



MediExpress (Malaysia) Sdn Bhd (474674-P)

No. 123, Jalan SS 25/2, 47301 Petaling Jaya, Selangor Darul Ehsan.

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 referred 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 occurred before? Yes / No	
If yes, when did this illness first occurred? (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/condition?	10 Is present illness:
(a) Hyperlipidemia Yes / No since _____	(a) congenital Yes / No
(b) Hypertension Yes / No since _____	(b) hereditary Yes / No
(c) Diabetes Yes / No since _____	(c) a psychiatric disorder Yes / No
(d) Heart disease Yes / No since _____	(d) pregnancy related Yes / No
(pls specify: _____)	(e) infertility related Yes / No
(e) Stroke / TIA / Epilepsy Yes / No since _____	(f) self-inflicted injury Yes / No
(f) SLE / Rheumatoid arthritis Yes / No since _____	(g) due to alcohol/drugs abuse Yes / No
(g) Cancer / Tumour Yes / No since _____	(h) treated for cosmetic reason Yes / No
(pls specify: _____)	
(i) Any other serious illness Yes / No since _____	
(pls specify: _____)	
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 - PATIENT / GUARDIAN CONSENT

I hereby authorize any physician, nurse, medical staff, hospital or clinic by whom I or the abovenamed have been observed or treated to release any medical information including any investigation results and past medical history to **MediExpress (Malaysia) Sdn Bhd** and the insurer in order to process the insurance claims. I hereby undertake to reimburse **MediExpress (Malaysia) Sdn Bhd** in the event that the hospitalization costs are not covered by the policy due to any reason whatsoever.

Name of Insured / Guardian

Signature

Date