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: