MediExpress (Malaysia) Sdn Bhd (474674-P)
F-G-7, BLOCK F,PUSAT KOMERSIAL PARKLANE
N0.21, JALAN SS7/26, PETALING JAYA, SELANGOR
Tel : 03 -7884 1919, Fax : 03 -7809 9333,
Email : 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 : ____________________
NRIC / Passport No. : ____________________
Correspondence Address : ____________________
____
____
Pay to (Name) : ____________________
NRIC / Passport No. of Payee : ____________________
Bank / Branch : ____________________
Account No. : ____________________
*Please provide Bank Account number to ensure prompt payment

Member No. : ____________________
Policy No. (1) : ____________________
Policy No. (2) ____________________
Insurer : ____________________
Tel (Home) : ____________________
Tel (Office) : ____________________
Tel (H/P) : ____________________
E-mail : ____________________

ADMISSION / TREATMENT REASON - (Tick) and anwer accordingly

☐ 1. Accident
a. Occurred on: Date____/____/____ Time________ am/pm
b. Details of Accident:____________________ c. Place of Accident : ____________________

☐ 2. Illness
a. Symptoms first appeared on: Date____/____/____
b. Name, Address and Contact No. of first doctor consulted for this symptom / condition : ____________________
____

PART 2 - 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				

PART 3 - EMPLOYER DETAILS

Name of employer : ____________________
Address : ____________________
____
____
Tel. No. : ____________________
Fax No. : ____________________
Are you insured under your company's medical insurance policy: Yes / No

PART 4 - CLINIC DETAILS

Name of Regular Clinic Visited : ____________________
Address of Clinic : ____________________
____
____
Tel. No. of Clinic : ____________________
Fax No. of Clinic : ____________________

PART 5 - OTHER INSURANCE POLICIES

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

PART 6 - AUTHORISATION TO RELEASE INFORMATION

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

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 and billing information or details of related accident/injury, to disclose to MediExpress (M) Sdn. Bhd. or its representative such information. I agree that MediExpress (M) Sdn. Bhd. or its representative may use or disclose any of the information collected or held to third parties (within or outside Malaysia, including reinsurers, medical examiners, claims investigators and industry associations/federations etc.) in relation to this claim. This authorization shall bind my/the Assured's/the Insured's/the Covered's successors and assigns and remain valid notwithstanding my/the Assured's/the Insured's/the Covered'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 Assured's/the insured's/the Covered's condition, MediExpress (M) Sdn. Bhd. shall absolutely forfeit my/the Insured's/ the Assured's / the Covered's right to compensation and further reserves the right to recover any amounts paid earlier as a result thereof.

________________ Signature of Insured/Claimant

________________ Signature of Policyowner

________________ Date

PART 7 - 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 ________ ICD Code: ________

What is the undelying cause of this diagnosis : ________

7 Has this illness occured before? ☐ Yes ☐ No

If yes, when did this illness first occured? (dd/mm/yy) ________

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) If yes, please provide details as follows :

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

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 / nervous / mental disorder ☐ Yes ☐ No

(d) pregnancy related ☐ Yes ☐ No

(e) infertility related ☐ Yes ☐ No

(f) self-inflicted injury ☐ Yes ☐ No

(g) influence of alcohol / drugs ☐ Yes ☐ No

(h) treated for cosmetic reason ☐ Yes ☐ No

(i) dental care ☐ Yes ☐ No

(j) developmental disorder ☐ Yes ☐ No

(k) sleeping disorder ☐ Yes ☐ No

(l) AIDS/ STD ☐ Yes ☐ No

11 Results of investigation: ________

12 Procedures / Treatment done: ________ MMA Code: ________

13 Can the condition be managed under the Outpatient basis: ☐ Yes ☐ No

If no please provide reasons of admission : ________

14 Treatment / Medication: ________

15 Is condition likely to recur: ☐ Yes ☐ No

16 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: