Metronic iCares Sdn Bhd

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

(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 /x-ray, radiological results and other related reports.

PART 1 - MEMBER DETAILS

Name of Patient : _____ Member No : _____
IC No. : _____ Certificate No : _____ Pay to (Name): _____
Address : _____ Bank/ Branch : _____
_____ Account No : _____
Tel No. (Home) : _____ Tel No. (Office): _____ Tel No. (H/P): _____ Email : _____

PART 2 –TREATMENT DETAILS (TO BE COMPLETED BY ATTENDING DOCTOR)

1. Is this patient referred to you? Yes / No If yes, please provide copy of referral letter
2. Is this admission due to an accident? Yes / No
a) Exact Nature of Accident : _____
b) Place of Accident : _____ Date : _____ Time: _____
c) Date First Treated : _____ Time : _____
3. Date Admitted : _____ Time : _____
4. Date Discharged : _____ Time : _____
5. Presenting Symptoms : _____ Duration: _____
6. Diagnosis : _____
7. When did patient first consult you for this condition? _____
8. Has this illness occurred before? Yes / No
If yes, when did this illness first occurred? (dd/mm/yy)_____
9. What is the underlying cause? _____
10. Is there any condition/illness that caused or is related to the present illness? Yes / No If yes, please specify: _____
11. Can this illness be treated as Outpatient? Yes/No
12. Is admission solely for investigation purpose? Yes/No

13. Has the patient ever had any of the following illness/condition?
(a) Hyperlipidemia Yes / No since _____
(b) Hypertension Yes / No since _____
(c) Diabetes Yes / No since _____
(d) Heart disease Yes / No since _____
Please specify: _____
(e) Stroke / TIA / Epilepsy Yes / No since _____
(f) SLE / Rheumatoid arthritis Yes / No since _____
(g) Cancer/ Tumour Yes / No since _____
Please specify : _____
(h) Any Other Serious Illness Yes / No since _____
Please specify : _____

14. Is present illness:
(a) Congenital Yes / No _____
(b) Hereditary Yes / No _____
(c) A psychiatric disorder Yes / No _____
(d) Pregnancy related/childbirth Yes / No _____
(e) Infertility related Yes / No _____
(f) Self-inflicted injury Yes / No _____
(g) Due to alcohols/drugs abuse Yes / No _____
(h) Treated for cosmetic reason Yes / No _____
(i) HIV infection/related disease Yes / No _____
(j) Sexually transmitted/related disease Yes / No _____
(k) Ischemic heart disease Yes / No _____

15. Results of investigation : _____
16. Procedures/Treatment done : _____
17. Treatment/Medication : _____
18. Complete this section if surgery was performed.
Please (√) where applicable: Is Operation Complex Major ☐ Major Plus ☐ Major ☐ Intermediate ☐ Minor ☐ Office
Kindly indicate the codes applied _____
(The above definition is in accordance to MMA's Schedule of Fees Guide)

19. Is condition likely to recur: Yes / No
20. Is follow-up required? Yes / No

I hereby certify that the information above is complete and true

Signature of Doctor :
Name of Doctor :
Date : Hospital/Clinic Stamp:

PART 3 – CLAIMS DETAILS

(A)Hospitalization Cost/Outpatient Accident (Attach Original Invoice/Receipts)

Item	Invoice No	Invoice Date	Receipts No	Amount
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

PART 4 – EMPLOYER DETAILS

Name of Employer : _____

Address : _____

Tel No : _____

Fax No : _____

Are you covered under your company's medical Insurance policy/ Takaful Certificate: Yes / No (if yes please fill the below)

Name of the insurance/ Takaful : _____

Name of your company : _____

Your company policy number / certificate No : _____

PART 5 – CLINIC DETAILS

Name of Regular Clinic Visited : _____

Address of Clinics : _____

Tel No of Clinic : _____

Fax No of Clinic : _____

PART 6 – OTHER INSURANCE POLICIES / TAKAFUL CERTIFICATE

Item	Takaful / Insurance Company	Policy No / Certificate No	Type Of Policy / Certificate	Coverage Amount
1				
2				
3				
4				

PART 7 – PATIENT / GUARDIAN CONSENT

I hereby authorize any physician, nurse, medical staff, hospital or clinic by whom I or the above named have been observed or treated to release any medical information including any investigation results and past medical history to Metronic iCares Sdn Bhd / the operator in order to process the Takaful claims. A photostat copy of this authorization shall be as effective and is valid as true original.

I hereby undertake to reimburse Metronic iCares Sdn Bhd / the operator in the event that the hospitalization costs are not covered by the certificate due to any reason whatsoever.

Name of Person Cover/Guardian	Signature of Person Covered/Guardian	Date
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