

INSULAR LIFE HEALTH CARE, INC.

2/F I-Care Bldg., 167 Legaspi St., Legaspi Village

City of Makati 1229

Tel. No. 813-01-31 to 39 Fax No. 813-79-03

CLAIMS MEDICAL CERTIFICATE

Patient: _____ ID No.: _____

Hospital/Clinic: _____ Treatment Date: _____

Diagnosis: _____

Nature of Services : () Consultation () In-Patient () ER Services () Others

Brief Clinical History:

Treatment/procedures performed:

I swear on my professional oath to the truth of all my foregoing statements.

PRINTED NAME OF PHYSICIAN

LICENSE NUMBER

SIGNATURE OF PHYSICIAN

ADDRESS

DATE