International Assistance Sdn. Bhd.
Healthcare Assistance and Contact Centre Outsourcing

PRE - ADMISSION FORM

Private and Confidential / Sulit dan Persendirian

IA International Assistance Sdn Bhd
Unit I-5, Sunway PJ51A Jalan SS9A/19
KG Baru Sungai Way 47300
Petaling Jaya, Selangor Darul Ehsan
Tel: 1800-22-0911 Fax: 603-7875 1911

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

1. Patient Name *Nama Pesakit*	2. NRIC (Old & New) *K.P. (Lama & Baru)*
3.a.Date of Birth *Tarikh lahir* b. Age : *Umur*	c. Sex : *Jantine* ☐ Male *Laki-laki* ☐ Female *Perempuan*
4. Policy No/Member ID/ Certificate No/Plan/Company Name : *No.Polisi/No.Ahli/ No. Sijil/Pelan/ Nama Syarikat*	5. Admission/ Planned Admission date *Tarikh kemasukan hospital*
6. Hospital Name : *Nama Hospital*	7. Name of attending Doctor / Speciality *Nama Doktor yang merawat / Kepakaran*

Admission Reason (✔) and answer accordingly
Sila tanda (✔) dan jawab soalan yang berkenan

☐ 8. Accident *Kemalangan*	a. Occurred on *Berlaku pada* Date _____ / _____ / _____ Time _____ ☐ am ☐ pm *Tarikh* *Masa* *pagi* *petang* b.Details of Accident *Butir - butir kemalangan*
☐ 9. Illness *Penyakit*	a. Symptoms first appeared on : *Tarikh simptom tersebut bermula* Date _____ / _____ / _____ *Tarikh* b. Doctor(s) consulted for this condition : *Doktor-doktor yang dilawati bagi pesakit ini* c. Doctor's or Clinic Contact (Address & Telephone) : *Alamat & Telefon Doktor*

Goods & Services Tax (GST) Information / *Maklumat Cukai Barangan dan Perkhidmatan*
Please tick (✔) and answer accordingly / Sila tanda (✔) dan jawab soalan yang berkenaan

10. Are you GST registered? ☐ Yes/Ya ☐ No/Tidak
Adakah anda bedaftar di bawah GST?

If "Yes", please provide your GST Registration Number:
Sekiranya "Ya", sila nyatakan nombor pendaftaran GST anda:

The Company shall rely on the above information provided by your tax credit purpose provided under the GST Act. The Company shall not be liable for any fine, charge or penalty as a result of relying on your incorrect advice. Should action be taken against the Company and / or penalties be imposed on the Company by any tax authority for relying n the same, the Company reserves its right to be indemnified by you to the fullest extent permitted by law and any GST liability arising from your incorrect advice shall be payable by you.
Syarikat akan bergantung pada maklumat di atas yang diberikan untuk tujuan kredit cukai anda yang diperuntukankan di bawah Akta GST. Syarikat tidak akan bertanggungjawab terhadap sebarang liabiliti atau denda, penalti atau caj jika maklumat yang diberikan tidak betul. Sekiranya tindakan diambil terhadap Syarikat dan / atau penalti yang dikenakan ke atas Syarikat oleh mana-mana pihak berkuasa, Syarikat berhak menuntut kerugian daripada anda sehingga tahap yang dibenarkan oleh undang-undang dan sebarang lialibiti GST yang wujud berdasarkan maklumat yang tidak betul.

11. Declaration and Authorization / *Pengisytiharan dan pemberikuasa*

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 Company's liability and payment to the hospital by the Company or its representative shall not be construed as final admission of the Company's liability and for this and any further claims arising. The Company 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 irrevocable authorize any organization, 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 accident/injury, to disclose to the Company or its representative such information. I agree that the Company or its representative may use or disclose any of the information collected or held to third parties (within or outside Malaysia, including the Company's parent company, subsidiaries or any other associated companies within the Company'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 concealed any material facts in respect of my/the Insured condition, the Company shall absolutely forfeit my/the Insured's/ Assured's right to compensation and further reserves the right to recover any amounts paid earlier a result thereof.

