



**Corporate Solutions - Hospital & Surgical Claim**  
**July 2018**

<b>CLAIM NO.</b> For Office Use Only
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IMPORTANT NOTE	CHECKLIST ON SUBMISSION OF CLAIM DOCUMENTS		
	TYPE OF CLAIM		
<p>1. One form for <b>ONE</b> admission and related to Pre &amp; Post visit.</p> <p>2. Claim for hospitalisation &amp; surgical expenses must be submitted within 90 days from the date of discharge or consultation.</p> <p>3. For Overseas Treatment, the original Detailed Admission Bill showing details of each charges must be provided. English translation must be provided if the bill is in foreign language.</p> <p>4. AIA Bhd. will keep the claim documents unless you requested for the documents to be returned to you within 60 days from the decision of the claim.</p> <p>5. A copy of Identity Card (NRIC) or Passport must be provided.</p> <p>6. Field marked with (*) is compulsory.</p>	<input type="checkbox"/> Hospitalisation / Daycare Treatment  *1. Copy of Identity Card (NRIC) or Passport 2. Original Official Receipt (Deposit & Final Payment) 3. Detailed Itemised Bill 4. Medical Report / Section II of this form <ul style="list-style-type: none"> <li>For Government Hospital bill above RM1,000.</li> <li>For Private Hospital bill above RM500.</li> </ul> 5. Copy of Investigation Report [Lab / Imaging / Procedure Performed (if any)] 6. Physiotherapy Details - visit date & amount for each treatment session done (Advance payment NOT accepted) <p style="text-align: right;"><i>GHS1</i></p>	<input type="checkbox"/> Pre & Post Hospitalisation  *1. Copy of Identity Card (NRIC) or Passport 2. Original Official Receipt (Deposit & Final Payment) 3. Detailed Itemised Bill 4. Copy of Investigation Report [Lab / Imaging / Procedure Performed (if any)] 5. Physiotherapy Details - visit date & amount for each treatment session done (Advance payment NOT accepted) <p style="text-align: right;"><i>POST</i></p>	<input type="checkbox"/> Accidental Claim  *1. Copy of Identity Card (NRIC) or Passport 2. Original Official Receipt (Deposit & Final Payment) 3. Detailed Itemised Bill 4. Medical Report / Section II of this form <ul style="list-style-type: none"> <li>For Government Hospital bill above RM1,000.</li> <li>For Private Hospital bill above RM500.</li> </ul> 5. Copy of Investigation Report [Lab / Imaging / Procedure Performed (if any)] 6. Copy of Police Report (if any) <p style="text-align: right;"><i>GHS1</i></p>
	Assessment of the claim may be delayed if documents are incomplete.		

**SECTION I - To be completed by the Employee / Patient (IN BLOCK LETTERS)**

**A. EMPLOYEE INFORMATION**

\*Name of Employee (as in NRIC)

\*Employee NRIC No. / Passport No.  Policy No.  Plan

\*Mobile No.  -  This number will be used for your claim status notification. Occupation

Date of Employment  -  -  Date of Group Insurance Participation  -  -  Gender  Male  Female

\*Email Address

\*Name of Company / Employer

**B. PATIENT INFORMATION**

\*Name of Patient   Same as above

\*Membership No. (as in Member ID Card)  Gender  Male  Female Relationship to Employee  Spouse  Child

**C. FOR ACCIDENTAL CAUSE ONLY**

\*Date of Accident  -  -  \*Time  :   am  pm \*Details of Accident (brief explanation of the cause):

**D. DETAILS OF OTHER INSURANCE POLICIES, SOCSO, WORKMEN'S COMPENSATION AND OTHERS**

Policy Type  Hospital & Surgical  Other(s) \_\_\_\_\_ (e.g. SOCSO) Policy No.

Insurance Company  Not insured under any program, benefits, schemes or insurance.

**E. CLAIM AMOUNT**

\*RM  .

**F. \*E-PAYMENT REGISTRATION (MANDATORY REQUIREMENT)**

Change of account number for this claim and future transactions.  Use the existing payment details in AIA Bhd. record.

