International Assistance
Healthcare Anywhere, Anytime

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MSIG
Formerly Sinarmas MSIG Life

PRE-AUTHORIZATION FORM / FORMULIR PRA-OTORISASI

PART 1 (TO BE COMPLETED BY INSURED ONLY) / BAHAGIAN 1 (UNTUK DILENGKAPI OLEH TERTANGGUNG)
MANDATORY / WAJIB DIISI

Patient Name: *Nama Pasien*		Identity Card (IC) / Passport: *KTP / Nomor Paspor*		
Date of Birth: *Tanggal lahir*	Age: *Umur*	Gender: *Jenis kelamin*	☐ Male *Pria*	☐ Female *Perempuan*
Policy No: *No.Polis*		Admission/ Planned Treatment date: *Tanggal masuk rumah sakit*		
Member ID: *No.kartu anggota*				
Insurance Name: *Nama Perusahaan Asuransi*				
Hospital Name: *Nama Rumah Sakit*		Name of attending Doctor / Specialty: *Nama Dokter yang merawat / Specialis*		

Admission Reason tick (√) and answer accordingly / *Alasan masuk rumah sakit*

☐ **Accident**: *Kecelakaan*	Occurred on: Date _____ / _____ / _____ Time _____ ☐ am ☐ pm *Terjadi pada Tanggal* *Masa pagi / siang / sore / malam*
	Details of Accident: *Rincian kecelakaan*
☐ **Illness**: *Penyakit*	Symptoms first appeared on: *Gejala awal muncul pada:* Date / *Tanggal:* _____ / _____ / _____
	Doctor(s) consulted for this condition: *Dokter yang dikonsultasikan untuk kondisi ini*
	Doctor(s) or Clinic Contact (Address & Telephone): *Kontak Dokter/Klinik*

Declaration and Authorization / *Pernyataan dan Pemberian Kuasa*

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 assoc iated 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 menyatakan bahwa jawaban yang diberikan di atas adalah benar dan lengkap sepanjang pengetahuan dan keyakinan saya. Saya memah ami penyerahan formulir ini sama sekali bukan merupakan pengakuan mengenai pertanggungjawaban Perusahaan dan pembayaran kepada rumah sakit oleh Perusahaan atau wakilnya tidak dapat ditafsirkan sebagai pengakuan final mengenai pertanggungjawaban Perusahaan dan atas klaim ini dan klaim lebih lanjut apa pun yang timbul. Perusahaan berhak untuk melakukan evaluasi jika perlu.

Saya menyadari sepenuhnya batas-batas mengenai asuransi medis saya/Tertanggung berdasarkan polis tersebut di atas. Saya dengan ini berjanji untuk menyelesaikan/mengganti biaya medis apa pun yang melebihi hak saya berdasarkan kontrak polis tersebut atau yang tidak tercakup.

Saya dengan ini memberikan kuasa yang tidak dapat dibatalkan kepada organisasi, lembaga, atau individu mana pun yang memiliki catatan atau pengetahuan apa pun mengenai kesehatan dan riwayat medis atau pengobatan saya atau nasihat yang sudah atau mungkin sesudah ini dikonsultasikan, informasi pribadi lain atau rincian kecelak aan/cedera, untuk mengungkapkan informasi tersebut kepada Perusahaan atau wakilnya.Saya setuju bahwa Perusahaan atau wakilnya dapat menggunakan atau mengungkapkan informasi apa pun yang dihimpun atau dipegang kepada pihak ketiga (di dalam maupun di luar Malaysia, termasuk peusahaan induk, anak perusahaan dari Perusahaan atau perusahaan terkait lain mana pun di dalam Grup Perusahaan, reasuradur, pemeriksa medis, penyelidik klaim dan asosiasi-asosiasi/federasi-federasi industri dan sebagainya sehubungan dengan klaim ini. Pemberian kuasa ini mengikat para penerus hak dan penerima kuasa saya/Penerima Manfaat Asuransi/Tertanggung dan tetap sah meskipun saya/Penerima Manfaat Asuransi/Tertanggung mengalami ketidakmampuan sejauh memungkinkan secara hukum. Fotokopi dari pemberian kuasa ini sah sebagaimana aslinya. Saya setuju bahwa dalam hal saya membuat, atau pernah membuat di masa lalu, pernyataan palsu atau tidak benar apa pun dan/atau menyembunyikan fakta materiil apa pun sehubun gan dengan kondisi saya/Tertanggung, Perusahaan asuransi akan mutlak menghapus hak saya/Tertanggung/Penerima Manfaat Asuransi atas kompensasi dan berhak lebih lanjut untuk menarik kembali biaya apa pun yang sudah dibayar lebih dulu sebagai akibatnya.