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 Syarikat ini ke atas tuntutan saya/Asured dan saya bersetuju bahawa bayaran kepada hospital oleh Syarikat atau wakilnya tidak akan ditafsirkan sebagai pengakuan muktamad liabiliti Syarikat dan Syarikat 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 telah 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 perubahan saya/Assured/Insured, yang telah atau mungkin kemudian dari ini dirujuk untuk mendedahkan kepada Syarikat atau wakilnya segala maklumat tersebut. Saya bersetujumembenarkan Syarikat atau wakilnya untuk mengguna dan mendedahkan apa - apa maklumat yang dikumpul atau dipegangkepada pihak ketiga (di dalam atau di luar Malaysia, termasuk syarikat induk, anak syarikat atau syarikat berkat dalam Syarikat, reinsurer, pemeriksa perubahan, penyiasat tuntutan dan pertubuhan/persekutuan industri dll) berkaitan dengan tuntutan ini. Pengesahan ini hendaklah mengikat waris-waris dan penama saya/Assured/Inssured dan kekal sah meskipun setelah kematian saya/Assured/Inssured 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, Syarikat berhak membatalkan tuntutan saya dan menarik balik sebarang tuntutan awal yang telah dibayar

Signature of Patient *Tandatangan Pesakit*	Signature of Assured/claimant *Tandatangan Pemilik Polisi / Penuntut*	Signature of Witness *Tandatangan saksi*
Full Name/*Nama Penuh* : IC No. / *No. KP* : Date /*Tarikh* : Contact No / *No Telefon* :	Full Name/ *Nama Penuh* : IC No. / *No. KP* : Date /*Tarikh* : Contact No / *No Telefon* : Relationship to Patient / *Hubungan dengan Pesakit* :	Full Name/ *Nama Penuh* : IC No. / *No. KP* : Date /*Tarikh* : Contact No / *No Telefon* :

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

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

1.a. Patient Name | b. NRIC | c. Age : | d. Sex ☐ Male ☐ Female

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

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

4. Admission Date and Time :
(dd/mm/yy) Date _____ / _____ / _____ Time _____ ☐ am ☐ pm

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. 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 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 : ☐ Yes ☐ No
If no please provide reasons of admission :

8. a. ☐ Admitting Diagnosis :
Or
b. ☐ Provisional Diagnosis :

c. Diagnosis confirm on _____ / _____ / _____
Advised patient on _____ / _____ / _____

d. Cause and pathology underlying the present diagnosis :

e. Any possibility of relapse? ☐ Yes ☐ No

9. Estimated Total Costs : RM

10.a. Admission requires :

- ☐ Hospitalization
- ☐ Day Care
- ☐ On Patient's request

11. Is the illness / condition related to : (please tick (√) if YES

- ☐ Pregnancy / Childbirth / Infertility / Caesarian section / miscarriage or any complications arising there from
- ☐ Congenital / Hereditary diseases
- ☐ Influence of drugs / alcohol
- ☐ Nervous / Mental / Emotional / Sleeping disorder
- ☐ Cosmetic reason / Dental care /refractive errors correction
- ☐ AIDS / HIV/ STD / VD
- ☐ Self - Inflicted injuries / Violation of laws / Strike/Riots
- ☐ None of the above

Please provide details

12. Medical treatment, investigation 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**

_____	_____	_____
Date	Name & Signature of Attending Doctor DR's Contract no and email address	Doctor / Hospital Stamp

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 :

21. a. Surgical procedures performed :

b. Date of surgery / procedure : _____ / _____ / _____

MMA Code/PHFSR code

22.a. Recovery complication that arise (if any) :

b. In 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**

_____	_____	_____
Date	Name & Signature of Attending Doctor	Doctor / Hospital Stamp