COMPUMED

HOSPITALISATION CLAIM FORM / *BORANG TUNTUTAN KEMASUKAN HOSPITAL*

Note: Completion of this form is not an admission of claim / Nota: Kelengkapan borang ini tidak bermakna tuntutan diluluskan

Please answer all questions and attach the documents below / *Sila jawab semua soalan dan sertakan dokumen-dokumen dibawah*

- ☐ Original Bills, Itemized Detailed Bills and Original Receipts / *Bil Asal, Bil Terperinci dan Resit Asal*
- ☐ Copy of NRIC / *Salinan Kad Pengenalan*
- ☐ Copy of lab test results/X-ray and radiological results / *Salinan keputusan makmal / X-ray dan keputusan radiologi*
- ☐ Copy of passport for overseas treatment / *Salinan pasport jika rawatan di luar negara*
- ☐ For admission claim, please submit Section E / *Untuk tuntutan kemasukan wad, sila kemukakan Seksyen E*

Please tick the Type of Claim / *Sila tanda jenis Tuntutan*

- ☐ Admission / *Kemasukan Wad*
- ☐ Pre/Post-Hospitalisation / *Pra/Susulan Hospital*
- ☐ Out-Patient Kidney Dialysis / Cancer / *Rawatan Dialisis / Kanser Pesakit Luar*
- ☐ Emergency Out-patient Accidental Treatment / *Rawatan Kecemasan Pesakit Luar Akibat Kemalangan*
- ☐ Government Hospital Cash Allowance / *Elaun Tunai di Hospital Kerajaan*
- ☐ Others: / *Lain-lain:* ____________________

SECTION A(I) : DETAILS OF LIFE ASSURED / COVERED PERSON / *SEKSYEN A(I) : MAKLUMAT ORANG YANG DIINSURANSKAN / DILINDUNGI*

Name of Patient / *Nama Pesakit* : ____________________

NRIC / Passport No. / *No. KP / Pasport* : ____________________

Date of Birth / *Tarikh Lahir* : ______ / ______ / ______

Correspondence Address / *Alamat Surat-Menyurat* : ____________________

____

____

Occupation / *Pekerjaan* : ____________________

Name of Employer / *Nama Majikan* : ____________________

Address of Employer / *Alamat Majikan* : ____________________

____

Name of Insurer / Takaful Operator / *Nama Syarikat Insurans / Takaful*: ____________________

Policy / Certificate No. / *No. Polisi / Sijil* : ____________________

Handphone No. / *No. Telefon Bimbit* : ____________________

Office Tel No. / *No. Tel Pejabat* : ____________________

E-mail Address / *Alamat E-mel* : ____________________

SECTION A(II) PAYMENT DETAILS / *SEKSYEN A(II) MAKLUMAT BAYARAN*

Kindly update your Bank Account Details in your mobile app or web portal.

SECTION B(I) : DETAILS OF TREATMENT / *SEKSYEN B(I) : MAKLUMAT RAWATAN*

☐ Accident

Date of Accident / *Tarikh kemalangan*: ______ / ______ / ______

Time of Accident / *Masa kemalangan*: ______ : ______ ☐ am ☐ pm

Circumstances and Place of Accident / *Bagaimana kemalangan berlaku* : ____________________

☐ Illness

Symptoms first appeared / *Tarikh gejala bermula* : ______ / ______ / ______

Date of Admission / *Tarikh kemasukan wad* : ______ / ______ / ______

Date of Discharge / *Tarikh keluar wad* : ______ / ______ / ______

Date First Treated / *Tarikh pertama rawatan* : ______ / ______ / ______

Name of first doctor seen / *Nama doktor pertama merawat* : ____________________

Name and address of clinic / hospital / *Nama dan alamat klinik / hospital* : ____________________

____

SECTION B(II) : DETAILS OF REGULAR DOCTOR(S) / *SEKSYEN B(II) : MAKLUMAT DOKTOR BIASA*

Name of regular doctor(s) / *Nama doktor yang biasa jumpa* : ____________________

Name and address of clinic / hospital / *Nama dan alamat klinik / hospital* : ____________________

____

____

Tel No. / *No. Tel* : ____________________

COMPUMED

SECTION B(III) : CLAIMS DETAILS / *SEKSYEN B(III) : MAKLUMAT TUNTUTAN*

No *No*	Invoice No *No Invois*	Invoice Date *Tarikh Invois*	Receipt No *No Resit*	Amount *Jumlah*
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

SECTION C : OTHER INSURANCE / TAKAFUL COVERAGE / *SEKSYEN C : PERLINDUNGAN INSURAN / TAKAFUL LAIN*

Item *Bil*	Insurance / Takaful Company Name *Nama Syarikat Insuran / Takaful*	Policy / Certificate No. *No. Polisi / Sijil*	Type of Policy / Certificate *Jenis Polisi / Sijil*	Coverage Amount *Jumlah Perlindungan*
1				
2				
3				

