Claim Form

Medical Reimbursement
Part 2 - Medical Report

To be completed by the attending physician at participant's expense

Certificate No.

Name of Patient

Gender Male / Female NRIC / Passport

1.	Hospitalisation Details		
(a)	Admission Date and Time	Date(dd/mm/yyyy)	Time (am/pm)
(b)	Discharge Date and Time	Date(dd/mm/yyyy)	Time (am/pm)
(c)	i. Was there any ward leave given to the patient? If yes, kindly provide us the date and time of the leave. ii. Please furnish us a certified true copy of the proof for the ward leave if available. If there is no proof, please indicate the reason.	☐ Yes ☐ No Date(dd/mm/yyyy)	Time (am/pm)
(d)	Hospitalisation requires	☐ Outpatient Accident ☐ Outpatient Kidney Dialysis ☐ Outpatient Chemotherapy / Radiotherapy ☐ Daycare ☐ Admission ☐ On Patient's Request	

2.	Diagnosis Details	
(a)	Final Diagnosis i) ii) iii)	Underlying cause and pathology of the diagnosis i) ii) iii)
(b)	Date of first diagnosed and by which doctor (dd/mm/yyyy)	
(c)	Date when the patient first consulted you (dd/mm/yyyy)	
(d)	How do you confirm the diagnosis? Please enclose a copy of the report(s).	
(e)	Date when symptoms first appeared prior to consultation (dd/mm/yyyy)	
(f)	If this condition existed before symptoms become apparent to the patient, please indicate in your professional opinion, how long has the condition existed?	
(g)	Type of symptoms presented	
(h)	Date patient first seek treatment (dd/mm/yyyy):	

(i)	Name and address of clinic/hospital where patient first seek treatment:	
(j)	Have any investigation (lab tests, imaging, procedures) been performed?	☐ No ☐ Yes, _____ Please furnish a certified true copy of all investigation reports (lab tests, imaging, procedures) and any relevant hospital reports performed for this patient.

3.	**Referral Doctor (Please enclose a copy of the referral letter (if any))**	
(a)	Name(s) and address of the referral doctor(s)	
(b)	Name(s) and address of other doctors who attended to the patient for the diagnosis	

4.	**Treatment Details**	
(a)	Type of treatment given for the diagnosis	
(b)	Planned surgery/ treatment to be performed	

5.	**If the condition is due to an accident**		
(a)	Date and time of accident	Date(dd/mm/yyyy)	Time (am/pm)
(b)	Full circumstances of accident		
(c)	Were there any external and visible injuries seen as a result of the accident? If yes, please describe the nature and extent of injuries including site and other characteristic features.	☐ Yes ☐ No Details:	
(d)	In your opinion, is it certain that these injuries resulted directly from the accident? Please elaborate.	☐ Yes ☐ No Details:	

6.	**Inpatient treatment rendered to patient for Outpatient treatment or daycare case**	
(a)	Can the condition be managed under outpatient basis?	☐ Yes ☐ No If No, kindly provide the medically necessary reasons for admissions _____

7.	For surgery or procedure:		
(a)	Indication and Nature of surgery or procedure performed		
(b)	Name of surgeon(s)		
(c)	MMA OPCS code / PHFSR Code		
(d)	Date(s) of surgery or procedure performed	Date(dd/mm/yyyy)	Time (am/pm)
(e)	Nature of Anaesthesia		

8.	Is the patient's condition caused by, is related to, or contributed directly/indirectly by:		
	Cosmetic/ Plastic Surgery/ Dental Care		Routine Health Screening/ Investigatory Purposes
	Eye Examination/ Eye Refractive Errors		Sleeping Disorder / Snoring Disorder / Hyperhidrosis
	Psychiatric/ Psychotic/ Mental/ Nervous Disorders		Pregnancy/ Pre Natal or Post Natal Care
	Child birth/ Surgical Delivery/ Miscarriage/ Abortion		Contraception/ Sterilization/ Infertility
	Sexual Dysfunction/ Gender Change		Venereal Diseases/ STD/ HIV or AIDS related complex
	Self-Inflicted Injury / Suicide attempt		Intoxication/ Illegal Drugs/ Illegal Activities
	Strike/ Riot/ Insurrection		None of the above

9.	Any possibility of having relapse?	☐ Yes	☐ No

10. Any other medical or surgical conditions present?				
Illness(s)	Date Symptoms First Appeared (dd/mm/yy)	Date of First Diagnosis (dd/mm/yy)	Clinic/Hospital Names where patient seek treatment	Treatment Details

11. Is this consultation meant to be for second opinion?	☐ Yes	☐ No

12.	**For Female only**		
(a)	Was the patient pregnant at the time of hospitalisation?	☐ Yes _____ months	☐ No
(b)	Is the current hospital admission/ treatment due to pregnancy complications?	☐ Yes	☐ No
(c)	If the above reply is yes, please indicates the diagnosis of the pregnancy complications:		
	Disseminated Intravascular Coagulation		
	Ectopic Pregnancy		
	Hydatidiform mole		
	Postpartum Hemorrhage Requiring Hysterectomy		
	Eclampsia		
	Amniotic fluid embolism		
	Pulmonary Embolism of Pregnancy		
	Toxaemia of Pregnancy		
	Others, please provide details:		

13.	**If this admission is unusually longer than usual period of stay, please provide us your professional opinion and findings to justify the lengthy period of stay.**

14.	**Discharge/Follow-Up Instructions**

15.	Additional information relating to this patient and all medical examination/ tests results that you can provide us the details and let us have the certified true copy of the documents for us to access the claim

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

Name & Address (Official Stamp)

_____ _____

Signature of Attending Physician

_____

Qualification _____

Contact No.

Date _____ _____