Notes:  
 (a) AIA shall not be responsible for losses as a result of inaccurate account details provided.  
 (b) Only employee bank account details allowed.

Bank Name   
 Bank Account Holder Name   
 Bank Account No.

**G. DECLARATION AND AUTHORISATION**

- I/We confirm that the information given are true and accurate.
- I/We understand that for Overseas Treatment, I/we must include Original Detailed Admission Bill showing details of each charges. The bill must have an English translation if it is in a foreign language.
- I/We understand AIA Bhd. will keep my/our claim documents unless if I/we request for the documents to be returned to me within 60 days from the decision of claim.
- I/We understand that AIA Bhd.'s acceptance of this Hospital & Surgical Claim Form is not an admission of AIA Bhd.'s liability of my/our claim.
- I/We authorise any institution or individual that has any records or knowledge of my/our health and medical history to disclose such information to AIA Bhd. or its representative.
- I/We understand and agree that any personal information collected or held by AIA Bhd. (whether through this Hospital & Surgical Claim form or otherwise obtained) may be used and disclosed by AIA Bhd. to individuals/institutions related to and associated with AIA Bhd. or any selected third party within or outside Malaysia such as reinsurers, claims investigation companies and industry associations to process this Hospital & Surgical Claim form. The information may also be used to provide service for this and other financial products and to communicate with me/us. I/We understand that I/we have a right to get access to and request for correction of any personal information held by AIA Bhd. Such requests can be made at any AIA Bhd. Customer Centres.

_____ Signature of Employee	_____ Date	_____ Employer's Signature, Stamp & Address
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**SECTION II - To be completed by the Attending Doctor (IN BLOCK LETTERS) - Please answer all questions** **MRN No.:** \_\_\_\_\_

1. a) Patient Name	b) NRIC	c) Age	d) Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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2. Admission Date and Time [d][d] - [m][m] - [y][y][y][y] [ ] : [ ] (hrs)	3. Discharge Date [d][d] - [m][m] - [y][y][y][y]
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4. Date of MC [d][d] - [m][m] - [y][y][y][y] to [d][d] - [m][m] - [y][y][y][y]	No. of MC days [ ] [ ] [ ]
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5. a) Symptoms / Conditions requiring admission:	b) How long is patient aware of the condition:
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c) Patient's BP / Temp / Pulse:
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d) Date symptoms first appeared: [d][d] - [m][m] - [y][y][y][y]	e) Date first consulted: [d][d] - [m][m] - [y][y][y][y]
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6. a) Any previous consultation / treatment / hospitalisation for this symptom / illness or related conditions, or other disorders whether in this hospital or any other facilities? <input type="checkbox"/> Yes <input type="checkbox"/> No
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b) Was this patient referred? If Yes, please provide details:
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c) If this condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed:
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<u>Date</u>	<u>Disease / Disorder</u>	<u>Details of Treatment / Hospitalisation</u>	<u>Doctor / Hospital / Clinic</u>
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d) Can the condition be managed under the Outpatient basis: <input type="checkbox"/> Yes <input type="checkbox"/> No
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If No, please provide reasons of admission: _____
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7. Any other medical / surgical conditions present? <input type="checkbox"/> No <input type="checkbox"/> Yes, details below:
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a) _____	since [d][d] - [m][m] - [y][y][y][y]
b) _____	since [d][d] - [m][m] - [y][y][y][y]

8. a) Final Diagnosis / ICD Coding i) ii) iii)	b) Cause and pathology of the diagnosis:
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9. Treatment given / Investigation done (Please supply copy of all investigation results):
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10. a) Surgical procedures performed:  MMA code / PHFSR code:	b) Date of surgery / procedure: [d][d] - [m][m] - [y][y][y][y]
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11. Is the illness / condition related to: (please tick ✓ if YES)	
a) <input type="checkbox"/> Childbirth / Infertility / Caesarean Section / Miscarriage or Any Complications Arising Therefrom b) <input type="checkbox"/> Congenital / Hereditary Disease c) <input type="checkbox"/> Influence of Drugs / Alcohol d) <input type="checkbox"/> Nervous / Mental / Emotional / Sleeping Disorder	e) <input type="checkbox"/> Cosmetic Reason / Dental Care / Refractive Errors Correction f) <input type="checkbox"/> AIDS / STD / VD / HIV g) <input type="checkbox"/> Self-inflicted Injuries / Violation of Laws / Strike / Riots h) <input type="checkbox"/> None of the above