SECTION D : DECLARATION AND AUTHORIZATION / SEKSYEN D : PENGISYITIHARAN DAN PEMBERIAN KUASA

a) I / We hereby declare that the answers given above are true and complete to the best of my / our knowledge and belief.
Saya / Kami mengisytiharkan bahawa jawapan yang diberikan di atas adalah benar dan lengkap setakat pengetahuan dan kepercayaan saya / kami.

b) I / We understand the delivery of this form is no way an admission of CompuMed Services Sdn Bhd's liability and payment to the claimant by CompuMed Services Sdn Bhd or its representative shall not be construed as final admission of CompuMed Services Sdn Bhd's liability and for this and any further claims arising, CompuMed Services Sdn Bhd reserve all rights for evaluation as appropriate.
Saya / Kami memahami bahawa penyerahan borang ini, tidak sama sekali boleh dianggap sebagai pengakuan liabiliti CompuMed Services Sdn Bhd ini ke atas tuntutan saya / kami / Orang yang Diinsuranskan / Pemegang Polisi dan saya / kami bersetuju bahawa bayaran kepada penuntut oleh CompuMed Services Sdn Bhd atau wakilnya tidak akan ditafsirkan sebagai pengakuan muktamad liabiliti CompuMed Services Sdn Bhd dan CompuMed Services Sdn Bhd berhak menjalankan penilaian sewajarnya berhubung tuntutan ini atau apa-apa tuntutan yang timbul selanjutnya.

c) I am / We are fully aware of the limits as to my / our / Insured Person's / Insured's medical insurance under the above-mentioned policy. I / We hereby undertake to settle / reimburse any medical expenses exceeding my / our entitlement under the said policy contract, or that is not covered by the same.
Saya / Kami memahami sepenuhnya had-had insurans perubatan saya / kami / Orang yang Diinsuranskan / Pemegang Polisi di bawah Polisi yang tersebut di atas. Saya / Kami dengan ini berjanji akan menyelesaikan sebarang amaun yang melebihi had kelayakan saya / kami, yang tidak dilindungi oleh insurans berkenaan.

d) I / We hereby irrevocably authorise any organisation, institution, or individual that has any record or knowledge of my / our / Insured's / Insured Person's 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 CompuMed Services Sdn Bhd or its representative such information. I / We agree that CompuMed Services Sdn Bhd or its representatives

Head Office: Unit 50-03-13A, Level 3, Wisma UOA Damansara, No.50, Jln Dungun, Damansara Heights, 50490 Kuala Lumpur, Malaysia. Tel: +603-2089 3883 Fax: +603-2093 1177

COMPUMED

may use or disclose any of the information collected or held to third parties (within or outside Malaysia, including CompuMed Services Sdn Bhd's parent company, subsidiaries or any other associated companies within CompuMed Services Sdn Bhd's Group, reinsurers, medical examiners, claims investigators and industry associations / federations etc.) in relation to this claim. This authorisation shall bind my / our / Insured Person's / Insured's successors and assigns and remains valid notwithstanding my / our / Insured Person's / Insured's incapacity in so far as legally possible. A photocopy of this authorisation shall be valid as the original. I / We agree that in the event I / we make, or in the past made, any false or untrue statement and / or suppressed and / or concealed any material facts in respect of my / our / the Insured Person's / Insured's condition, CompuMed Services Sdn Bhd shall absolutely forfeit my / our / the Insured Person's / Insured's right to compensation and reserves the right to recover any amount paid earlier as a result thereof.
Saya / Kami 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 nasihat perubatan saya / kami / Orang yang Diinsuranskan / Pemegang Polisi, yang telah atau mungkin kemudian dari ini dirujuk untuk mendedahkan kepada CompuMed Services Sdn Bhd atau wakilnya segala maklumat tersebut. Saya / Kami bersetuju membenarkan CompuMed Services Sdn Bhd 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 CompuMed Services Sdn Bhd, penanggung insurans semula, pemeriksa perubatan, penyiasat tuntutan dan pertubuhan / persekutuan industry dan lain-lain.) berkaitan dengan tuntutan ini. Pengesahan ini hendaklah mengikat waris-waris dan penama saya / kami / Orang yang Diinsuranskan / Pemegang Polisi dan kekal sah meskipun kematian saya / kami / Orang yang Diinsuranskan / Pemegang Polisi setakat yang dibenarkan di sisi undang-undang. Salinan pengesahan ini adalah sah. Saya / Kami bersetuju sekiranya saya / kami membuat pengakuan palsu atau tidak mendedahkan maklumat yang berkaitan, CompuMed Services Sdn Bhd berhak membatalkan tuntutan saya / kami / Orang yang Diinsuranskan / Pemegang Polisi dan menarik balik sebarang tuntutan awal yang telah dibayar.

