Physiotherapy Session Reimbursement Cover Sheet

No.	Session Date	Physiotherapist's Name	Physiotherapist's Stamp & Signature	Cost per Session (RM)	Patient's Signature
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

Summary: Total Amount Claimed (RM): _____

Patient's Certification

I hereby certify that the above information is true and correct, and that I have attended the physiotherapy sessions as stated.

Insured/Person Covered's Full Name:	
Insured/Person Covered's IC Number:	
Signature of Insured/Person Covered:	
Date:	