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GROUP INPATIENT & SURGERY BENEFIT CLAIM FORM

Instructions:

1. This form shall be filled completely by the patient/insured* and the doctor and stamped by the hospital/clinic. This claim form shall be valid for ONE patient only.
2. This Group Inpatient & Surgery Benefit Claim Form must be submitted within 90 (ninety) days after the completion date of hospitalization and surgery.
3. In submitting a claim, the patient/insured must complete the claim documents as follows:
   a. Completely filled claim form.
   b. Original payment receipt with stamp duty.
   c. Details of charges.
   d. Copy of the results of diagnostic tests (X-ray, ultrasound, CT scan, MRI, etc.) and laboratory tests (blood tests, etc.).
   e. Copy of prescriptions given by the doctor.

NOTE: This form MUST be filled completely, otherwise the claim process will be suspended.

DATA AND UNDERTAKING OF PATIENT/INSURED (FILLED COMPLETELY BY PATIENT/INSURED) *

A. PATIENT'S DATA / INSURED

Company's Name

Policy No.

Employee's Name

Membership No.

Patient's Name (if not the employee)

Relationship between patient/insured with employee

Gender ☐ Male ☐ Female

Birth date ☐☐ - ☐☐ - ☐☐☐☐ (DD - MM - YYYY)

Type of Claim : ( ) Hospitalization ( ) Maternity ( ) Pre/Post of Hospitalization

Total Billed Amount : IDR _____ Other Currency (ies) : _____

B. STATEMENT OF PATIENT/INSURED

I, as the patient of hospital/clinic, hereby irrevocably and without any coercion from any party whomsoever, declare as follows :

1. I authorize Avrist Assurance with right of substitution to obtain all information/medical record from hospital/other party relating to diagnose and or medical treatment provided to me according to the prevailing regulations. I waive provisions stipulated under Articles 1813, 1814 and 1816 of Indonesian Civil Law Code regarding the termination of authorization.
2. Authorization provided by Me under this Group Inpatient & Surgery Benefit Claim Form, either the original as well as its copy, has the valid legal power.
3. All information mentioned in Group Inpatient & Surgery Benefit Claim Form are complete and accurate and hereby understand and agree that Avrist Assurance may reject the claim submitted by me in this form if any information and statement provided by me or doctor in this form are known incorrect and inaccurate by Avrist Assurance.
4. I have full right and entitlement to provide statement and authorization mentioned in this Group Inpatient & Surgery Benefit Claim Form.

Signed in _____ Date _____

_____

Patient's/Employee's Name & Signature

*) If the age of insured is below 18 years old, this form shall be filled by employee.

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MEDICAL RESUME (FILLED COMPLETELY BY TREATING DOCTOR)

A. PATIENT'S/INSURED'S DATA

Patient's Name _____ Medical Record Number _____

Gender ( ) Male ( ) Female Birth Date _____

Date of Service _____ Admission Date _____ Discharge Date _____

B. MEDICAL RESUME

A. ANAMNESIS

1. Main complaint or additional complaint ? _____
2. Since when has the patient suffered from the complaint(s) ? _____
3. Is there any other disease(s) related to the current condition ? If "Yes", please state and since when ?

_____

_____

4. If caused by an accident, when and how did the accident happen (dd/mm/yy) ?

_____

_____

_____

5. If hospitalization is needed, please state the medical indication. _____
6. If caused by pregnancy, please state the first month of the pregnancy. _____

B. PHYSICAL EXAMINATION

_____

_____

DIAGNOSE	ICD X	TREATMENT	ICD IX CM
(1) Principal Diagnosis			
(2) Comorbidity			
(3) Complication(s)			
(4) Other Diagnosis			
(5) External Causes of Injury			

Is the diagnose associated with:

1. Congenital Abnormalities	( ) Yes	( ) No
2. Fertility and Infertility	( ) Yes	( ) No
3. Cosmetics	( ) Yes	( ) No
4. Mental or Psychiatric Disorder	( ) Yes	( ) No

Non Operating Procedures:

1. Tracheostomy
2. Respirator Support
3. Lumbar Function
4. _____
5. _____

C. ETIOLOGY

_____

D. PLEASE STATE THE INDICATION, IF THE DIAGNOTICS EXAMINATION IS NECESSARY (PA, LAB, X-RAY, USG, ECG, CT SCAN, MRI, etc)

_____

_____

E. THERAPY

_____

_____

I hereby declare that my written statements above are true and complete, and hereby understand and agree that Avrist Assurance may reject the claim submitted under this form if any information and statement provided by me in this form are known incorrect and inaccurate by Avrist Assurance.

NOTE: This form MUST be filled completely, otherwise the claim process will be suspended.

_____ _____

Hospital's Name, Address & Stamp Treating Doctor's Full Name & Signature

PT Avrist Assurance

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