redefining / standards

**AXA Affin General Insurance Berhad** (23820-W)
Ground Floor, Wisma Boustead, 71 Jalan Raja Chulan
50200 Kuala Lumpur, Malaysia
1800 88 2236, (603) 2026 0929
(603) 2031 2500
healthservices@axa.com.my
www.axa.com.my

# Reimbursement claim form (in-patient)

This claim form is not an admission of liability.
**Please use a separate claim form for each separate visit to the doctor.**

**Date received:**

Dear Doctor, we thank you for filling in medical sections B, C and D of this claim form and for signing, dating and stamping it.
We thank you for completing all other sections of this claim form and for signing and dating it. All fields on the front page are compulsory.
We thank you in advance for your cooperation which will enable fast and accurate processing.

## A. ADMINISTRATIVE

| | | |
|---|---|---|
| Policy/membership nos: | | Policyholder/company name: |
| Patient date of birth: dd/mm/yyyy | Gender: | Patient name: |
| NRIC/passport no: | Plan: | Patient phone: |
| Email address: | | For hospitalisation only<br>Date of admission: |
| Date of treatment: dd/mm/yyyy For reimbursement only | | Date of discharge: |

## B. MEDICAL SECTION

| | | |
|---|---|---|
| Symptoms presented | Date the patient first became aware of any signs or symptoms for this condition: dd/mm/yyyy | Date on which the patient first presented to any doctor for this condition: dd/mm/yyyy |
| Medical condition/diagnosis | | |
| Investigation (describe necessary investigations requested to define the diagnosis) | | |
| If claim is related to pregnancy, is pregnancy related to natural conception? Yes ☐ No ☐ | | |

## C. TREATMENT ADVISED

| | | | |
|---|---|---|---|
| Drugs | Dose | Frequency | Duration |
| Procedure (please give details of medical procedures if any) | | | |

## D. FURTHER TREATMENT PLANNED

Please give details of any further planned treatment.

## E. OTHER INSURER'S DETAILS

| | |
|---|---|
| Is the treatment accident related? Yes ☐ No ☐<br>(If you have answered 'yes', please give details of the accident.) | Is it covered under another insurance policy? Yes ☐ No ☐ |
| If you have answered 'yes' to either of these questions, please give the name of the insurance company involved.<br>(Kindly submit a copy of the other insurance company's claim settlement letter/payment voucher) | |

## PATIENT'S DECLARATION

I hereby authorise any physician, hospital, clinic, insurance company or any organisation, institutions or person to give full particulars about my health including my/ward's whole medical history and billing information in respect of this hospitalisation/surgery to AXA Affin General Insurance Berhad. I further consent to the redisclosure of all such medical information & records to insurers, re-insurers, solicitors, my employer, agents/ brokers & other third parties in connection with my insurance claims. A duplicate of this authorisation shall be as effective and valid as the original.

Signature: Date:

## MEDICAL PRACTITIONER DECLARATION

I declare that I am the patient's medical practitioner, and that the particulars given are to the best of my knowledge true and correct.

Name: Stamp:

Signature:

Date:

HAP/HAG-CF-RI-1114

This part of the claim form aims at gathering additional information on the member in order to facilitate the processing of the claim. We thank you in advance for providing us the most complete information.

## F. ADMINISTRATIVE SPECIFIC TO REIMBURSEMENT CLAIMS

Amount claimed:
Please ensure that the amount claimed here is supported by original invoices and prescription.

Cheque beneficiary name: (IN CAPITAL LETTERS)

Telegraphic bank transfer: (Bank details will be required if previously not declared in application form)

Bank account no: | Bank SWIFT code:

Name of bank: | Bank address:

Payment will be made in the currency defined in your plan unless we agreed otherwise in writing.
In which currency was the treatment originally billed?

**Member's and patient's details**

Patient's name and address:

Telephone no: | Email address:

Mobile no:

Address to which payment should be sent if different from above:

## G. MEDICAL PROVIDERS DETAILS:

Name of medical provider: | Telephone no:

Address of medical provider: | Fax no:

## H. IF YOU ARE CLAIMING FOR TREATMENT RECEIVED OUTSIDE YOUR AREA OF COVER, PLEASE ANSWER THE FOLLOWING QUESTIONS:

(a) Country where the treatment took place:

(b) The reason for the patient being abroad:

(c) Date of departure and return to own area of cover: From : dd / mm / yyyy To : dd / mm / yyyy

Are you claiming cash benefit for in-patient treatment? Please tick Yes ☐ No ☐

If Yes, please enclose a hospital certificate confirming the dates of stay.

For AXA use only:

Batch no: | Batch opening date:

If you have any questions regarding this form or any other aspects of the cover, please contact our Health Services Team on 1800 88 2236 quoting your policy/ membership numbers.
Claims must be submitted along with supporting documents within 90 days from date of service. Send this claim form together with supporting material to Health Services Team, AXA Affin General Insurance Berhad, Ground Floor, Wisma Boustead, 71 Jalan Raja Chulan, 50200 Kuala Lumpur, Malaysia.