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

SEKSYEN I - Untuk diisi oleh Pekerja / Pesakit (DALAM HURUF BESAR)
SECTION I - To be completed by the Employee / Patient (IN BLOCK LETTER)

MAKLUMAT PEKERJA/PESERTA / *EMPLOYEE/PARTICIPANT INFORMATION*

Nama Pekerja/Peserta (seperti di dalam KP) *Name of Employee/Participant (as in IC)*

No. Kad Rawatan Ahli *Membership ID Card No.*

No. Kad Pengenalan Ahli *Employee NRIC No*

No. Sijil *Certificate No.*

Pekerjaan *Occupation*

No. Tel *Tel No.*

Nama Syarikat/Majikan *Company Name/Employer*

Tandatangan & Cop Majikan & Alamat
Employer's Signature & Stamp with Address

MAKLUMAT PENUNTUT/PESAKIT / *CLAIMANT/PATIENT INFORMATION*

Nama Penuntut/Pesakit (selain daripada Peserta)
Name of Claimant/Patient (other than the Participant)

Tarikh Lahir Penuntut/Pesakit
Birth Date of Claimant/Patient

Pelan / *Plan*

Tarikh Cuti Sakit / *Date of MC* -

Jumlah Hari Cuti Sakit / *No. of Medical Certificate Days*

Perhubungan dengan pekerja
Relationship to Employee
- ☐ Diri Sendiri *Self*
- ☐ Suami/Isteri *Spouse*
- ☐ Anak *Child*

Jantina Penuntut
Sex of Claimant
- ☐ Lelaki *Male*
- ☐ Perempuan *Female*

JENIS TUNTUTAN / *TYPE OF CLAIM*

☐ Dimasukkan ke Hospital / *Hospitalisation*
Jenis Penyakit/Kecederaan / *Nature of Illness/Injury*

☐ Pesakit Luar / *Outpatient*
Jenis Penyakit/Kecederaan / *Nature of Illness/Injury*

☐ Kemalangan / *Accident*
Tarikh & Masa Kemalangan / *Date & Time of Accident*
Bagaimana ia berlaku / *State how it happened*

BUTIR-BUTIR INSURAN LAIN, PERKESO, INSURANS PAMPASAN PEKERJA DAN LAIN-LAIN
DETAILS OF OTHER INSURANCE POLICIES, SOCSO, WORKMEN'S COMPENSATION AND OTHERS

Jenis Sijil / *Certificate Type*

No. Sijil / *Certificate No.*

Syarikat Insurans/Takaful / *Insurance/Takaful Company*

MAKLUMAT PEMBAYARAN *PAYMENT DETAILS*

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

☐ Syarikat / *Company* ☐ Pekerja / *Employee* ☐ Hospital/Pusat Rawatan / *Hospital/Medical Centre*

KEBENARAN KEPADA DOKTOR PERUBATAN, HOSPITAL ATAU KLINIK UNTUK MEMBERI MAKLUMAT
AUTHORISATION TO PHYSICIAN, HOSPITAL OR CLINIC TO RELEASE INFORMATION

Saya dengan ini memberi kebenaran kepada doktor perubatan, pengamal perubatan, hospital atau klinik yang merawat saya / tanggungan saya untuk memberi maklumat-maklumat lengkap berhubung dengan riwayat kesihatan saya / tanggungan saya termasuk latarbelakang penuh perubatan saya / tanggungan saya semasa dimasukkan ke hospital / menjalani pembedahan kepada Takaful IKHLAS General

I hereby authorise any physician, medical practitioner, hospital or clinic by whom or where I have/my ward has been observed or treated, to give full particulars about my/ward's health including my/ward's whole medical history in respect of this hospitalisation/survey, to Takaful IKHLAS General.

Tandatangan Pesakit / Pihak Menuntut	Tandatangan Pekerja / Peserta	Tarikh
Signature of Patient / Claimant	*Signature of Employee / Participant*	*Date*

SEKSYEN II - Discharge Medical Report Form
To be completed by the Attending Doctor (IN BLOCK LETTERS) **MNR No:**

Name of Hospital and Address

Name of patient NRIC No.

Date and Time of Admission
d d m m y y y y (hrs)

Date and Time of Discharge
d d m m y y y y (hrs)

Name of Referring Doctor and Address

Admitting Doctor	Attending Doctors	Speciality

1a. Diagnosis / ICD Coding

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

2a. When did patient first consult you for this condition?
(dd) (mm) (yy)

2b. Was the patient previously treated for this condition? ☐ No ☐ Yes, give details and when
(dd) (mm) (yy)

2c. How long in your professional opinion has the condition existed?
(dd) (mm) (yy)

4a. Please √ Nature of Treatment and Investigation:
- ☐ OPERATION
- ☐ PHYSIOTHERAPY
- ☐ DIETARY COUNSELLING
- ☐ MEDICATIONS
- ☐ X-RAY
- ☐ BLOOD TESTS
- ☐ OTHERS, give details

4b. If more than one procedure was involved, please state Type of Procedures performed:

	TYPE	DATE	NAME OF DOCTOR
i.			
ii.			
iii.			

4c. Other medical conditions present?

Since (dd mm yy)

Since (dd mm yy)

Since (dd mm yy)

3. Any possibility of a relapse?
☐ Yes ☐ No

5. Was the condition
☐ congenital ☐ nervous ☐ mental

6. Was the patient pregnant at the time of hospitalisation? (For Females Only)
☐ No ☐ Yes, _____ months

7. If the hospitalisation was due to accident, please indicate date / time of accident:
(dd) (mm) (yy) (hrs)

8. Discharge / Follow-up instructions

Signature and Name of Attending Doctor | Hospital Stamp | Date