HOSPITAL & SURGICAL BENEFIT/DAILY CASH ALLOWANCE CLAIM FORM
BORANG TUNTUTAN BAGI MANFAAT HOSPITAL & PEMBEDAHAN/ELAUN TUNAI HARIAN

PMCare

EMPLOYEE INFORMATION/*MAKLUMAT PEKERJA*

Name of Employee *Nama Pekerja*		
Name of Employer *Nama Majikan*		PMCare Membership Number *(Nombor keahlian PMCare)*
Date Employed *Tarikh mula bekerja*	Day/*Hari* : Month/*Bulan* : Year/*Tahun* :	MyKad Number (*Nombor MyKad)* - -
Mailing Address *Alamat surat-menyurat*		Birth Certificate/Passport Number *(Nombor Sijil Lahir/Nombor Pasport)* Office telephone number *(Nombor telefon pejabat)*
E-mail Address *Alamat e-mel*		Mobile number *(Nombor telefon mudah alih)*
Bank Name *Nama Bank*		Bank Account number *(Nombor akaun bank)*

PATIENT INFORMATION / *MAKLUMAT PESAKIT*

Name of Patient *Nama Pesakit*		PMCare Membership number *(Nombor keahlian PMCare)*
Date of Birth *Tarikh Lahir*	Day/*Hari* : Month/*Bulan* : Year/*Tahun* :	MyKad Number *(Nombor MyKad)* - -
Relation to the Employee *Hubungan dengan Pekerja*	☐ Self/*Diri sendiri* ☐ Spouse/*Pasangan* ☐ Child/*Anak*	Birth Certificate/Passport Number (*Nombor Sijil lahir/ Nombor Pasport)*

TREATMENT INFORMATION / *MAKLUMAT RAWATAN*

Date of Admission *Tarikh masuk hospital*	Day/*Hari* : Month/*Bulan* : Year/*Tahun* :
Date of Discharge *Tarikh keluar hospital*	Day/*Hari* : Month/*Bulan* : Year/*Tahun* :
Time of admission *Masa rawatan*	_____ am/pm

DETAILS OF MOTOR VEHICLE ACCIDENT / *BUTIR-BUTIR KEMALANGAN KENDERAAN BERMOTOR*

Date of Accident *Tarikh kemalangan*	Day/*Hari* : Month/*Bulan* : Year/*Tahun* :
Time of Accident *Masa kemalangan*	_____ am/pm
	Please enclose **Certified True Copy of Police Report** *Sila sertakan* ***Salinan Laporan Polis yang disahkan***

IMPORTANT NOTICE / *MAKLUMAT PENTING*

Please submit the following documents to support your claim/*Sila sertakan dokumen-dokumen di bawah untuk menyokong tuntutan anda:*

- ◇ Hospital & Surgical benefit/Daily Cash Allowance form duly completed
  Borang tuntutan bagi manfaat Hospital & Pembedahan/Elaun Tunai Harian lengkap diisi
- ◇ Certified True Copy of Employee's Identity Card
  Salinan kad pengenalan pekerja yang disahkan
- ◇ Certified True Copy of Patient's Identity Card
  Salinan kad pengenalan pesakit yang disahkan
- ◇ Original medical bills
  Bil-bil asal perbelanjaan perubatan
- ◇ Itemized billing
  Bil-bil terperinci
- ◇ Original medical receipts (proof of payments)
  Resit-resit asal perbelanjaan perubatan (bukti pembayaran)
- ◇ Original discharge note or copy of medical bill for Daily cash allowance only
  Nota discaj asal atau salinan bil perbelanjaan perubatan untuk elaun tunai harian sahaja
- ◇ Certified True Copy of Police Report (if due to motor vehicle accident)
  Salinan Laporan Polis yang disahkan (jika berkaitan dengan kemalangan kenderaan bermotor)

MEDICAL INFORMATION AUTHORISATION / *KEBENARAN MAKLUMAT PERUBATAN*

I hereby authorize any hospitals, surgeons, medical practitioners or clinics or other persons who have attended or examined me or my dependent for any reasons to disclose any and all information with respect to any illnesses or injuries and to provide copies of all medical reports, including earlier medical history to PMCare Sdn Bhd and/or my Employer for claims processing, payment, and to produce report.