12. Was the patient pregnant at the time of hospitalisation? (For Females Only) <input type="checkbox"/> No <input type="checkbox"/> Yes, _____ months
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13. 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.
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_____ Name & Signature of Attending Doctor	_____ Doctor / Hospital Stamp	_____ Date
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**Corporate Solutions - Tuntutan Hospital & Pembedahan  
July 2018**

**NO. TUNTUTAN** Untuk Kegunaan Pejabat Sahaja

NOTA PENTING	SENARAI SEMAK BAGI PENYERAHAN DOKUMEN-DOKUMEN TUNTUTAN		
	JENIS TUNTUTAN		
<p>1. Setiap borang tuntutan adalah untuk <b>SATU</b> kemasukan ke hospital &amp; rawatan sebelum &amp; selepas yang berkaitan dengannya.</p> <p>2. Tuntutan hospitalisasi &amp; perbelanjaan pembedahan mesti dihantar dalam masa 90 hari daripada tarikh keluar hospital atau tarikh rundingan.</p> <p>3. Untuk Rawatan Di Luar Negara, Butiran Bil Asal yang terperinci menyenaraikan butir-butir setiap caj perlu disertakan. Terjemahan Bahasa Inggeris perlu disertakan jika bil dalam bahasa asing.</p> <p>4. AIA Bhd. akan menyimpan dokumen tuntutan melainkan anda memohon dokumen tersebut dikembalikan kepada anda dalam masa 60 hari dari tarikh keputusan tuntutan.</p> <p>5. Salinan Kad Pengenalan (KP) atau Pasport perlu disertakan.</p> <p>6. Ruangan bertanda (*) wajib diisi.</p>	<input type="checkbox"/> Kemasukan ke Hospital / Jagaan Harian *1. Salinan Kad Pengenalan (KP) atau Pasport 2. Resit Rasmi Asal (Deposit & Bayaran Akhir) 3. Butiran Bil Terperinci 4. Laporan Perubatan / Section II di dalam borang ini <ul style="list-style-type: none"> <li>• Sekiranya bil melebihi RM1,000 untuk Hospital Kerajaan.</li> <li>• Sekiranya bil melebihi RM500 untuk Hospital Swasta.</li> </ul> 5. Salinan Laporan Penyiasatan [Makmal / Pengimejan / Prosedur Dilakukan (jika ada)] 6. Maklumat Fisioterapi - tarikh rawatan dan jumlah bagi setiap sesi rawatan (Resit bayaran pendahuluan TIDAK akan diterima) <p style="text-align: right;"><i>GHS1</i></p>	<input type="checkbox"/> Pra & Selepas Rawatan Hospital *1. Salinan Kad Pengenalan (KP) atau Pasport 2. Resit Rasmi Asal (Deposit & Bayaran Akhir) 3. Butiran Bil Terperinci 4. Salinan Laporan Penyiasatan [Makmal / Pengimejan / Prosedur Dilakukan (jika ada)] 5. Maklumat Fisioterapi - tarikh rawatan dan jumlah bagi setiap sesi rawatan (Resit bayaran pendahuluan TIDAK akan diterima) <p style="text-align: right;"><i>POST</i></p>	<input type="checkbox"/> Tuntutan Kemalangan *1. Salinan Kad Pengenalan (KP) atau Pasport 2. Resit Rasmi Asal (Deposit & Bayaran Akhir) 3. Butiran Bil Terperinci 4. Laporan Perubatan / Section II di dalam borang ini <ul style="list-style-type: none"> <li>• Sekiranya bil melebihi RM1,000 untuk Hospital Kerajaan.</li> <li>• Sekiranya bil melebihi RM500 untuk Hospital Swasta.</li> </ul> 5. Salinan Laporan Penyiasatan [Makmal / Pengimejan / Prosedur Dilakukan (jika ada)] 6. Salinan Laporan Polis (jika ada) <p style="text-align: right;"><i>GHS1</i></p>

Penilaian ke atas tuntutan ini mungkin akan megalami kelewatan jika dokumen tidak lengkap.

