



Allianz PNB Life Insurance, Inc.

## Medical Consultation Report

Dear Doctor:

We are requesting your good office to provide responses to a series of inquiries related to the insured's recent medical check-up, hospitalization, or treatment procedure. We kindly ask that you draw upon your professional expertise and the insured's medical records to ensure comprehensive and accurate information.

Your cooperation in this matter is greatly appreciated, as it will assist us in delivering the highest standard of care and support to the insured. Please rest assured that all information provided will be treated with the utmost confidentiality and used solely for the intended purpose.

Thank you in advance for your attention to this request and for your continued dedication to patient care.

**INSTRUCTION:** Please complete this form using **PRINT and BLACK INK**. If any corrections or erasures are made, kindly countersign them. For sections that do not apply, please indicate "N/A." **Allianz will deem the document unacceptable should it exhibit any omissions or incomplete sections.** If your response to a particular question requires more space than provided, please use an additional sheet to complete your answer and include the question number on the sheet.

### A. INSURED INFORMATION

Policy Number	Name (last, given, middle name)		
Date of Birth (mm/dd/yyyy)	Age	Gender	Contact Number

### B. PHYSICIAN'S STATEMENT (To be accomplished by the Attending Physician only)

1. Date you were first consulted by the insured for the disease or illness. (Please indicate the date, month, & year)	2. Date signs and symptoms are first experienced by the insured. (Please indicate the date, month, & year)
3. What are the signs and symptoms experienced by the insured?	4. When you were first consulted, how long did you believe the signs and symptoms were present?
5. Provide the complete and exact details of diagnosis. If cancer, please specify the stage.	
6. Describe the detailed underlying cause of the insured's condition.	
7. What kind of treatments have the insured received in relation to the condition? Provide all treatments the insured has undergone, including medications, procedures, therapy, or other interventions.	

**8.** Has the insured had any other medical conditions or undergone surgery in the past? If yes, please provide the date, month & year

**9.** Has the insured had any significant medical condition, accident, or permanent neurological deficits that necessitate physical rehabilitation? If applicable, please provide a brief explanation of the condition, accident, or deficits, along with the rehabilitation plan

**10.** Objective findings supporting the diagnosis and prognosis. Present results of tests such as histopathology, imaging, ECG, MRI, etc with test dates. (Please indicate the date, month, and year)

**11.** Breakdown of estimated cost of hospitalization including professional fees including the date of hospitalization or surgery.

**12.** Additional Information relevant to the insured's condition. Provide full details.

Are you the regular physician of the insured?       Yes  No    If Yes, since when \_\_\_\_\_

Are you related to the insured?                       Yes  No    If Yes, please state relationship \_\_\_\_\_

How long have you known the insured?                      \_\_\_\_\_

Were other doctors consulted, or is this a referral?     Yes  No    If Yes, please provide details below:

Name of Doctor & Specialization	Clinic / Hospital Affiliation	Contact Details

**C. AUTHORIZATION**

I hereby declare that all statements provided in the foregoing answers are true, complete, and accurate to the best of my knowledge and belief. Furthermore, I affirm that no material facts relevant to this case have been omitted or undisclosed.

_____	_____	_____
Attending Physician Signature over Printer Name & License No.	Specialization	Date Signed (mm/dd/yyyy)
_____	_____	_____
Name of Clinic / Hospital	Clinic Room Number	Contact Number