MiCare Sdn Bhd (727400-M)
(formerly known as Metronic iCares Sdn Bhd)
Block A, No. 22, Jalan Astaka U8/84, Seksyen U8, Bukit Jelutong,
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Website : www.micaresvc.com

MSC MALAYSIA Status Company

OUTPATIENT REIMBURSEMENT CLAIM FORM

(for Outpatient Clinic, Outpatient Specialist, Health Screening, Dental & Optical Claims)

Personal Detail

Company Name : _____ Employee ID : _____

Employee Name : _____ Employee NRIC : _____

Patient Name : _____ Patient NRIC : _____

Contact Number : _____ Self : ☐ Dependant : ☐

Mailing Address : _____

_____

Email Address : _____

Bank Detail

Payee Name : _____

Bank Name : _____

Bank Account Number : _____

Claim Detail

No	Clinic / Hospital	Date	Diagnosis	Receipt No	(RM)

Reason / Remark : _____

_____

Declaration:

I solemnly and sincerely declare that the information provided is full, complete and true.

I hereby authorize any physician, nurse or medical staff of the hospital/ GP clinic who has observed or treated me/ my above named spouse/ my above named child to release my/ my above named spouse/ my above named child's medical information and medical history to Micare Sdn Bhd, my employer and the Insurer for the purpose of processing my medical claim.

I hereby undertake to reimburse Micare Sdn Bhd, my employer or the Insurer in the event that my/ my above named spouse/ my above named child's hospitalization/ clinical cost are not covered by the medical policy of my employer due to any reason whatsoever.

_____ _____

Signature of Employee/Patient Date

Name :

Relationship :

Received by:

_____ _____

Signature of Employer / HR Company Stamp

Name :

Date :

For Micare use only

Remark:

Claim status : Approved ☐ Approved Amount : RM_____

: Rejected ☐ Reason for Rejection _____

Processed by: Approved by

_____ _____

Name: Name :