



**Corporate Solutions - Outpatient Claim  
 July 2018**

**CLAIM NO.** For Office Use Only

**IMPORTANT NOTE**

- \*1. Provide copy of Identity Card (NRIC) or Passport.
- 2. Please complete the information for Employee and Patient based on the NRIC and Member ID Card.
- 3. One form is applicable for one visit only.
- 4. Field marked with (\*) is compulsory.

**A. EMPLOYEE INFORMATION**

\*Name of Employee (as in NRIC)

\*Employee NRIC No. / Passport No.  \*Mobile No.  -  This number will be used for your claim status notification.

\*Email Address

\*Name of Company / Employer

**B. PATIENT INFORMATION**

\*Name of Patient   Same as above

\*Membership No. (as in Member ID Card)  Relationship to Employee  
 Spouse  Child

**C. DETAILS OF VISIT**

\*Date of Visit  -  -  Time of Visit  :   am  pm No. of Medical Certificate Days

**D. TYPE OF CLAIM**

Please tick one of the below box.	Required Document				Details	Amount (RM)
	Original Receipt	Detailed Itemised Bill For Each Medication / Immunisation / Injection / Lab Test / X-ray If Your Bill Amount Is	Referral Letter	Lab / X-ray Report (if any)		
<input type="checkbox"/> <b>GP Claim</b> GGP1	<input checked="" type="checkbox"/>	Above RM80.00		<input checked="" type="checkbox"/>	<input type="checkbox"/> Panel GP <input type="checkbox"/> Non-Panel GP	
<input type="checkbox"/> <b>Specialist Claim</b> GSP1 <i>(Paediatrician Claim only applicable for direct access benefit with no referral letter required.)</i>	<input checked="" type="checkbox"/>	Above RM150.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Follow up visit? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, is it related to <input type="checkbox"/> Specialist Care <input type="checkbox"/> Hospitalisation Date of last visit / admission <input type="text"/> - <input type="text"/> - <input type="text"/>	
<input type="checkbox"/> <b>Immunisation Claim</b> GSP1 <i>(Only mandatory vaccination approved by Ministry of Health for children is eligible for reimbursement)</i>	<input checked="" type="checkbox"/>	Above RM80.00			Name of Immunisation 1. _____ 2. _____ 3. _____ 4. _____	
<input type="checkbox"/> <b>Optical Claim</b> OPTC	<input checked="" type="checkbox"/>	Not Applicable				
<input type="checkbox"/> <b>Health Screening Claim</b> GMEX	<input checked="" type="checkbox"/>	Not Applicable		<input checked="" type="checkbox"/>		
<input type="checkbox"/> <b>Dental Claim</b> GDN1	<input checked="" type="checkbox"/>	Above RM100.00			Dental Consultation Extraction Filling Scaling / Polishing Medication Others	_____ _____ _____ _____ _____

Please tick one of the below box.	Required Document				Details	Amount (RM)
	Original Receipt	Detailed Itemised Bill For Each Medication / Immunisation / Injection / Lab Test / X-ray If Your Bill Amount Is	Referral Letter	Lab / X-ray Report (if any)		
<input type="checkbox"/> <b>Maternity Claim</b>  GMT1	✓	Above RM150.00		✓	Pre-Natal _____ Post-Natal _____ Delivery <input type="checkbox"/> Normal <input type="checkbox"/> Caesarean _____ Miscarriage _____	
<b>*Total Claim Amount</b>						

