

Metronic iCares Sdn Bhd



No 2, Jalan Astaka U8/83, Seksyen U8, Bukit Jelutong, 40150 Shah Alam, Selangor Darul Tel: 1-800-88-2678 (24 hours) Fax: +6 03-78474304 Ehsan, Malaysia

(A subsidiary of Metronic Global Bhd)

REIMBURSEMENT MEDICAL FORM

- i. Please answer all questions and attach all original bills and receipts. ii. Incomplete form may result in delay of insurance claims.

- ii. Please provide a copy of passport if treated overseas. iv. Please provide copy of lab test results *l*x-ray, radiological results and other related reports.

Date

C No. : Certificate No : Address : Tel No. (Office): Tel No. (Home) : Tel No. (Office): RT 2-TREATMENT DETAILS (TO BE COMPLETED BY ATTENDING DOCTOR) I. Is this patient referred to you? Yes / No If yes, please provide 2. Is this admission due to an accident? Yes / No a) Exact Nature of Accident : D) Place of Accident : D) Date First Treated : B. Date Admitted :	Ba Acc Tel No. (H/P): copy of referral letter	count No :	:
Tel No. (Home):Tel No. (Office): RT 2—TREATMENT DETAILS (TO BE COMPLETED BY ATTENDING DOCTOR) I. Is this patient referred to you? Yes / No If yes, please provide 2. Is this admission due to an accident? Yes / No a) Exact Nature of Accident : b) Place of Accident : c) Date First Treated :	Act	count No :	
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b) Place of Accident :			
c) Date First Treated :	_		
<u> </u>	Date :	Time:	
3. Date Admitted :	Time :		
	Time :		
1. Date Discharged :	Time :		
5. Presenting Symptoms :	Duration:		
S. Diagnosis :			
7. When did patient first consult you for this condition?	8. Has this illness occurred		
NAME of the considerability and the considerability an	If yes, when did this iline	ess first occurred? (dd/mm/y	'y)
What is the underlying cause?	-0.V/N If		
10. Is there any condition/illness that caused or is related to the present illnes		-	
Can this illness be treated as Outpatient? Yes/No	12. Is admission solely for it	investigation purpose? Yes/	No
3. Has the patient ever had any of the following illness/condition?	14. Is present illr	ness:	
a) Hyperlipidemia Yes / No since	(a) Congenital		Yes / No
b) Hypertension Yes / No since	(b) Hereditary		Yes / No
c) Diabetes Yes / No since	(c) A psychiatric	c disorder	Yes / No
d) Heart disease Yes / No since	(d) Pregnancy r	related/childbirth	Yes / No
Please specify:	(e) Infertility rela	ated	Yes / No
e) Stroke / TIA / Epilepsy Yes / No since	(f) Self-inflicted	l injury	Yes / No
f) SLE / Rheumatoid arthritis Yes / No since	(g) Due to alcoho	ols/drugs abuse	Yes / No
g) Cancer/ Tumour Yes / No since	(h) Treated for o	cosmetic reason	Yes / No
Please specify : h) Any Other Serious Illness Yes / No since	(i) HIV infection	n/related disease	Yes / No
h) Any Other Serious Illness Yes / No since Please specify:	(j) Sexually tran	nsmitted/related disease	Yes / No
· · ·	(k) Ischemic hea	art disease	Yes / No
15. Results of investigation :			
16. Procedures/Treatment done :			
7. Treatment/Medication :			
8. Complete this section if surgery was performed.	_	_	
Please ($$) where applicable: Is Operation Complex Major \square Major	Plus Major Interme	ediate Minor Office)
Kindly indicate the codes applied			
(The above definition is in accordance to MMA's Schedule of Fees Gu	ide)		
9. Is condition likely to recur: Yes / No	20. Is follow	w-up required? Y	'es / No
hereby certify that the information above is complete and true			

Hospital/Clinic Stamp:

PART 3 - CLAIMS DETAILS

1	Item	ation Cost/Outpatient Accident (Attach Original Invoi Invoice No	Invoice Date	Dominto No.	Amount
2 3 3 4 4 5 5 6 6 7 7 8 8 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	item	INVOICE INO	Invoice Date	Receipts No	Amount
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4	2				
5 6 6 7 7 8 8 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	3				
6 7 8 9 9 10 10 10 10 10 10 10 10 10 10 10 10 10	4				
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Signature of Person Covered/Guardian

Date

Name of Person Cover/Guardian