FWHS MEDIK SDN. BHD.
(Company No.: 841234-P)
No. 123, Jalan SS 25/2, 47301 Petaling Jaya
Tel . 03-7803 2003
Email : fwhs@medix.com.my

RMF Ver 1

REIMBURSEMENT MEDICAL FORM

Skim Perlindungan Insurans Kesihatan Pekerja Asing (SPIKPA)
Skim Kemasukan Hospital dan Pembedahan Pekerja Asing (SKHPPA)

Patient: _____ Passport / ID: _____

Tel (H/P):_____ Tel (O) : _____Fax:_____email:_____

Address:_____

Policy No: _____ Insurer: _____

Pay to (Name) : _____ Bank : _____

Account No.. _____ (Please provide account no to ensure prompt payment)

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 Date Admitted: _____
3 Date Discharged: _____
4 Symptoms: _____Since : _____
5 Diagnosis & _____
(ICD Code) _____
6 Is the treatment related to the following illness:-
- (a) Cardiovascular Yes / No
- (b) Cancer Yes / No
- (c) AIDS, HIV or STD Yes / No
- (d) Congenital or Hereditary Yes / No
- (e) Pregnancy or Reproduction related Yes / No
- (f) Attempted Suicide or Self-inflicted Injury Yes / No
- (g) Sleep or Snoring disorder Yes / No
- (h) Psychotic, Mental or Nervous disorder Yes / No
- (i) Sports or Flying Injury Yes / No
- (j) Work related Yes / No

7 Warded more than 30 days? Yes / No
8 ICU more than 15 days? Yes / No
9 Procedures Done:_____

_____

10 Investigation done: _____

_____

Date	Name of doctor	Signature	Hospital's Stamp

CLAIMS DETAILS

HOSPITALIZATION COST (Please Attach Original Invoices and Receipts)

Item	Invoice No	Invoice Date	Receipt No	Amount
1				
2				
3				
4				
5				
6				
7				
8				

LAB TEST, X-RAY, ANGIOGRAM AND OTHER INVESTIGATION REPORT (Please attached)

1. _____
2. _____
3. _____

EMPLOYER DETAILS

Name of employer . _____

Address _____

Tel. No. _____ Fax No. : _____

OTHER INSURANCE POLICIES, IF ANY

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

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 and investigation results including past medical history to the insurer and its appointed TPCA in order to process the insurance claims.

_____ Date

_____ Name

_____ Relationship

_____ Signature