Metronic iCares Sdn Bhd
No. 2, Jalan Astaka U8/83,
Seksyen U8, Bukit Jelutong,
40150 Shah Alam,
Selangor Darul Ehsan

General Line: 03-78439459
24 HOURS HOTLINE:
03-7839 3213
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PRE-AUTHORISATION FORM

Borang Pra-kebenaran

Private and Confidential / Sulit dan Persendirian

Part 1 (To be completed by Patient / Claimant)
Bahagian 1 *(Untuk diisi oleh Pesakit / Penuntut)*

1. Patient Name: *Nama Pesakit*	2. NRIC (Old & New): *K.P. (Lama & Baru)*
3. a. Date of Birth: *Tarikh lahir*	b. Age: *Umur*
c. Sex: ☐ Male ☐ Female *Jantina Laki-laki Perempuan*	
4. Policy No. / Member ID/ Certificate No/ Plan/ Company Name : *No. Polisi / No. Ahli / No. Sijil / Pelan / Nama Syarikat*	5. Admission / Planned Admission Date: *Tarikh kemasukan hospital*
6. Hospital Name: *Nama Hospital*	7. Name of Attending Doctor/ Speciality: *Nama Doktor yang merawat/ Kepakaran:*

Admission Reason (tick) and answer accordingly
Sila tanda ( ) dan jawab soalan yang berkenaan

☐ 8. Accident *Kemalangan*	a. Occurred on: Date _____/_____/_____Time _____ ☐ am ☐ pm *Berlaku pada Tarikh Masa pagi petang* b. Details of Accident: *Butir-butir kemalangan*
☐ 9. Illness *Penyakit*	a. Symptoms first appeared on: Date _____/_____/_____ *Tarikh simptom tersebut bermula Tarikh* b. Doctor(s) consulted for this condition: *Doktor-doktor yang dilawati bagi penyakit ini* c. Doctor's or Clinic Contact(Address & Telephone): *Alamat & Telefon Doktor*

10. <u>Declaration and authorization</u>

I declare that the answers given above are true and complete to the best of my knowledge and belief.

I understand the delivery of this form is in no way an admission of claim by MiCare/Payor Company and payment to the hospital by MiCare/Payor Company or its representative shall not be construed as final admission of claim by MiCare/Payor Company for this and any further claims arising, MiCare/Payor Company reserves all rights for evaluation as appropriate.

I am fully aware of the limits as to my/covered person's medical/Takaful entitlement under the above-mentioned policy. I hereby undertake to settle/reimburse any medical expenses exceeding my entitlement under the said policy contract, or that is not covered by the same.

I hereby irrevocably authorize any organisation, institution, or individual that has any record or knowledge of my health and medical history or treatment or advice that has been or may hereafter be consulted, other personal information or details of related accident/injury, to disclose to MiCare/Payor Company or its representative such information. I agree that MiCare/Payor Company or its representative may use or disclose any of the information collected or held to third parties (within or outside Malaysia, including MiCare's/Payor Company's parent company, subsidiaries or any other associated companies within the MiCare/Payor Company Group, reinsurers/retakaful, medical examiners, claims investigators and industry associations/federations etc.) in relation to this claim. This authorization shall bind my/the covered person's successors and assigns and remain valid notwithstanding my/ covered person's incapacity in so far as legally possible. A photocopy of this authorization shall be valid as the original.
I agree that in the event I make, or have in the past made, any false or untrue statement and/or suppressed and/or concealed any material facts in respect of my/the covered person's condition, MiCare/Payor Company shall absolutely forfeit my/the covered person's right to compensation and further reserves the right to recover any amounts paid earlier as a result thereof.

<u>Pengisytiharan dan pemberikuasa</u>

Saya mengisytiharkan bahawa jawapan yang diberikan di atas adalah benar dan lengkap setakat pengetahuan dan kepercayaan saya.

Saya memahami bahawa penyerahan borang ini, tidak sama sekali boleh dianggap sebagai persetujuan tuntutan saya/orang yang dilindungi ke atas MiCare/Syarikat Pembayar dan saya bersetuju bahawa bayaran kepada hospital oleh MiCare/Syarikat Pembayar atau wakilnya tidak akan ditafsirkan sebagai persetujuan muktamad tuntutan ke atas MiCare/Syarikat Pembayar dan MiCare/Syarikat Pembayar berhak menjalankan penilaian sewajarnya berhubung tuntutan ini atau apa-apa tuntutan yang timbul selanjutnya.

Saya memahami sepenuhnya had-had kelayakanTakaful/Perubatan saya di bawah Polisi yang tersebut di atas. Saya dengan ini berjanji akan menyelesaikan sebarang amaun yang melebihi had kelayakan saya, yang tidak dilindungi oleh Polisi berkenaan.

Saya yang bertandatangan di bawah, dengan ini membenarkan pada setiap masa, mana-mana organisasi, institusi atau individu yang mempunyai apa-apa rekod atau pengetahuan tentang kesihatan dan latar belakang atau rawatan atau nasihat perubatan saya/orang yang dilindungi, yang telah atau mungkin kemudian dari ini dirujuk untuk mendedahkan kepada MiCare/Syarikat Pembayar atau wakilnya segala maklumat tersebut. Saya bersetuju membenarkan MiCare/Syarikat Pembayar atau wakilnya untuk mengguna dan mendedahkan apa-apa maklumat yang dikumpul atau dipegang kepada pihak ketiga (di dalam atau di luar Malaysia, termasuk syarikat induk, anak syarikat atau syarikat berkait dalam Syarikat, syarikat reinsurans/retakaful, pemeriksa perubatan, penyiasat tuntutan dan pertubuhan/persekutuan industri dll.) berkaitan dengan tuntutan ini. Pengesahan ini hendaklah mengikat waris-waris dan penama saya/ nyawa yang dilindungi dan kekal sah meskipun setelah kematian saya/orang yang dilindungi setakat yang dibenarkan di sisi undang-undang. Salinan pengesahan ini adalah sah. Saya bersetuju sekiranya saya membuat pengakuan palsu atau tidak mendedahkan maklumat yang berkaitan, MiCare/Syarikat Pembayar berhak membatalkan tuntutan saya dan menarik balik sebarang tuntutan awal yang telah dibayar.