Bahawasanya dengan ini, saya membenarkan mana-mana hospital, pakar bedah, pegawai perubatan atau klinik atau orang perseorangan lain yang pernah merawat atau memeriksa saya atau tanggungan saya atas apa jua sebab, untuk memberikan sebarang dan semua maklumat berkaitan penyakit atau kecederaan dan menyediakan salinan laporan perubatan termasuk sejarah perubatan terdahulu kepada PMCare Sdn Bhd dan/atau Majikan untuk pemprosesan tuntutan, bayaran, dan menghasilkan laporan.

_____
Date/*Tarikh*

_____
Signature of patient/claimant
Tandatangan pesakit/pihak yang menuntut

MEDICAL REPORT OF TREATMENT BY ATTENDING PHYSICIAN
LAPORAN PERUBATAN

THE FOLLOWING INFORMATION MUST BE COMPLETED BY **ATTENDING PHYSICIAN** (Please use separate sheet of paper if additional space is required)

PATIENT INFORMATION / *MAKLUMAT PESAKIT*

Patient Name			MyKad Number	
Date of Birth	Day: Month: Year:		Birth Certificate/Passport Number	
Period of hospitalization	Admission Date	Day: Month: Year:		
	Discharge Date	Day: Month: Year:		
Attending Doctors & Specialty	Doctor's Name		Specialty	
	Doctor's Name		Specialty	
	Doctor's Name		Specialty	

Past Medical History

Has patient suffered /is patient suffering from any illnesses stated below	Hypertension	☐ No ☐ Yes	Since when?	Day: Month: Year:	
	Cardiovascular Disease	☐ No ☐ Yes		Day: Month: Year:	
	Gastrointestinal Disease	☐ No ☐ Yes		Day: Month: Year:	
	Malignancy of any kind	☐ No ☐ Yes		Day: Month: Year:	
	Diabetes	☐ No ☐ Yes		Day: Month: Year:	
	Others	☐ No ☐ Yes		Day: Month: Year:	

Current Admission

Admitting Diagnosis				
Etiology of the above diagnosis				
Presenting symptoms during admission				
Final Diagnosis				
When was the date patient seek your consultation for this condition?	Day: Month: Year:			
Was the patient previously treated for this condition?	☐ No ☐ Yes Since when? Day: Month: Year:			
In your professional opinion, when did the condition first develop?	Day: Month: Year:			
Any possibility of relapse?	☐ No ☐ Yes			
Please indicate (√) if the illness/injury or treatment is/are	Motor vehicle accident related	☐ No ☐ Yes	Date & Time of accident	Day: Month: Year: _____ am / pm
	Chronic	☐ No ☐ Yes	Congenital	☐ No ☐ Yes
	Cosmetic	☐ No ☐ Yes	Work related	☐ No ☐ Yes
	Pregnancy related	☐ No ☐ Yes	Psychological related	☐ No ☐ Yes
	Fertility related	☐ No ☐ Yes		

Current Treatment

Please indicate (√) nature of treatment and investigation

☐ Operation ☐ Physiotherapy ☐ Medications ☐ X-ray ☐ Blood Test

☐ Dietary Counseling ☐ Others Please specify : _____

Please state procedures, investigation and operations performed

Type of Operation / Procedure / Investigation	Date Performed	Performed by

To the best of my knowledge, I hereby declare that all the information given above are true and accurate.

_____ Signature of Attending Doctor

_____ Attending Doctor's Stamp

_____ Date

PMCARE SDN BHD (458443-P)
No.1, Jalan USJ 21/10, UEP Subang Jaya, 47630 Selangor, Malaysia. General Line: 03-8026 6888
Careline: 1-300-88-6868 Careline Centre Fax: 03-8023 9999