**SEKSYEN I - Untuk diisi oleh Pekerja / Pesakit (DALAM HURUF BESAR)**

**A. MAKLUMAT PEKERJA**

\*Nama Pekerja (seperti di dalam KP)

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\*No. KP Pekerja / No. Pasport

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No. Polisi

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Pelan

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\*No. Tel. Bimbit

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Nombor telefon ini akan digunakan untuk makluman tuntutan anda.

Pekerjaan

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Tarikh Mula Bekerja

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Tarikh menyertai Skim Insurans Berkumpulan

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Jantina

Lelaki  Perempuan

\*Alamat Emel

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\*Nama Syarikat / Majikan

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**B. MAKLUMAT PESAKIT**

\*Nama Pesakit

Sama seperti di atas

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\*No. Keahlian (seperti di dalam Kad Keahlian)

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Jantina

Lelaki  Perempuan

Hubungan dengan Pekerja

Suami / Isteri  Anak

**C. UNTUK KES KEMALANGAN SAHAJA**

\*Tarikh Kemalangan

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\*Masa

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\*Butiran Kemalangan (penjelasan ringkas mengenai punca kemalangan):

**D. BUTIR-BUTIR INSURANS LAIN, PERKESO, INSURANS PAMPASAN PEKERJA DAN LAIN-LAIN**

Jenis Polisi

Hospital & Pembedahan

Lain-lain \_\_\_\_\_ (e.g. SOCSO)

No. Polisi

Syarikat Insurans

Tidak dilindungi oleh mana-mana program, faedah ataupun skim insurans lain.

**E. AMAUN YANG DITUNTUT**

\*RM 

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**F. \*PENDAFTARAN E-PEMBAYARAN (MANDATORI UNTUK DIISI)**

Perubahan nombor akaun bagi transaksi pembayaran masa hadapan.

Gunakan butiran pembayaran sedia ada dalam rekod AIA Bhd.

Nota:

(a) AIA tidak akan bertanggungjawab terhadap sebarang kerugian sekiranya maklumat akaun yang diberikan tidak tepat.

(b) Hanya maklumat akaun bank pekerja diterima.

Nama Bank

Nama Pemegang Akaun Bank

No. Akaun Bank

**G. PENGAKUAN DAN PEMBERIAN KUASA**

1. Saya/Kami mengesahkan bahawa maklumat yang diberikan adalah benar dan tepat.
2. Saya/Kami memahami bahawa untuk Rawatan Di Luar Negara, saya/kami perlu menyertakan Butiran Bil Asal yang terperinci menyenaraikan buti-butir setiap caj bil tersebut dan bil perlu diterjemahkan ke Bahasa Inggeris jika ianya dalam bahasa asing.
3. Saya/Kami memahami bahawa AIA Bhd. akan menyimpan dokumen tuntutan saya/kami melainkan jika saya/kami memohon untuk dokumen tersebut dikembalikan kepada saya/kami dalam masa 60 hari dari tarikh keputusan tuntutan.
4. Saya/Kami memahami bahawa penerimaan Borang Tuntutan Hospital & Pembedahan oleh AIA Bhd. tidak boleh dianggap sebagai penerimaan liabiliti ke atas tuntutan yang dibuat.
5. Saya/Kami memberi kuasa kepada mana-mana institusi atau individu yang mempunyai rekod atau maklumat tentang kesihatan dan sejarah perubatan saya/kami untuk mendedehkannya kepada AIA Bhd atau wakil AIA Bhd.
6. Saya/Kami memahami dan bersetuju bahawa maklumat peribadi yang dikumpul atau dipegang oleh AIA Bhd. (sama ada melalui Borang Tuntutan Hospital & Pembedahan ini ataupun cara lain) boleh digunakan dan didedahkan kepada individu atau institusi yang berkaitan dengan AIA Bhd. atau mana-mana pihak ketiga di dalam atau di luar Malaysia seperti penanggung insurans semula (reinsurer), syarikat penyiasatan tuntutan dan persatuan industri bagi memproses Borang Tuntutan Hospital & Pembedahan ini. Maklumat tersebut juga boleh digunakan untuk memberikan perkhidmatan ke atas permohonan ini dan juga produk kewangan lain. Saya/Kami memahami bahawa saya/kami mempunyai hak untuk mendapatkan dan memohon pembetulan dibuat ke atas mana-mana maklumat persendirian yang disimpan oleh AIA Bhd. Permohonan tersebut boleh dibuat di mana-mana cawangan Pusat Khidmat Pelanggan AIA Bhd.