Signature of Patient /*Tandatangan Pesakit*	Signature of Covered person/ claimant / *Tandatangan Orang yang dilindungi /Penuntut*	Signature of Witness / *Tandatangan Saksi*
_____	_____	_____
Full Name/*Nama Penuh* : IC No./*No. KP* : Date/*Tarikh* : Contact No / No Telefon :	Full Name/*Nama Penuh*: IC No./*No. KP*: Date/*Tarikh*: Contact No / No Telefon: Relationship to Patient:/ *Hubungan dengan Pesakit:*	Full Name/*Nama Penuh*: IC No./*No. KP*: Date/*Tarikh*: Contact No / No untuk dihubungi:

NOTE: COMPLETION OF THIS PRE AUTHORISATION FORM DOES NOT GUARANTEE THE ISSUANCE OF GUARANTEE LETTER.
Nota: Melengkapkan borang permintaan ini tidak semestinya menjamin bahawa Surat Jaminan akan dikeluarkan.

MiCARE

Part 2 ADMISSION SECTION ***(To be completed upon admission by Doctor)***

1.a. Patient name: b. NRIC: c. Age: d. Sex: ☐ Male ☐ Female

2. Policy No. / Member ID/ Certificate No/Plan/ Company No:	3. Admission No. / MRN and Hospital Name/ Hospital Contact and Fax No :
4. Admission Date and Time:	5. Expected days of stay / Discharge Date:

6. a. Symptoms / Conditions requiring admission: b. How long is patient aware of the condition:

b. Patient's BP/ Temp/ Pulse:

d. Date symptoms first appeared: _____/_____/_____ e. Date first consulted: _____/_____/_____

7.a. Any previous consultation / treatment / hospitalization for this symptom / illness or related conditions, or other disorders whether in this hospital or any other facilities? ☐ Yes ☐ No.

b. Was this patient referred? If Yes, please provide details below:

c. If this condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed :

Date	Disease / Disorder	Details of Treatment / Hospitalization	Doctor / Hospital/ Clinic

d. Can the condition be managed under the Outpatient basis: □ Yes □ No
If no please provide reasons of admission :

8. a. ☐ Admitting Diagnosis:
or
b. ☐ Provisional Diagnosis:

c. Diagnosis confirmed on _____/_____/_____
Advised patient on _____/_____/_____
d. Cause and pathology underlying the present diagnosis:

9. Estimated Total Costs : RM

e. Any possibility of relapse? ☐ Yes ☐ No

10a. Admission requires:
□ Hospitalisation
□ Day Care
□ On Patient's Request

11. Is the illness / condition related to: (please tick (✓) if YES). Please provide details:

a) ☐ Pregnancy / Childbirth / Infertility/ Caesarean section/ miscarriage Or any complications arising therefrom.
b) ☐ Congenital / Hereditary diseases
c) ☐ Influence of Drugs / Alcohol
d) ☐ Nervous / Mental / Emotional / Sleeping Disorder
e) ☐ Cosmetic reason / Dental care / refractive errors correction
f) ☐ AIDS / STD / VD/ HIV
g) ☐ Self-inflicted injuries / Violation of laws / Strike / Riots
h) ☐ None of the above

12. Medical treatment, Investigations and Surgical procedure to be performed, if any (please supply copy of all investigation results):

13. Any other medical/surgical conditions present? ☐ No ☐ Yes, details below:

a. _____ since _____/_____/_____
b. _____ since _____/_____/_____

14. Was the patient pregnant at the time of hospitalization? (For Female Only)
☐ No ☐ Yes, _____ months

15. a. If hospitalization was due to injury, please describe circumstances and cause of injury:

b. Please indicate date/time of accident: (dd/mm/yy) _____/_____/_____ (hrs) _____☐ am ☐ pm

16. *I hereby certify that I have personally examined and treated the Patient for his/her injuries/illness described above and that the facts as stated above represent my medical opinion of his/her condition.*

_____ Date
_____ Name & Signature of Attending Doctor
DR's Contact no and Email address:
_____ Doctor / Hospital Stamp

DISCHARGE SECTION ***(To Be Completed Upon Discharge by Doctor)***

17. Undertaking Letter Ref No:(If available)	18. Date of Discharge:

19. a. Final Diagnosis: b. Cause and pathology of the diagnosis:

ICD code:

20. Treatment given / Investigation done: (Please supply copy of all investigation results)

21. a. Surgical procedures performed: b. Date of surgery / procedure:

MMA code / PHFSR code:

22.a. Recovery complication that arose (if any):

b. In the case of DEATH, please advise Date/ Time and Cause of death :

23. *I hereby certify that I have personally examined and treated the Patient for his/her injuries/illness described above and that the facts as stated above represent my medical opinion of his/her condition.*

_____ Date
_____ Name & Signature of Attending Doctor
_____ Doctor / Hospital Stamp