MiCare Sdn Bhd (727400-M)
(formerly known as Metronic iCares Sdn Bhd)
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HOSPITALIZATION REIMBURSEMENT CLAIM FORM
Borang Tuntutan Kemasukan Hospital
Private and Confidential / Sulit dan Persendirian

Part 1 (To be completed by Patient / Claimant)
Bahagian 1 *(Untuk diisi oleh Pesakit / Penuntut)*

1. Patient Name: *Nama Pesakit*	2. NRIC (Old & New): *K.P. (Lama & Baru)*
3. a. Date of Birth: *Tarikh lahir* b. Age: *Umur*	c. Sex: ☐ Male ☐ Female *Jantina Laki-laki Perempuan*
4. Address *Alamat*	5. Policy No. / Member ID/ Certificate No/ Plan/ Company Name : *No. Polisi / No. Ahli / No. Sijil / Pelan / Nama Syarikat*
6. Tel No : *No.Tel* (Home) : _____ (Office) : _____ *Kediaman Pejabat* (Mobile) : _____(Email) : _____ *Bimbit Emel*	7. Pay to (Name) : _____ *Bayar kepada (Nama)* Bank & Branch : _____ *Bank & Cawangan* Account No : _____ *No Akaun*

Admission Reason (tick) and answer accordingly
Sila tanda ( ) dan jawab soalan yang berkenaan

☐ 8. Accident *Kemalangan*	a. Occurred on: Date _____/_____/_____Time _____ ☐ am ☐ pm *Berlaku pada Tarikh Masa pagi petang* b. Details of Accident: *Butir-butir kemalangan*
☐ 9. Illness *Penyakit*	a. Symptoms first appeared on: Date _____/_____/_____ *Tarikh simptom tersebut bermula Tarikh* b. Doctor(s) consulted for this condition: *Doktor-doktor yang dilawati bagi penyakit ini* c. Doctor's or Clinic Contact(Address & Telephone): *Alamat & Telefon Doktor*

10. Is the claim for Pre / Post-hospitalization treatment? Yes / No (If yes, kindly indicate the date of admission) ____/____/_____
Adakah tuntutan ini untuk rawatan Pra/Susulan hospital? Ya / Tidak (Jika ya, sila nyatakan tarikh kemasukan wad)

11. **Declaration and authorization**

I declare that the answers given above are true and complete to the best of my knowledge and belief.

I understand the delivery of this form is in no way an admission of claim by MiCare/Payor Company and payment to the hospital by MiCare/Payor Company or its representative shall not be construed as final admission of claim by MiCare/Payor Company for this and any further claims arising, MiCare/Payor Company reserves all rights for evaluation as appropriate.

I am fully aware of the limits as to my/covered person's medical/Takaful entitlement under the above-mentioned policy. I hereby undertake to settle/reimburse any medical expenses exceeding my entitlement under the said policy contract, or that is not covered by the same.

I hereby irrevocably authorize any organisation, institution, or individual that has any record or knowledge of my health and medical history or treatment or advice that has been or may hereafter be consulted, other personal information or details of related accident/injury, to disclose to MiCare/Payor Company or its representative such information. I agree that MiCare/Payor Company or its representative may use or disclose any of the information collected or held to third parties (within or outside Malaysia, including MiCare's/Payor Company's parent company, subsidiaries or any other associated companies within the MiCare/Payor Company Group, reinsurers/retakaful, medical examiners, claims investigators and industry associations/federations etc.) in relation to this claim. This authorization shall bind my/the covered person's successors and assigns and remain valid notwithstanding my/ covered person's incapacity in so far as legally possible. A photocopy of this authorization shall be valid as the original.
I agree that in the event I make, or have in the past made, any false or untrue statement and/or suppressed and/or concealed any material facts in respect of my/the covered person's condition, MiCare/Payor Company shall absolutely forfeit my/the covered person's right to compensation and further reserves the right to recover any amounts paid earlier as a result thereof.

Pengisytiharan dan pemberikuasa

Saya mengisytiharkan bahawa jawapan yang diberikan di atas adalah benar dan lengkap setakat pengetahuan dan kepercayaan saya.

Saya memahami bahawa penyerahan borang ini, tidak sama sekali boleh dianggap sebagai persetujuan tuntutan saya/orang yang dilindungi ke atas MiCare/Syarikat Pembayar dan saya bersetuju bahawa bayaran kepada hospital oleh MiCare/Syarikat Pembayar atau wakilnya tidak akan ditafsirkan sebagai persetujuan muktamad tuntutan ke atas MiCare/Syarikat Pembayar dan MiCare/Syarikat Pembayar berhak menjalankan penilaian sewajarnya berhubung tuntutan ini atau apa-apa tuntutan yang timbul selanjutnya.

Saya memahami sepenuhnya had-had kelayakanTakaful/Perubatan saya di bawah Polisi yang tersebut di atas. Saya dengan ini berjanji akan menyelesaikan sebarang amaun yang melebihi had kelayakan saya, yang tidak dilindungi oleh Polisi berkenaan.

