ZURICH®

Borang Pra-kebenaran
Pre-Authorisation Form

Private and Confidential / Sulit dan Persendirian

Bahagian 1 (Untuk diisi oleh Pesakit / Penuntut)
Part 1 (To be completed by Patient / Claimant)

1. Nama Pesakit / *Patient Name:* _____

2. K.P. (Lama & Baru) / *NRIC (Old & New):* _____

3. (a) Tarikh lahir / *Date of Birth:* _____

   (b) Umur / *Age:* _____

   (c) Jantina / *Sex:* _____

4. No. Polisi / No. Ahli / No. Sijil / Pelan / Nama Syarikat
   Policy No. / Member ID / Certificate No / Plan / Company Name:
   _____

5. Tarikh kemasukan hospital:
   Admission / Planned Admission Date: _____

6. Nama Hospital
   Hospital Name: _____

7. Nama Doktor yang merawat/ Kepakaran:
   Name of Attending Doctor / Speciality: _____

   Sila tanda (X) dan jawab soalan yang berkenaan
   Admission Reason (X) and answer accordingly

8. ◯ Kemalangan / *Accident*

   (a) Berlaku pada Tarikh _____ Masa _____ pagi / petang
   Occurred on: Date *Time* *am / pm*

   (b) Butir-butir kemalangan
   Details of Accident _____

9. ◯ Penyakit / *Illness*

   (a) Tarikh simptom tersebut bermula: Tarikh
   Symptoms first appeared on: Date _____

   (b) Doktor-doktor yang dilawati bagi penyakit ini
   Doctor(s) consulted for this condition _____

   (c) Alamat & Telefon Doktor
   Doctor's or Clinic Contact(Address & Telephone) _____

NOTA: MELENGKAPKAN BORANG PERMINTAAN INI TIDAK SEMESTINYA MENJAMIN BAHAWA SURAT JAMINAN AKAN DIKELUARKAN.
NOTE: COMPLETION OF THIS PRE AUTHORISATION FORM DOES NOT GUARANTEE THE ISSUANCE OF GUARANTEE LETTER.

Pengisytiharan dan pemberikuasa / *Declaration and authorization*

Saya mengisytiharkan bahawa jawapan yang diberikan di atas adalah benar dan lengkap setakat pengetahuan dan kepercayaan saya.

Saya memahami bahawa penyerahan borang ini, tidak sama sekali boleh dianggap sebagai pengakuan liabiliti Zurich General Insurance Malaysia Berhad ini ke atas tuntutan saya/Assured dan saya bersetuju bahawa bayaran kepada hospital oleh Zurich General Insurance Malaysia Berhad atau wakilnya tidak akan ditafsirkan sebagai pengakuan muktamad liabiliti Zurich General Insurance Malaysia Berhad dan Zurich General Insurance Malaysia Berhad berhak menjalankan penilaian sewajarnya berhubung tuntutan ini atau apa-apa tuntutan yang timbul selanjutnya.

Saya memahami sepenuhnya had-had insurans perubatan saya di bawah Polisi yang tersebut di atas. Saya dengan ini berjanji akan menyelesaikan sebarang amaun yang melebihi had kelayakan saya, yang tidak dilindungi oleh insurans berkenaan.

Saya yang bertandatangan di bawah, dengan ini membenarkan pada setiap masa, mana-mana organisasi, institusi atau individu yang mempunyai apa-apa rekod atau pengetahuan tentang kesihatan dan latar belakang atau rawatan atau nasihat perubatan saya/Assured/Insured, yang telah atau mungkin kemudian dari ini dirujuk untuk mendedahkan kepada Zurich General Insurance Malaysia Berhad atau wakilnya segala maklumat tersebut. Saya bersetuju membenarkan Zurich General Insurance Malaysia Berhad atau wakilnya untuk mengguna dan mendedahkan apa-apa maklumat yang dikumpul atau dipegang kepada pihak ketiga (di dalam atau di luar Malaysia, termasuk syarikat induk, anak syarikat atau syarikat berkait dalam Zurich General Insurance Malaysia Berhad, reinsurer, pemeriksa perubatan, penyiasat tuntutan dan pertubuhan/persekutuan industri dan lain-lain.) berkaitan dengan tuntutan ini. Pengesahan ini hendaklah mengikat waris-waris dan penama saya/Assured/insured dan kekal sah meskipun setelah kematian saya/Assured/insured setakat yang dibenarkan di sisi undang-undang. Salinan pengesahan ini adalah sah. Saya bersetuju sekiranya saya membuat pengakuan palsu atau tidak mendedahkan maklumat yang berkaitan, Zurich General Insurance Malaysia Berhad berhak membatalkan tuntutan saya dan menarik balik sebarang tuntutan awal yang telah dibayar.

I declare that the answers given above are true and complete to the best of my knowledge and belief.

I understand the delivery of this form is in no way an admission of Zurich General Insurance Malaysia Berhad's liability and payment to the hospital by Zurich General Insurance Malaysia Berhad or its representative shall not be construed as final admission of Zurich General Insurance Malaysia Berhad's liability and for this and any further claims arising, Zurich General Insurance Malaysia Berhad reserves all rights for evaluation as appropriate.

I am fully aware of the limits as to my/Assured medical insurance under the above-mentioned policy. I hereby undertake to settle/ reimburse any medical expenses exceeding my entitlement under the said policy contract, or that is not covered by the same.

