FWHS Medik Sdn. Bhd. (841234-P)
F-G-7, Block F, Parklane Commercial Hub,
No.21, Jalan SS7/26,
47301 Petaling Jaya, Selangor
Tel: 03-7884 1818
Email: fws@medix.com.my
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Part 1 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)

Part 2: 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

Part 3: 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				

Part 4: LAB TEST, X-RAY, ANGIOGRAM AND OTHER INVESTIGATION REPORT (Please attached)

1. ____
2. ____
3. ____

Part 5: EMPLOYER DETAILS

Name of employer : ____

Address : ____

Tel. No. : ____________________ Fax No. : ____________________

Part 6: OTHER INSURANCE POLICIES, IF ANY

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

Part 7: EMPLOYER CONSENT

I hereby authorize any physician, nurse, medical staff, hospital or clinic by whom I or the above-named 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 & Company Chop