E. REASON FOR SEEKING TREATMENT	F. *CLARIFICATION FOR REIMBURSEMENT						
<input type="checkbox"/> DN Dental <input type="checkbox"/> 06G Optical <input type="checkbox"/> MT Maternity  <b>General Illness</b> <input type="checkbox"/> 789 Abdominal Pain <input type="checkbox"/> 724 Backache <input type="checkbox"/> 466 Bronchitis <input type="checkbox"/> 879 Cuts / Wound / Scalding <input type="checkbox"/> 311 Depression <input type="checkbox"/> 787 Diarrhea / Vomiting <input type="checkbox"/> 388 Ear Disorder <input type="checkbox"/> 379 Eye Disorder <input type="checkbox"/> 465 Fever / Cough / Cold <input type="checkbox"/> 005 Food Poisoning <input type="checkbox"/> 535 Gastritis <input type="checkbox"/> 629 Gynaecology <input type="checkbox"/> 346 Headache / Migraine <input type="checkbox"/> V06 Immunisation <input type="checkbox"/> 719 Joint Pain <input type="checkbox"/> 709 Skin Disease <input type="checkbox"/> 599 Urinary Tract Infection <input type="checkbox"/> 06G Others, please specify _____	Emergency <input type="checkbox"/> Yes <input type="checkbox"/> No Please explain your reasons for the claim submission. _____ _____ _____ _____ _____						
	<b>G. *E-PAYMENT REGISTRATION (MANDATORY REQUIREMENT)</b> <input type="checkbox"/> Change of account number for this claim and future transactions. <input type="checkbox"/> Use the existing payment details in AIA Bhd. record.  <table border="1" style="width: 100%;"> <tr> <td style="width: 50%;">Bank Name</td> <td></td> </tr> <tr> <td>Bank Account Holder Name</td> <td></td> </tr> <tr> <td>Bank Account No.</td> <td></td> </tr> </table> Notes: (a) AIA shall not be responsible for losses as a result of inaccurate account details provided. (b) Only employee bank account details allowed.	Bank Name		Bank Account Holder Name		Bank Account No.	
Bank Name							
Bank Account Holder Name							
Bank Account No.							
<b>Long Term Illness</b> <input type="checkbox"/> 715 Arthritis <input type="checkbox"/> 493 Asthma <input type="checkbox"/> 433 Stroke <input type="checkbox"/> 250 Diabetes Mellitus <input type="checkbox"/> 345 Epilepsy <input type="checkbox"/> 274 Gout <input type="checkbox"/> 272 Hyperlipidemia <input type="checkbox"/> 401 Hypertension <input type="checkbox"/> 411 IHD / Coronary Heart Disease <input type="checkbox"/> 332 Parkinson <input type="checkbox"/> 533 Peptic Ulcer <input type="checkbox"/> 696 Psoriasis <input type="checkbox"/> 246 Thyroid <input type="checkbox"/> 06G Others, please specify _____	<b>H. DECLARATION AND AUTHORISATION</b> 1. I/We understand that a copy of my/our Identity Card (NRIC) or Passport must be provided. 2. I/We confirm that the information given are true and accurate. 3. I/We understand that claims without the Original Official Receipt and Detailed Itemised Bill for each medication / immunisation / injection / lab test / x-ray will be declined. 4. I/We understand that AIA Bhd. will keep my/our claim documents unless if I/we request for the documents to be returned to me/us within 60 days from the decision of claim. 5. I/We understand that assessment of the claim may be delayed if all the necessary sections are incomplete or if the required documents are not provided to AIA Bhd. 6. I/We understand that for Overseas Treatment, I/we must include the Original Detailed Admission Bill showing details of each charges. The bill must have the English translation if it is in a foreign language. 7. I/We understand that AIA Bhd.'s acceptance of this Outpatient Claim form is not an admission of AIA Bhd.'s liability of my/our claim. 8. I/We authorise any institution or individual that has any records or knowledge of my/our health and medical history to disclose such information to AIA Bhd. or its representative. 9. I/We understand and agree that any personal information collected or held by AIA Bhd. (whether through this Outpatient Claim form or otherwise obtained) may be used and disclosed by AIA Bhd. to individuals/institutions related to and associated with AIA Bhd. or any selected third party within or outside Malaysia such as reinsurers, claims investigation companies and industry associations to process this Outpatient Claim form. The information may also be used to provide service for this and other financial products and to communicate with me/us. I/We understand that I/we have a right to get access to and request for correction of any personal information held by AIA Bhd. Such requests can be made at any AIA Bhd. Customer Centres.						
	_____ Signature of Employee						
	_____ Date						



Sila tandakan salah satu kotak di bawah.	Dokumen Diperlukan				Maklumat Lanjut	Jumlah (RM)
	Resit Asal	Butiran Bil Terperinci Untuk Kos Setiap Ubat / Imunisasi / Suntikan / Ujian Makmal / X-ray Jika Bil Amaun Anda	Surat Rujukan	Ujian Makmal / Laporan X-ray (jika ada)		
<input type="checkbox"/> <b>Tuntutan Kehamilan</b>  GMT1	✓	Melebihi RM150.00		✓	Pra-Natal Selepas Bersalin Bersalin <input type="checkbox"/> Normal <input type="checkbox"/> Pembedahan Keguguran	_____ _____ _____ _____
<b>*Jumlah Tuntutan</b>						