Signature of Patient/Signature of Patient Authorized Representative *Tandatangan Pasien atau perwakilan resmi*	**Signature of Insured/Claimant** *Tandatangan Tertanggung / Penuntut*	**Signature of Witness** *Tandatangan Saksi*
_____	_____	_____
Full Name/*Nama Penuh* :	Full Name/*Nama Penuh* :	Full Name/*Nama Penuh* :
IC No. / *No. KTP* :	IC No. / *No. KTP* :	IC No. / *No. KTP* :
Date /*Tarikh* :	Date /*Tarikh* :	Date /*Tarikh* :
Contact No / *No Telepon* :	Contact No / *No Telepon* :	Contact No / *No Telepon* :
Email address / *Email* :	Relationship to Patient / *Hubungan dengan Pasien* :	

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

PART 2. TREATMENT SECTION (TO BE COMPLETED BY DOCTOR – BEFORE TREATMENT)

MANDATORY TO FILL UP ALL SECTIONS / WAJIB DIISI

Patient's Name:	Age:	Gender: ☐ Male ☐ Female	MRN No. / Hospital Contact:

Treatment Date _____ / _____ / _____

Treatment Time _____ ☐ am ☐ pm

Anamnesis, **presenting symptoms requiring admission**:

How long is patient aware of the condition: _____ day(s)/month(s)/year(s)

Symptoms first appeared: _____ / _____ / _____

Date first consulted: _____ / _____ / _____

Physical examination findings:

Expected day(s) of stay: _____ days

Estimated discharged date: ____/____/_____

Vital signs:

GCS		Respiration rate	
Blood pressure		Temperature	
Pulse		Pain score	

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

Was this patient referred? If yes, please provide details below (**e.g. From which Medical Provider/Specialist/Initial findings**):

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

Can the condition be managed under **outpatient/day surgery** basis:

☐ Yes ☐ No

If **NO**, please provide indications for hospitalization:

☐ Diagnosis:

Or

☐ Provisional Diagnosis:

Diagnosis confirmed on: _____/ _____ / _____

Advised patient on: _____/ _____ / _____

Cause and pathology underlying the present diagnosis:

Any possibility of relapse? ☐ Yes ☐ No

Estimated Total Cost (in the currency of the country of treatment)**:**	
Facility cost / hospital cost	
Inpatient consultation cost	
Procedure cost	Surgeon: Anesthetist:
Implant/prosthesis cost	
Medications/Investigations/Any additional cost	

Treatment requires:

- ☐ Hospitalization / Inpatient
- ☐ Post Hospitalization
- ☐ Day Care / Day Surgery
- ☐ Outpatient Cancer Treatment
- ☐ Patient's request for Admission (Please provide reason below)

_____

Is the illness / condition related to: (please tick (√) if **YES**	**PLEASE PROVIDE DETAILS**
☐ 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	

Examinations and investigations to be performed (Please provide **copy of all examination/investigation results**):

Medical treatment and surgical procedure to be performed:

If any procedures related to *Robotics* please elaborate further:

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Any other medical / surgical conditions present? ☐ Yes ☐ No, details below a. _____since _____ / _____ / _____ b. _____since _____ / _____ / _____	Was the patient pregnant at the time of hospitalization? (for Female only) ☐ Yes ☐ No, _____ Months

If treatment was due to injury, please describe circumstances and cause of injury:

Please indicate date / time of accident: (dd/mm/yyyy) _____ / _____ / _____ (time) _____ ☐ am ☐ pm

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. I, the attending doctor, hereby authorize the Hospital/Facility/Clinic to release the results of the investigation reports as charged in the interim/discharge bill and/or as required by IA International Assistance Sdn Bhd which has been legally appointed as the third-party administrator by the insurer.

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

Dr's Contact No: _____

Email Address: _____

PART 3. DISCHARGE SECTION (TO BE COMPLETED BY DOCTOR – AFTER TREATMENT)

Undertaking Letter Ref No: (if available)	Date of Discharge: _____ / _____ / _____
Final Diagnosis: ICD code:	Cause and pathology of the diagnosis:
Surgical procedures performed: MMA Code/PHFSR code:	Date of surgery / procedure: _____ / _____ / _____

Recovery complication that may arise (please explain):

In case of DEATH, please advise date/time and cause of death:

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. I, the attending doctor, hereby authorize the Hospital/Facility/Clinic to release the results of the investigation reports as charged in the interim/discharge bill and/or as required by IA International Assistance Sdn Bhd which has been legally appointed as the third-party administrator by the insurer.

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

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