Cognitive Impairment Care Claim Form

Patient Name

Date of Birth

Patient ID / Policy No.

Address

Contact Number

Email

Diagnosis (Cognitive Impairment)

Date of Diagnosis

Treating Physician

Physician Contact

Nature of Impairment

Assistance Required

Duration of Assistance

Details of Caregiver (if any)

Additional Notes

Claimant Name

Relationship to Patient

Signature

Date