e) I / We hereby give my / our unconditional and unequivocal consent to you and all your related companies to process my / our personal data revealed hereto. You are at liberty to process the data and share the information thereto with any of your service providers and your other related companies provided that the revelation of my / our personal data strictly for the purposes in relation to the insurance which I / we have applied hereto. The consent given hereto is in line with the requirement set forth in the Personal Data Protection Act 2010.
Saya / Kami dengan ini memberi kebenaran tanpa syarat dan tanpa keraguan kepada pihak syarikat dan syarikat-syarikat bersekutunya untuk memproses data peribadi saya / kami yang didedahkan di sini. Pihak syarikat adalah bebas untuk memproses data berkenaan dan berkongsi maklumat yang didedahkan di sini kepada mana-mana penyedia perkhidmatan dan mana-mana syarikat bersekutunya dengan syarat bahawa pendedahan maklumat peribadi berkenaan adalah bertujuan dan berkaitan dengan insurans yang saya / kami pohon di sini. Kebenaran yang diberikan adalah selaras dengan peruntukan di bawah Akta Perlindungan Data Peribadi 2010.

Signature of Policy / Certificate Owner
Tandatangan Pemilik Polisi / Sijil

Full Name :
Nama Penuh

NRIC No. :
NO. KP

Tel No. :
No. Tel

Signature of Life Assured/Covered Person
Tandatangan Orang Yang Diinsuranskan/Dilindungi

Full Name :
Nama Penuh

NRIC No. :
NO. KP

Tel No. :
No. Tel

Signature of Witness
Tandatangan Saksi

Full Name :
Nama Penuh

NRIC No. :
NO. KP

Tel No. :
No. Tel

Date
Tarikh

Company's Stamp (For Group Policy/Certificate)
Cop Syarikat (Untuk Insurans/Sijil Berkelompok)

Head Office: Unit 50-03-13A, Level 3, Wisma UOA Damansara, No.50, Jln Dungun, Damansara Heights, 50490 Kuala Lumpur, Malaysia. Tel: +603-2089 3883 Fax: +603-2093 1177

COMPUMED

SECTION E : ATTENDING PHYSICIAN'S STATEMENT / *SEKSYEN E : LAPORAN PERUBATAN DOKTOR*

NAME OF PATIENT: ______________________ **NRIC / PASSPORT NO**: ______________________

1. Date of Admission : ______________________
2. Time of admission : ____________ am / pm
3. Date of Discharge : ______________________
4. Time of discharge : ____________ am / pm
5. First consultation date with you: ______________________
6. Name of referral clinic/hospital: ______________________
7. Name of referral doctor: ______________________
8. If due to accident :
   (a) Date of accident : ______________________
   (b) Time of accident: ____________ am / pm
   (c) Name of clinic/hospital first treated: ______________________
   (d) Date first treated: ______________________
   (e) Circumstances of accident: ______________________
9. Symptoms presented: ______________________
10. Duration of symptoms: ______________________
11. Date symptoms first appeared: ______________________
12. Final Diagnosis: ______________________
13. Date first diagnosed: ______________________
14. MMA Code(s): ______________________
15. Name of clinic/hospital first diagnosed: ______________________
16. Name of doctor first diagnosed: ______________________
17. Underlying cause of diagnosis: ______________________
18. a) Has the patient ever had any of the following illness/condition?

(i)	Hyperlipidemia	☐ Yes ☐ No	onset: ________	(i)	Congenital	☐ Yes	☐ No
(ii)	Hypertension	☐ Yes ☐ No	onset: ________	(ii)	Hereditary	☐ Yes	☐ No
(iii)	Diabetes	☐ Yes ☐ No	onset: ________	(iii)	Psychiatric / Mental Disorder	☐ Yes	☐ No
(iv)	Heart disease	☐ Yes ☐ No	onset: ________	(iv)	Pregnancy related / Fertility	☐ Yes	☐ No
(v)	Stroke/TIA/Epilepsy	☐ Yes ☐ No	onset: ________	(v)	Self-inflicted injury	☐ Yes	☐ No
(vi)	SLE / Rheumatoid Arthritis	☐ Yes ☐ No	onset: ________	(vi)	Cosmetic reason	☐ Yes	☐ No
(vii)	Cancer / Tumour	☐ Yes ☐ No	onset: ________	(vii)	Dental care	☐ Yes	☐ No
(viii)	Others: ________	☐ Yes ☐ No	onset: ________	(viii)	AIDS / STD	☐ Yes	☐ No

18. b) If any condition above is Yes, please provide further details: ______________________
19. Result of investigations (e.g. MRI, CT-Scan, Ultrasound, Lab tests): ______________________
20. Procedure(s)/Treatment done: ______________________
21. Date of surgery(ies): ______________________
22. MMA Code(s): ______________________
23. Can condition/procedure be managed under an out-patient arrangement? ☐ Yes ☐ No
    If no, please explain reason for admission: ______________________
24. Any consultation / treatment for this illness or other disorders in this hospital or any other facilities? ☐ Yes ☐ No
    If yes, please provide details below:

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

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 of his/her condition:

Doctor' Signature : ______________________

____
Doctor's Clinic/Hospital Stamp

Name : ______________________

Contact No. : ______________________

Date : ______________________