Saya yang bertandatangan di bawah, dengan ini membenarkan pada setiap masa, mana-mana organisasi, institusi atau individu yang mempunyai apa-apa rekod atau pengetahuan tentang kesihatan dan latar belakang atau rawatan atau nasihat perubatan saya/orang yang dilindungi, yang telah atau mungkin kemudian dari ini dirujuk untuk mendedahkan kepada MiCare/Syarikat Pembayar atau wakilnya segala maklumat tersebut. Saya bersetuju membenarkan MiCare/Syarikat Pembayar atau wakilnya untuk mengguna dan mendedahkan apa-apa maklumat yang dikumpul atau dipegang kepada pihak ketiga (di dalam atau di luar Malaysia, termasuk syarikat induk, anak syarikat atau syarikat berkait dalam Syarikat, syarikat reinsurans/retakaful, pemeriksa perubatan, penyiasat tuntutan dan pertubuhan/persekutuan industri dll.) berkaitan dengan tuntutan ini. Pengesahan ini hendaklah mengikat waris-waris dan penama saya/ nyawa yang dilindungi dan kekal sah meskipun setelah kematian saya/orang yang dilindungi setakat yang dibenarkan di sisi undang-undang. Salinan pengesahan ini adalah sah. Saya bersetuju sekiranya saya membuat pengakuan palsu atau tidak mendedahkan maklumat yang berkaitan, MiCare/Syarikat Pembayar berhak membatalkan tuntutan saya dan menarik balik sebarang tuntutan awal yang telah dibayar.

Signature of Patient /*Tandatangan Pesakit*	Signature of Covered person/ claimant / *Tandatangan Orang yang dilindungi /Penuntut*	Signature of Witness / *Tandatangan Saksi*
_____ Full Name/*Nama Penuh* : IC No./*No. KP* : Date/*Tarikh* :	_____ Full Name/*Nama Penuh*: IC No./*No. KP*: Date/*Tarikh*: Relationship to Patient:/ *Hubungan dengan Pesakit*	_____ Full Name/*Nama Penuh*: IC No./*No. KP*: Date/*Tarikh*: Contact No / No untuk dihubungi:

MiCARE

Part 2 TREATMENT DETAILS (TO BE COMPLETED BY ATTENDING DOCTOR)

1.a. Patient name: b. NRIC: c. Age: d. Sex: ☐ Male ☐ Female

2. Policy No. / Member ID/ Certificate No/Plan/ Company No:

3. Admission No. / MRN and Hospital Name/ Hospital Contact and Fax No :

4. Admission Date and Time:

5. Discharge Date and Time:

6. a. Symptoms / Conditions requiring admission:

b. How long is patient aware of the condition:

c. Patient's BP/ Temp/ Pulse:

d. Date symptoms first appeared: _____/_____/_____

e. Date first consulted: _____/_____/_____

7. a. Any previous consultation / treatment / hospitalization for this symptom / illness or related conditions, or other disorders whether in this hospital or any other facilities? ☐ Yes ☐ No.

b. Was this patient referred? If Yes, please provide details below:

c. If this condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed :

Date	Disease / Disorder	Details of Treatment / Hospitalization	Doctor / Hospital/ Clinic

d. Can the condition be managed under the Outpatient basis: □ Yes □ No
If no please provide reasons of admission :

e. Any possibility of relapse? ☐ Yes ☐ No

8. Is the illness / condition related to: (please tick (✓) if YES). Please provide details:

a) ☐ Pregnancy / Childbirth / Infertility/ Caesarean section/ miscarriage Or any complications arising therefrom.
b) ☐ Congenital / Hereditary diseases
c) ☐ Influence of Drugs / Alcohol
d) ☐ Nervous / Mental / Emotional / Sleeping Disorder
e) ☐ Cosmetic reason / Dental care / refractive errors correction
f) ☐ AIDS / STD / VD/ HIV
g) ☐ Self-inflicted injuries / Violation of laws / Strike / Riots
h) ☐ None of the above

9. Medical treatment and Investigations performed, if any (please supply copy of all investigation results):

10. Any other medical/surgical conditions present? ☐ No ☐ Yes, details below:

a. _____ since _____/_____/_____
b. _____ since _____/_____/_____

11. Was the patient pregnant at the time of hospitalization? (For Female Only)
☐ No ☐ Yes, _____ months

12. a. If hospitalization was due to injury, please describe circumstances and cause of injury:

b. Please indicate date/time of accident: (dd/mm/yy) _____/_____/_____ (hrs) _____ ☐ am ☐ pm

13. Undertaking Letter Ref No:(If available)

14. a. Final Diagnosis:

ICD code:

b. Cause and pathology of the diagnosis:

15. Treatment given / Investigation done: (Please supply copy of all investigation results)

16. a. Surgical procedures performed:

MMA code / PHFSR code:

b. Date of surgery / procedure:

17.a. Recovery complication that arose (if any):

b. In the case of DEATH, please advise Date/ Time and Cause of death :

18. *I hereby certify that I have personally examined and treated the Patient for his/her injuries/illness described above and that the facts as stated above represent my medical opinion of his/her condition.*

_____	_____	_____
Date	Name & Signature of Attending Doctor	Doctor / Hospital Stamp