E. SEBAB-SEBAB MENDAPAT RAWATAN	F. *PENJELASAN UNTUK PEMBAYARAN BALIK						
<input type="checkbox"/> DN Pergigian <input type="checkbox"/> 06G Optik <input type="checkbox"/> MT Kehamilan  <b>Penyakit Umum</b> <input type="checkbox"/> 789 Sakit Perut <input type="checkbox"/> 724 Sakit Tulang Belakang <input type="checkbox"/> 466 Bronkitis <input type="checkbox"/> 879 Luka / Melecur <input type="checkbox"/> 311 Kemurungan <input type="checkbox"/> 787 Cirit-birit / Muntah-muntah <input type="checkbox"/> 388 Sakit Telinga <input type="checkbox"/> 379 Sakit Mata <input type="checkbox"/> 465 Demam / Batuk / Selsema <input type="checkbox"/> 005 Keracunan Makanan <input type="checkbox"/> 535 Gastrik <input type="checkbox"/> 629 Sakit Puan <input type="checkbox"/> 346 Sakit Kepala / Migrain <input type="checkbox"/> V06 Imunisasi <input type="checkbox"/> 719 Sakit Sendi <input type="checkbox"/> 709 Penyakit Kulit <input type="checkbox"/> 599 Jangkitan Saluran Kencing <input type="checkbox"/> 06G Lain-lain, sila nyatakan _____	Kecemasan <input type="checkbox"/> Ya <input type="checkbox"/> Tidak Sila jelaskan tujuan tuntutan ini dibuat. _____ _____ _____ _____ _____ _____						
	<b>G. *PENDAFTARAN E-PEMBAYARAN (MANDATORI UNTUK DIISI)</b> <input type="checkbox"/> Perubahan nombor akaun bagi transaksi pembayaran masa hadapan. <input type="checkbox"/> Gunakan butiran pembayaran sedia ada dalam rekod AIA Bhd. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Nama Bank</td> <td></td> </tr> <tr> <td>Nama Pemegang Akaun Bank</td> <td></td> </tr> <tr> <td>No. Akaun Bank</td> <td></td> </tr> </table> Nota: (a) AIA tidak akan bertanggungjawab terhadap sebarang kerugian sekiranya maklumat akaun yang diberikan tidak tepat. (b) Hanya maklumat akaun bank pekerja diterima.	Nama Bank		Nama Pemegang Akaun Bank		No. Akaun Bank	
Nama Bank							
Nama Pemegang Akaun Bank							
No. Akaun Bank							
	<b>H. PENGAKUAN DAN PEMBERIAN KUASA</b> 1. Saya/Kami memahami bahawa salinan Kad Pengenalan (KP) atau Pasport perlu disertakan. 2. Saya/Kami mengesahkan bahawa maklumat yang diberikan adalah benar dan tepat. 3. Saya/Kami memahami bahawa tuntutan akan dikembalikan jika Resit Rasmi Asal dan Butiran Bil Terperinci untuk kos setiap ubat / imunisasi / suntikan / ujian makmal / x-ray tidak disertakan. 4. Saya/Kami memahami bahawa AIA Bhd. akan menyimpan dokumen tuntutan saya/kami melainkan jika saya/kami memohon untuk dokumen tersebut dikembalikan kepada saya/kami dalam masa 60 hari dari tarikh keputusan tuntutan. 5. Saya/Kami memahami penilaian ke atas tuntutan ini akan mengalami kelewatan sekiranya maklumat penting yang diserahkan kepada pihak AIA Bhd. tidak lengkap. 6. Saya/Kami memahami bahawa untuk Rawatan Di Luar Negara, saya/kami perlu menyertakan Butiran Bil Asal yang terperinci menyenaraikan butir-butir setiap caj bil tersebut dan bil perlu diterjemahkan ke Bahasa Inggeris jika ianya dalam bahasa asing. 7. Saya/Kami memahami bahawa penerimaan Borang Tuntutan Pesakit Luar oleh AIA Bhd. tidak boleh dianggap sebagai penerimaan liabiliti ke atas tuntutan yang dibuat. 8. Saya/Kami memberi kuasa kepada mana-mana institusi atau individu yang mempunyai rekod atau maklumat tentang kesihatan dan sejarah perubatan saya/kami untuk mendedahkannya kepada AIA Bhd. atau wakil AIA Bhd. 9. Saya/Kami memahami dan bersetuju bahawa maklumat peribadi yang dikumpul atau dipegang oleh AIA Bhd. (sama ada melalui Borang Tuntutan Pesakit Luar ini ataupun cara lain) boleh digunakan dan didedahkan kepada individu atau institusi yang berkaitan dengan AIA Bhd. atau mana-mana pihak ketiga di dalam atau di luar Malaysia seperti penanggung insurans semula (reinsurer), syarikat penyiasatan tuntutan dan persatuan industri bagi memproses Borang Tuntutan Pesakit Luar ini. Maklumat tersebut juga boleh digunakan untuk memberikan perkhidmatan ke atas permohonan ini dan juga produk kewangan lain. Saya/Kami memahami bahawa saya/kami mempunyai hak untuk mendapatkan dan memohon pembedaan dibuat ke atas mana-mana maklumat persendirian yang disimpan oleh AIA Bhd. Permohonan tersebut boleh dibuat di mana-mana cawangan Pusat Khidmat Pelanggan AIA Bhd.						
<b>Penyakit Jangka Panjang</b> <input type="checkbox"/> 715 Sakit Artritis <input type="checkbox"/> 493 Asma <input type="checkbox"/> 433 Strok <input type="checkbox"/> 250 Kencing Manis <input type="checkbox"/> 345 Sawan <input type="checkbox"/> 274 Gout <input type="checkbox"/> 272 Kolesterol Tinggi <input type="checkbox"/> 401 Darah Tinggi <input type="checkbox"/> 411 Penyakit Jantung <input type="checkbox"/> 332 Parkinson <input type="checkbox"/> 533 Ulser Peptik <input type="checkbox"/> 696 Penyakit Kulit <input type="checkbox"/> 246 Penyakit Tiroid <input type="checkbox"/> 06G Lain-lain, sila nyatakan _____	_____ Tandatangan Pekerja <span style="float: right;">_____</span> Tarikh						