BORANG TUNTUTAN PERIBADI
PERSONAL CLAIM FORM - OUTPATIENT

1) Borang ini hendaklah diisi oleh pesakit atau orang membuat tuntutan / ibu bapa sekiranya pesakit adalah di bawah umur.
This form is to be completed by the patient or by the claimant / parent if the patient is a minor.
2) Tuntutan untuk perbelanjaan perubatan hendaklah dibuat dalam tempoh **30 hari dari tarikh rawatan diterima.**
*Claims for medical expenses should be submitted **within 30 days from the date of service.***
3) Tuntutan yang melibatkan perkara-perkara yang disenaraikan dalam senarai **PENGECUALIAN** dalam Pelan Kesihatan anda tidak akan dibayar.
*Claims for items and conditions as listed under **EXCLUSIONS** in your Medical Plan Summary are not payable.*
4) Borang ini perlu diisi dengan lengkap untuk memastikan pemprosesan yang cepat. Sebarang borang yang tidak lengkap akan dikembalikan.
Claimants are requested to complete this form to expedite the process. Any incomplete forms shall be returned to the claimant.
5) Borang ini perlu dikepilkan bersama surat rujukan doktor jika mendapatkan rawatan pakar atau surat temujanji diperlukan bagi rawatan susulan.
Claimants are requested to attach this form with referral letter for specialist treatment or appointment letter is required for follow up visit.
6) Borang ini dikhususkan untuk SATU RESIT / SATU TUNTUTAN sahaja.
This form is to be used for ONE RECEIPT / ONE CLAIM only.
7) Ubat - ubatan yang dibeli daripada farmasi hendaklah disertakan dengan preskripsi doktor.
Medication purchased directly from a pharmacy must attach with Doctor's description.
8) Sekiranya bil anda adalah **RM100.00 dan keatas**, sila sertakan bil terperinci termasuk ubat-ubatan yang diberikan.
*If your bill is **RM100.00 and above**, please attach the itemized bill including details of medications prescribed to you.*
9) Resit asal, bil terperinci, surat rujukan doktor atau surat temujanji (jika ada) mesti dikepilkan bersama borang ini dan dihantar ke:
Original bills, receipts and referral letter (if any) for the claims expenses must be attached with this form and send to:

PMCARE SDN BHD
BAHAGIAN TUNTUTAN
Level 12 Menara Insignia, Persiaran Kewajipan USJ 1, 47600 Subang Jaya, Selangor.

Nama pekerja:
Name of employee

No. keahlian PMCare *(PMCare membership no.)*

Nama majikan:
Name of employer

No. MyKad *(MyKad No.)* - -

Alamat pejabat:
Office address

No. yang boleh dihubungi :
Contact No.:

Alamat e-mel:
E-mail address

Nama pesakit:
Name of patient

Tarikh lahir pesakit
Date of birth of patient H H B B T T T T

Hubungan dengan pekerja : Sendiri [ ] Suami / isteri [ ] Anak [ ]
Relation to employee: Self [ ] Spouse [ ] Child [ ]

Tarikh rawatan
Date of consultation / service H H B B T T T T

Masa rawatan
Time of consultation / service am / pm

Jumlah tuntutan
Claim amount RM -

Nama bank:
Bank name _____

No. resit:
Receipt no. _____

No. akaun bank
Bank account no.

Jenis rawatan
Types of service

- [ ] Panel GP
- [ ] Pergigian *Dental*
- [ ] Bukan / Non Panel GP
- [ ] Pakar *Specialist*
- [ ] Bersalin *Delivery*
- [ ] Optik *Optic*
- [ ] Pakar Kanak-kanak *Paeditrician*

Jenis-jenis penyakit/rawatan. Sila tanda [✓]
Types of medical conditions/treatment. Please mark [✓]

- [ ] Demam *(fever)*
- [ ] Batuk / selsema / sakit tekak *(cough / cold / sore throat)*
- [ ] Lelah *(asthma)*
- [ ] Kencing manis *(diabetes)*
- [ ] Jangkitan telinga *(ear infection)*
- [ ] Jangkitan mata *(eye infection)*
- [ ] Lain-lain (nyatakan) *others (please specify)* _____
- [ ] Sakit belakang / sendi *(backache / joint pain)*
- [ ] Cirit birit / sakit perut / muntah *(diarrhea / colic / vomit)*
- [ ] Sakit kepala / pening *(headache / dizziness)*
- [ ] Gastrik / sakit perut *(gastritis / peptic ulcer)*
- [ ] Kecederaan / luka *(bruises / scalds / cuts)*
- [ ] Darah tinggi *(hypertension)*

Sebab mendapat rawatan di klinik bukan panel / tidak menggunakan Surat Jaminan Perubatan untuk kemasukan wad.
Reason for seeking treatment at non-panel clinic / without GL for Inpatient treatment
Sila tanda [✓] */ please mark* [✓]

- [ ] Kecemasan *(emergency / urgent care)*
- [ ] Tiada klinik panel berdekatan *(panel clinic not within the vicinity)*
- [ ] Sila nyatakan jika lain-lain sebab *(Please explain for other reasons)*

Immunisasi / *Immunisation*
Sila nyatakan jenis dan jumlah bayaran:-
Please provide type(s) & cost:-
1. _____ RM _____
2. _____ RM _____

Nota: Sila sertakan salinan jadual immunisasi.
Please provide a copy of immunisation schedule.

Penjagaan gigi / *Dental Care*

- [ ] Cabutan gigi *(extraction)*
- [ ] Tampalan gigi *(filling)*
- [ ] Cucian karang gigi *(scaling & polishing)*
- [ ] Lain-lain. Sila nyatakan _____ *(others. please specify _____)*

Rawatan Alternatif / *Alternative Treatment*

- [ ] *(Homeopathy)*
- [ ] *(Chiropractor)*
- [ ] *(Acupunture)*

Bersalin/ *Maternity*

- [ ] Pemeriksaan sebelum bersalin. Sila Nyatakan tempoh kandungan. _____ *(pre natal check up. to specify month of pregnancy _____)*
- [ ] Pemeriksaan selepas bersalin *(post natal check up)*
- [ ] Bersalin biasa *(normal delivery)*
- [ ] Bersalin secara pembedahan (caesarean delivery)
- [ ] (assisted delivery)

Rawatan Pakar / *Specialist Treatment*
Adakah ini rawatan susulan?
Is this a follow up case?

- [ ] Ya *(yes)*
- [ ] Tidak *(no)*

Jika anda membuat rawatan susulan, sila tandakan [✓]
If this apply for follow up visit, please tick [✓]

- [ ] Pakar *(specialist)*
- [ ] Kemasukan wad *(hospitalisation)*

Tarikh mendapatkan rawatan / kemasukan wad
Date of last visit/ admission H H B B T T T T

Saya bersetuju memberi segala maklumat yang diperlukan kepada PMCare Sdn Bhd dan/atau Majikan untuk memproses, membayar tuntutan, serta menghasilkan laporan. Salinan kebenaran ini dikira sah sepertimana salinan asal.
I hereby consent to the release of relevant information to PMCare Sdn Bhd and/or my Employer to process, reimburse claim, and to produce report. A copy of this authorisation shall be considered as effective and valid as the original.

_____ Tarikh *(date)*

_____ Tandatangan pesakit / yang menuntut *(signature of patient / claimant)*