PanGlobal INSURANCE

MEDICAL CLAIM REPORT FORM

SECTION I – To be completed by the Insured / Claimant (IN BLOCK LETTERS)
SEKSYEN 1– Untuk diisi oleh Pihak Diinsuranskan/Pihak Menuntut (DALAM HURUF BESAR)

Name of Insured *Nama Pihak Diinsuranskan*	NRIC No. *No. K/P*	Policy No. *No. Polisi*

Claimant (other than the Insured) *Pihak Menuntut (selain daripada Pihak Diinsuranskan)*	Claimant is: *Pihak Menuntut ialah:* ☐ Self/*Diri Sendiri* ☐ Spouse/*Pasangan* ☐ Child/*Anak*	NRIC No. (if applicable) *No. K/P (jika diterima pakai)*

Birth Date *Tarikh Lahir* ☐ (dd) *Tarikh* ☐ (mm) *Bulan* ☐ (yy) *Tahun*	Age *Umur* ☐	Sex *Jantina* ☐ Male/*Lelaki* ☐ Female/*Perempuan*	Race *Bangsa*

Religion *Agama*	Marital Status *Status Perkahwinan*	Occupation *Pekerjaan*
Employer Tel. No./No. Tel:	Employee's/Insured Person Address *Alamat Pekerja/Yang Diinsurans*	Employer's Address *Alamat Majikan*

Type of Claim
Jenis Tuntutan

☐ Hospitalisation/*Dimasukkan ke hospital* ☐ Outpatient/*Pesakit Luar*

☐ Accident/*Kemalangan*
Circumstances of Accident/*Keadaan Kemalangan*

Details of other insurance policies, Socso, Workmen's Compensation and others:-
Butir-Butir insuran lain, Perkeso, Insurans Pampasan Pekerja dan lain-lain:-

Policy Type/*Jenis Polisi*	Insurance Company/*Syarikat Insuran*	Policy No./*No. Polisi*

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

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/surgery, to the above insurance company.
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 di hospital/menjalani pembedahan kepada syarikat insuran.

……………………………… Signature of Patient *Tandatangan Pesakit*	……………………………………… Signature of Insured/Claimant *Tandatangan Pihak Diinsuranskan/Pihak Menuntut*	…………………………………. Date *Tarikh*

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DISCHARGE FACESHEET

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

Name of Hospital and Address

Name of Patient	NRIC No.

Date and Time of Admission	Date and Time of Discharge
☐ (dd) ☐ (mm) ☐ (yy) ☐ (hrs)	☐ (dd) ☐ (mm) ☐ (yy) ☐ (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. Discharge/Follow-up instructions

……………………………………………. ………………………………. ……………………………
Signature and Name of Attending Doctor Hospital Stamp Date