by any other Health Insurance Plan providing benefits for this injury or sickness? _____

   If yes give (a) Name of Insurance Company _____

   (b) if Group Plan, Name of Group or Company Insured under_____
9. Check if statements\bills for ALL expenses are attached in support of your claim ___**YES** ___**No**

I hereby certify that the foregoing answers are true and correct to the best of my knowledge and herby authorize all doctors or other persons who treated me and all hospitals or other institutes to furnish full information (including full copies of their records) regarding this claim to THE G.U.T. GROUP MEDICAL PLAN.

DATE_____20_____ _____ _____

SIGNATURE OF MEMBER/EMPLOYEE **SIGNATURE OF SPOUSE (IF PATIENT)**

SCHOOL OR INSTITUTION_____

PREVIOUS SCHOOL OR INSTITUTION_____

Contact Number(s) **Email Address:**