Borang Tuntutan Hospital & Pembedahan Ahli
Member Hospital & Surgical Claim Form

CLAIM NO. For Office Use only

AIA Bhd. (790895-D)
Corporate Solutions Department
P.O. Box 10846
50927 Kuala Lumpur
24-hour Call Centre : 1300 8888 60/70

Jenis Tuntutan ***Type of Claim***

- ❑ Kemasukan ke Hospital *Hospitalisation*
- ❑ Pra & Selepas Rawatan Hospital *Pre & Post Hospitalisation*
- ❑ Rawatan Pesakit Luar Dialisis Buah Pinggang & Kanser *Outpatient Kidney Dialysis & Cancer Treatment*
- ❑ Rawatan Kecemasan Pesakit Luar/Kemalangan (Sila lampirkan Laporan Doktor) *Emergency Outpatient Accidental Treatment/Accident (Please attach Doctor's Report)*
- ❑ Pesakit Luar/Penjagaan Harian *Outpatient/Daycare*
- ❑ Jenis Penyakit/Kecederaan *Nature of Illness/Injury*

SEKSYEN I - Untuk diisi oleh Pekerja/Pesakit (DALAM HURUF BESAR) & diserahkan kepada AIA untuk tuntutan.
SECTION I - To be completed by the Employee/Patient (IN BLOCK LETTERS) for submission to AIA for claim processing.

Maklumat Pekerja ***Employee Information***

Nama Pekerja (seperti di dalam KP) *Name of Employee (as in NRIC)*

No. Kad Pengenalan Pekerja *Employee NRIC No.*

No. Polisi *Policy No.*

Pelan *Plan*

Pekerjaan *Occupation*

No. Tel *Tel No.*

Nama Syarikat/Majikan *Name of Company/Employer*

Tandatangan, Cop Rasmi & Alamat Majikan
Employer's Signature, Stamp & Address

Maklumat Pesakit ***Patient Information***

Nama Pesakit *Name of Patient*

No. Keahlian (Pesakit) *Membership No. (Patient)*

Tarikh Lahir Pesakit *Birth Date of Patient* d d m m y y y y

Tarikh Cuti Sakit *Date of MC* d d m m y y y y - d d m m y y y y

Jumlah Hari Cuti Sakit *No. of MC Days*

Hubungan dengan Pekerja *Relationship to Employee*
- ❑ Diri Sendiri *Self*
- ❑ Suami/Isteri *Spouse*
- ❑ Anak *Child*

Jantina Pihak Menuntut *Gender of Claimant*
- ❑ Lelaki *Male*
- ❑ Perempuan *Female*

Untuk Kes Kemalangan - Sila lampirkan Laporan Doktor ***For Accidental Cause - Please attach Doctor's Report***

Tarikh Kemalangan *Date of Accident* d d m m y y y y

Masa *Time* : ❑ am ❑ pm

Bagaimana kemalangan berlaku? *How did the accident occur?*

Jenis dan Tahap Kecederaan *Nature & Extend of Injury*

Butir-butir Insuran Lain, Perkeso, Insuran Pampasan Pekerja dan Lain-lain
Details of Other Insurance Policies, Socso, Workmen's Compensation and Others

Jenis Polisi *Policy Type* _____ No. Polisi *Policy No.* _____

Syarikat Insuran *Insurance Company* _____

❑ Tidak dilindungi oleh mana-mana syarikat insuran, program, faedah, ataupun skim. *Not insured under any program, benefits, schemes or insurance.*

Maklumat Pembayaran ***Payment Details***

Pembayaran Tuntutan hendaklah dibayar kepada *Payment of Claim is to be made to*

❑ Syarikat *Company* ❑ Pekerja *Employee*

Amaun RM yang dituntut *Claim Amount* : RM . .

Penyerahan Tuntutan - SENARAI SEMAK
Submission of Claims - CHECKLIST
- ❑ Resit Asal *Original Receipt*
- ❑ Bil Terperinci *Itemised Bill*
- ❑ Laporan Kesihatan *Medical Report*

Sila lengkapi Bahagian Seksyen II
Section II to be completed
- Sekiranya bil melebihi RM 1,000 untuk Hospital Kerajaan *For Government Hospital bill above RM 1,000*
- Sekiranya bil melebihi RM 500 untuk Hospital Swasta *For Private Hospital bill above RM 500*

Nota:
- Dokumen-dokumen untuk setiap jenis tuntutan seperti yang dinyatakan **MESTI** dilampirkan bersama dengan borang tuntutan ini untuk pemprosesan tuntutan.
- Tuntutan **akan dikembalikan** untuk ubat-ubatan yang dibeli secara terus dari farmasi tanpa mengepilkan preskripsi doktor.
- Setiap borang tuntutan adalah untuk **satu** Resit Asal & Bil Terperinci sahaja.

