MediExpress (Malaysia) Sdn Bhd (474674-P)
20 & 22 Jalan SS4D/14, Taman Peoples Park, 47301 Petaling Jaya, Selangor.
Tel No: 03-7803 2003 Fax No: 03-7803 2005
E-mail: medix@medix.com.my Website: www.medix.com.my

REIMBURSEMENT MEDICAL FORM

(i) Please answer all questions and attach all original bills and receipts.
(ii) Direct them to MediExpress to ensure prompt payment. Avoid sending to insurance company or branches.
(iii) Incomplete form may result in delay of insurance claims.
(iv) Please provide copy of lab test results / x-ray and radiological results.
(v) Please provide a copy of passport if treated overseas.

PART 1 - MEMBER DETAILS

Name of patient: _____ Member No. : _____
IC No. : _____ Policy No. : _____
Address : _____ Insurer : _____
_____ Tel (Home) : _____
_____ Tel (Office) : _____
Pay to (Name) : _____ Tel (H/P) : _____
Bank / Branch : _____ E-mail : _____
Account No. : _____ _____
*Please provide Bank Account number to ensure prompt payment

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

1 Is this patient refered to you? Yes / No If yes, please provide copy of referral letter
2 Is this admission due to an accident? Yes / No
Exact nature of accident: _____
Place of accident : _____ Date: _____ Time: _____
Date first treated : _____ Time: _____
3 Date Admitted : _____ Time: _____
4 Date Discharged : _____ Time: _____
5 Presenting symptoms : _____ Duration: _____
6 Diagnosis : _____
7 Has this illness occured before? Yes / No
If yes, when did this illness first occured? (dd/mm/yy) _____
8 Is there any condition/illness that caused or is related to the present illness? Yes / No
If yes, pls specify: _____ Since _____
9 Has the patient ever had any of the following illness/conditon?
(a) Hyperlipidemia Yes / No since _____
(b) Hypertension Yes / No since _____
(c) Diabetes Yes / No since _____
(d) Heart disease Yes / No since _____
(pls specify: _____)
(e) Stroke / TIA / Epilepsy Yes / No since _____
(f) SLE / Rheumatoid arthritis Yes / No since _____
(g) Cancer / Tumour Yes / No since _____
(pls specify: _____)
(i) Any other serious illness Yes / No since _____
(pls specify: _____)
10 Is present illness:
(a) congenital Yes / No
(b) hereditary Yes / No
(c) a psychiatric disorder Yes / No
(d) pregnancy related Yes / No
(e) infertility related Yes / No
(f) self-inflicted injury Yes / No
(g) due to alchohol/drugs abuse Yes / No
(h) treated for cosmetic reason Yes / No
11 Results of investigation: _____
12 Procedures/Treatment done: _____
13 Treatment/Medication: _____
14 Is condition likely to recur: Yes / No
15 Is follow-up required? Yes / No
I hereby certify that the information above is true and correct.

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

PART 3 - CLAIMS DETAILS

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

Item	Invoice No	Invoice Date	Receipt No	Amount
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

PART 4 - EMPLOYER DETAILS

Name of employer : _____

Address : _____

_____

_____

Tel. No. : _____

Fax No. : _____

PART 5 - CLINIC DETAILS

Name of Regular Clinic Visited : _____

Address of Clinic : _____

_____

_____

Tel. No. of Clinic : _____

Fax No. of Clinic : _____

Are you insured under your company's medical insurance policy: Yes / No

PART 6 - OTHER INSURANCE POLICIES

Item	Insurance Company	Policy No	Type of Policy	Coverage Amount
1				
2				
3				

PART 7 - AUTHORISATION TO RELEASE INFORMATION

I hereby authorise any physician, hospital, clinic, insurance company or any organization, Institution or person to give full particulars about my health including my/ward's whole medical history and billing information in respect of this hospitalization/surgery to **MediExpress (Malaysia) Sdn Bhd** in order to process my medical claim.

_____ _____ _____

Signature of Insured/Claimant | Signature of Policyowner | Date