Tandatangan, Cop Rasmi & Alamat Majikan

Tandatangan Pekerja

Tarikh

**SECTION II - To be completed by the Attending Doctor (IN BLOCK LETTERS) - Please answer all questions**

**MRN No.:**

1. a) Patient Name	b) NRIC	c) Age	d) Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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2. Admission Date and Time [d][d] - [m][m] - [y][y][y][y] [ ] : [ ] (hrs)	3. Discharge Date [d][d] - [m][m] - [y][y][y][y]
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4. Date of MC [d][d] - [m][m] - [y][y][y][y] to [d][d] - [m][m] - [y][y][y][y]	No. of MC days [ ] [ ] [ ]
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5. a) Symptoms / Conditions requiring admission:	b) How long is patient aware of the condition:
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c) Patient's BP / Temp / Pulse:
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d) Date symptoms first appeared: [d][d] - [m][m] - [y][y][y][y]	e) Date first consulted: [d][d] - [m][m] - [y][y][y][y]
--	--

6. a) Any previous consultation / treatment / hospitalisation for this symptom / illness or related conditions, or other disorders whether in this hospital or any other facilities? <input type="checkbox"/> Yes <input type="checkbox"/> No
--

b) Was this patient referred? If Yes, please provide details:
---

c) If this condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed: <u>Date</u> <u>Disease / Disorder</u> <u>Details of Treatment / Hospitalisation</u> <u>Doctor / Hospital / Clinic</u>
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d) Can the condition be managed under the Outpatient basis: <input type="checkbox"/> Yes <input type="checkbox"/> No
--

If No, please provide reasons of admission: _____
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7. Any other medical / surgical conditions present? <input type="checkbox"/> No <input type="checkbox"/> Yes, details below:
--

a) _____ since [d][d] - [m][m] - [y][y][y][y]
b) _____ since [d][d] - [m][m] - [y][y][y][y]

8. a) Final Diagnosis / ICD Coding	b) Cause and pathology of the diagnosis:
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i)	
ii)	
iii)	

9. Treatment given / Investigation done (Please supply copy of all investigation results):
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10. a) Surgical procedures performed:  MMA code / PHFSR code:	b) Date of surgery / procedure: [d][d] - [m][m] - [y][y][y][y]
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11. Is the illness / condition related to: (please tick ✓ if YES)
---

a) <input type="checkbox"/> Childbirth / Infertility / Caesarean Section / Miscarriage or Any Complications Arising Therefrom	e) <input type="checkbox"/> Cosmetic Reason / Dental Care / Refractive Errors Correction
b) <input type="checkbox"/> Congenital / Hereditary Disease	f) <input type="checkbox"/> AIDS / STD / VD / HIV
c) <input type="checkbox"/> Influence of Drugs / Alcohol	g) <input type="checkbox"/> Self-inflicted Injuries / Violation of Laws / Strike / Riots
d) <input type="checkbox"/> Nervous / Mental / Emotional / Sleeping Disorder	h) <input type="checkbox"/> None of the above

12. Was the patient pregnant at the time of hospitalisation? (For Females Only) <input type="checkbox"/> No <input type="checkbox"/> Yes, _____ months
--

13. 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.
---

Name & Signature of Attending Doctor

Doctor / Hospital Stamp

Date