Please contact 24-Hour Customer Service at

(021) 2997 6365 if you need help or further information.

**Reimbursement Claim Form**

Complete the form below clearly to facilitate payment services.

Important for claim payments:

To ensure your claim is paid on time, please make sure:

\* This claim form is completed in full

\* The statement below is signed and dated.

\* Diagnosis and causes have been mentioned.

\* Every bill that does not include details of the name of the drug, details of laboratory tests and others, will not be paid.

\* Every bill that is not in accordance with prescription treatment from the treating doctor will not be paid. Make sure you attach the original letters from your doctor.

\* Medical resume (for inpatient / one day care claims)

# Patient Identity

|  |  |
| --- | --- |
| Name: | Date of birth (day/month/year): |
| Company name: | Phone no: |
| Home address: | Phone no: |
| Email Address: | Mobile phone: |
| Patient members number: | Bill amount: |
| Bank name: Branch: Bank Account: |
| Are you entitled to submit this claim to other insurers? Yes No Insurance company name: |

1. **Patient Consultation Information**

|  |  |
| --- | --- |
| Hospital/Clinic: | Date of treatment(day/month/year): |
| Have you been treated for the same medical conditions previously: Yes No |
| Name of treating doctor: Umum Specialist Specialization: |
| Chief complaints: Since: |
| Diagnose: |
| Does this include workplace illness: Yes No if yes, please explain: |
| Is this related to cosmetic care: Yes No if yes, please explain: |
| Does this include congenital conditions / diseases: Yes No if yes, please explain: |
| Is this an pre inpatient treatment: Yes No |
| Is this a post-hospitalization treatment: Yes No |
| Date of treatment(day/month/year): Time: | Discharged date(day/month/year): Time: |
| Treatment / treatment description: |
|  |

Please attach a discharged letter from your doctor or hospital.

# Power of attorney statement

I hereby give full power to my Plan Administrator, Fullerton Health Indonesia and its authorized agents, to obtain medical data and my medical history related to my health in the past, present or future as far as necessary to assess this claim. I also authorize Plan Administrators and agents to inform claim details and health status to my treating doctor or to the company I work for, if the treatment I receive is part of the benefits of the Employee Health Program, and to the Insurance Company, if this claim includes the guaranteed benefit in an insurance policy.

I am willing to return (Reimburse) to the insurance company above. If the usage of treatment has exceeded the limit and is not covered by the policy

X X

Signed by Treating doctor Signed by Patient (or parents if the child under 17 years old) date(day/month/year):