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 information or details of related accident/injury, to disclose to Zurich General Insurance Malaysia Berhad or its representative such information. I agree that Zurich General Insurance Malaysia Berhad or its representative may use or disclose any of the information collected or held to third parties (within or outside Malaysia, including Zurich General Insurance Malaysia Berhad's parent company, subsidiaries or any other associated companies within Zurich General Insurance Malaysia Berhad's Group, reinsurers, medical examiners, claims investigators and industry associations/federations etc.) in relation to this claim. This authorization shall bind my/the Assured's/ Insured's successors and assigns and remain valid notwithstanding my/Assured's/Insured'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 insured's condition, Zurich General Insurance Malaysia Berhad shall absolutely forfeit my/the Insured's/Assured's right to compensation and further reserves the right to recover any amounts paid earlier as a result thereof.

Tandatangan Pesakit / *Signature of Patient*

_____

Tarikh/Date: _____

Nama Penuh/*Full Name:*

_____

No K/P. / *I/C No.:* _____

No Telefon/*Contact No:* _____

Email Address*:* _____

Tandatangan Pemilik Polisi /Penuntut */Signature of Assured/ Claimant*

_____

Tarikh/*Date:* _____

Tandatangan Saksi */ Signature of Witness*

_____

Tarikh/Date: _____

Nama Penuh/*Full Name:* _____

No K/P. */ I/C No.:* _____

No Telefon/*Contact No:* _____

Hubungan dengan Pesakit
Relationship to Patient: _____

Nama Penuh/Full Name: _____

No K/P. */ I/C No.:* _____

No Telefon/Contact No: _____

Part 2 ADMISSION SECTION (To be completed upon admission by Doctor)

1. (a) Patient name: _____

(b) NRIC (Old & New): _____

(c) Age: _____

(d) Sex: ◯ *Male* ◯ *Female*

2. Policy No. / Member ID/ Certificate No/ Plan/ Company Name:

_____

3. Admission No. / MRN and Hospital Name/ Hospital Contact and Fax No:

4. Admission Date and Time: _____

5. Expected days of stay / Discharge Date: _____

6. (a) Symptoms / Conditions requiring admission: _____

(b) How long is patient aware of the condition: _____

(c) Patient's BP / Temp / Pulse: _____

(d) Date symptoms first appeared: _____

(e) Date first consulted: _____

7. (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) Was this patient referred? If Yes, please provide details below:

_____

(c) If this condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed:

Date _____

Disease / Disorder _____

Details of Treatment / Hospitalization _____

Doctor / Hospital/ Clinic _____

(d)Can the condition be managed under the Outpatient basis:
If no please provide reasons of admission: ◯ *Yes* ◯ *No*

8. ◯ *(a) Admitting Diagnosis:* _____ *(c) Diagnosis confirmed on* _____
or *Advised patient on* _____
◯ *(b) Provisional Diagnosis:* _____

(d) Cause and pathology underlying the present diagnosis: _____

(e) Any possibility of relapse? ◯ *Yes* ◯ *No*

9. *Estimated Total Costs : RM* _____

10. *Admission requires:* ◯ *Hospitalisation* ◯ *Day Care* ◯ *On Patient's Request*

11. *Is the illness / condition related to: (please tick (X) if YES). Please provide details:*

◯ *(a) Pregnancy / Childbirth / Infertility / Caesarean section / miscarriage Or any complications arising therefrom.*
◯ *(b) Congenital / Hereditary diseases*
◯ *(c) Influence of Drugs / Alcohol*
◯ *(d) Nervous / Mental / Emotional / Sleeping Disorder*
◯ *(e) Cosmetic reason / Dental care / refractive errors correction*
◯ *(f) AIDS / STD / VD / HIV*
◯ *(g) Self-inflicted injuries / Violation of laws / Strike / Riots*
◯ *(h) None of the above*

12. *Medical treatment, Investigations and Surgical procedure to be performed, if any (please supply copy of all investigation results):*

_____

13. *Any other medical/surgical conditions present?* ◯ *Yes* ◯ *No*
details below:

(a) _____

since _____/_____/_____

(b) _____

since _____/_____/_____

14. *Was the patient pregnant at the time of hospitalization? (For Female Only)* ◯ *Yes* ◯ *No*
_____ *months*

15. *(a) If hospitalization was due to injury, please describe circumstances and cause of injury:*

_____

_____

(b) Please indicate date/time of accident: (dd/mm/yy) _____/_____/_____ *(hrs)* _____ *am / pm*

16. *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 *DR's Contact no and Email addresss:*	*Doctor / Hospital Stamp*

Tarikh/Date : _____

DISCHARGE SECTION (To Be Completed Upon Discharge by Doctor)

17. *Undertaking Letter Ref No:(If available)* _____

18. *Date of Discharge:* _____

19. *(a) Final Diagnosis:* _____

    (b) Cause and pathology of the diagnosis: _____

    ICD code: _____

20. *Treatment given / Investigation done: (Please supply copy of all investigation results).*

    _____

21. *(a) Surgical procedures performed:* _____

    (b) Date of surgery / procedure: _____

    MMA code / PHFSR code: _____

22. *(a) Recovery complication that arose (if any):* _____

    (b) In the case of DEATH, please advise Date/ Time and Cause of death : _____

23. *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*

Tarikh/Date *:* _____

Zurich General Insurance Malaysia Berhad
Registration No. 201701035345 (1249516-V)
Level 23A, Mercu 3, No. 3, Jalan Bangsar, KL Eco City, 59200 Kuala Lumpur, Malaysia
Tel: 03-2109 6000 Fax: 03-2109 6888 Call Centre: 1-300-888-622
www.zurich.com.my

ZURICH®