Note:
- *Documents for each type of claim as stated **MUST** be attached with this form for claim processing.*
- *Claims for medication purchased directly from a pharmacy without a copy of the doctor's prescription slip will **NOT** be processed.*
- *Each claim form is applicable for **one** Original Receipt and Itemised Bill.*

Memberi Kebenaran Kepada Doktor Perubatan, Hospital atau Klinik Untuk Memberi Maklumat
Authorisation to Physician, Hospital or Clinic to Release Information

Saya dengan ini mengesahkan bahawa semua maklumat yang diberikan di dalam borang tuntutan ini adalah benar dan lengkap. Saya dengan ini memberi kebenaran kepada doktor perubatan, pengamal perubatan, hospital atau klinik yang merawat saya/pihak menuntut untuk memberi maklumat-maklumat lengkap berhubung dengan riwayat kesihatan saya/pihak menuntut termasuk latarbelakang penuh perubatan saya/pihak menuntut semasa dimasukkan di hospital/menjalani pembedahan kepada AIA Bhd. Salinan surat kebenaran ini adalah dianggap sah dan berkuatkuasa sebagaimana salinan asal. Saya faham bahawa maklumat ini akan dianggap sulit oleh AIA dan AIA tidak akan melepaskan maklumat ini kepada sesiapa tanpa kebenaran bertulis dari saya. Semua maklumat yang diberikan adalah benar dan tepat.

I hereby declared that the above information given in this claim form is complete and true. I hereby authorise any physician, medical practitioner, hospital or clinic by whom or where I/claimant have been observed or treated, to give full particulars about my/claimant's health including my/claimant's whole medical history in respect of this hospitalisation/surgery, to AIA Bhd. A photocopy of this authorisation shall be considered as effective and valid as the original. I understand that this information will be kept strictly confidential by AIA and that AIA undertakes not to disclose this information to any third party without my separate written consent. All information provided is true and accurate.

Tandatangan Pekerja *Signature of Employee* _____ Tarikh *Date* _____

SECTION II - To be completed by the Attending Doctor (IN BLOCK LETTERS) **MRN No:**

Name of Patient

NRIC No.	Date and Time of Admission	Date and Time of Discharge
	d d m m y y y y (hrs)	d d m m y y y y (hrs)

Name of Referring Doctor and Address

Admitting Doctor	Attending Doctors	Speciality

Symptoms/Conditions requiring admission:

Date first appeared d d m m y y y y

Any previous consultation/treatment/hospitalisation for this symptom/illness or related conditions,

Date	Disease/Disorder	Details of Treatment/Hospitalisation	Doctor/Hospital

1a) Diagnosis/ICD Coding

i)

ii)

iii)

1b) Cause and Pathology (if applicable) of the above diagnosis

4a) Please ✓ Nature of Treatment and Investigation:

- ☐ Operation
- ☐ Physiotherapy
- ☐ Dietary Counselling
- ☐ Medications
- ☐ X-ray
- ☐ Blood Tests
- ☐ Others, give details _____

4b) Please state Type of Procedures/Surgery performed:

Type	Date	Name of Doctor
i)		
ii)		
iii)		

4c) Other medical conditions present?

2a) When did patient first consult you for this condition?

d d m m y y y y

2b) Was the patient previously treated for this condition by yourself or by any other medical practitioner?

- ☐ No
- ☐ Yes, give details and when d d m m y y y y

_____

_____

2c) How long in your professional opinion has the condition existed?

d d m m y y y y

3) Any possibility of relapse?

☐ Yes ☐ No

5) Was the illness/condition related to: (Please tick ✓ if YES)

- a) ☐ Pregnancy _____ weeks
- b) ☐ Congenital/Hereditary Disease
- c) ☐ Psychotic/Nervous Disorder/Mental/Emotional
- d) ☐ Cosmetic Reason/Plastic Surgery
- e) ☐ Dental Care/Refractive errors correction
- f) ☐ Suicide/Self-inflicted injuries
- g) ☐ Childbirth/Fertility

6a) Is the hospitalisation/treatment medically necessary?

☐ No ☐ Yes, please give details

_____

_____

6b) Is it possible to provide this treatment on an outpatient basis?

☐ No ☐ Yes, please give details

_____

_____

7) Did any complications arise during hospitalisation?

☐ No ☐ Yes, please give details

_____

_____

9) If the hospitalisation was due to accident, please indicate date/time of accident: d d m m y y y y (hrs)

Discharge/Follow-up instructions

Signature and Name of Attending Doctor | Hospital Stamp | Date