

### REIMBURSEMENT

### **CLAIMS PROCEDURE**

Private and Confidential



#### Submit via Original Hardcopy

- 1. Admission to non Panel Hospital
- 2. Annual Out-patient Cancer Treatment
- 3. Funeral Expenses
- 4. Medical Report
- 5. Compassionate Visitation Expenses
- 6. Tuition Fees, replacement of missed subjects (max per semester) For student only

#### Submit via MyMed (Micare Apps/ Portal)

- 1. Pre Hospitalization Diagnostics test
- 2. Pre Hospitalization Specialist Consultation
- 3. Post Hospitalization follow up
- 4. Daily Cash Allowance at Malaysia GH
- 5. Emergency Accidental Outpatient Treatment
- 6. Emergency Accidental Dental Treatment
- 7. Emergency Sickness Treatment
- 8. Annual Out-patient Kidney Dialysis Treatment



## Submission Via Original Hardcopy

### **REIMBURSEMENT CLAIM PROCEDURE**

Claims that required to submit original hardcopy, below are the steps:

Submit the **ORIGINAL** copy of: Original Bill, Itemised Bill & Receipts, Completed Claim Form, Medical Report and diagnostic report (if any). Submit all the required claim documents to Berjaya Sompo Insurance for processing. Payment will be credited to member's bank account within 14 Working Days upon receiving completed claim documents and approval of claims.

\*\*Remarks: Send the claim notification with full set of claim documents to <u>ebusm@bsompo.com.my</u> before send out the hardcopy documents.





## HOW TO COMPLETE THE GHS CLAIM FORM

### HOW TO COMPLETE THE CLAIM FORM



BERJAYA SOMPO INSURANCE

SOMPO, A Century of Trust

#### Claim Form HOSPITAL AND SURGICAL INSURANCE

PART I: TO BE COMPLETED BY CLAIM	ANT	
SECTION 1 - PATIENT DETAILS		
Policy No.	Patient Name	
NRIC / Passport No.	Date of Birth	
SECTION 2 - POLICYHOLDER / EMPLO	YEE DETAILS (for Group Insurance or patient is depende	nt)
Policyholder Name	Date of Employment	
Employee Name	Mobile No.	
Relationship to patient	Email Address	
SECTION 3 - E-PAYMENT FOR PROMP	I SETTLEMENT	
Name of Account Holder	NRIC / Passport No.	
Bank Account No.	Business Registration No.	
Name of Bank	E-mail Address	

Note: Please support your bank account details by providing copy of bank statement or passbook for verification. The settlement sum paid or credited to my/our bank account will constitute a valid and final discharge of all your obligations as insure due to me/us.

#### SECTION 4 - STATEMENT BY CLAIMANT (By Parent if claimant is a minor)

	the second s		
For Accident, please state the location			
Date and Time of Accident	Date	Time	

#### PART I: To be Completed by Student

#### **Section 1. Particulars of claimant**

-Provide claimant details, e.g. full name, passport no. etc

#### **Section 2. Policyholder/Employee Details**

- Further details on the student/ dependent

#### Section 3. E-Payment

- Provide Malaysia bank account details

#### **Section 4. Statement by Claimant**

- Further explanation on the accident/ sickness

Claim Form -(HSI 0820) 1/3

### HOW TO COMPLETE THE CLAIM FORM



Please describe clearly how the accident occurred and what you were doing at the time (Use a supplementary sheet, if necessary)		
For Sickness, please specify the diagnosis		
Doyou have other parties	Received from	
If yes, please provide	Amount received	
DECLARATION AND AUT	HORISATION	

I hereby declare that to the best of my knowledge and belief, the above details/information as provided by me are true and complete and i understand that the Company reserves all rights for final evaluation as appropriate on all or any part of the claims made. If I made or shall make any false/fraudulent statements, or withhold any material facts whatsoever in respect of this claim, I shall forteit all rights to recover from the Company.

I authorise any hospital's doctor and/or other person who has attended or examined me, to turnish to the Company, and/or its authorised representatives, all information relating to any illness or injury, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A copy of this authorisation shall be considered as effective and valid as the original.

I hereby authorise any insurer/s to give full particulars about my claim history to Berjaya Sompo Insurance Berhad.

I hereby authorise any relevant merchant (as shown as supporting document/s on this insurance claim) to give full particulars about my purchased history to Berjaya Sompo insurance Berhad.

In relation to the personal information collected in this claim form, I agree and consent, and if I am submitting information relating to another individual, I represent and warrant that I have the authority or obtained the consent to provide that information to the Company and/or its service provider, and have informed the said individual about the purposes for which his/her personal information is collected, used and disclosed as well as the parties to whom such personal information may be disclosed by the Company and/or its service provider, and the individual agrees and consents, that the Company and/or its service provider may collect, use and process my/his/her personal information for the purpose as it was provided and as indicated in the Company's Privacy Notice at <u>www.bergivasormpo.com.mv</u>

Signature	Namo -	Data :
Signature .	Name.	Date .
"If Claimant is company, please affix company	/ stamp	

#### PART I: To be Completed by Student

#### **Declaration and Authorization**

- Signature, name and passport no. of the claimants

### HOW TO COMPLETE THE CLAIM FORM



Name of Patient:       2.       Name of Hespital:         Admission Date and Time:       4.       Discharge Date and Time:         Symptoms / Conditions requiring admission:       Pute:       BP:         Provisional Diagnosis:       8.       Date you were first consulted:         Hare you seen first patient before for other problem?       Yes       No         (If Yes, please provide data and type of problem?       Yes       No         (If Yes, please provide data and type of problem?       Yes       No         (If Yes, please provide data and type of problem?       Yes       No         (If Yes, please provide data and type of problem?       Yes       No         (If Yes, please state when)       No       (If Yes, please state when)       No         Has patient ever had the same or similar related condition existed?       days       months       years         Prial Diagnosis / ICD Coding:       Cause and pathology (If applicable) for the above diagnosis:       Is its admission primarily for investigations and Surgical procedure performed, if any (please provide copy of results)         Any other medical / surgical conditions present?       Yes       No       If Yes, please provide details a.         a.	PAI	RT II: TO BE COMPLETED BY ATTENDING	G PHYSICIAN	I/SURG	EON					
Admission Date and Time:       4.       Discharge Date and Time:         Symptoms / Conditions requiring admission:       Image: Conditions requiring admission:       Image: Conditions requiring admission:         Vital signs:       Temperature:       Pulse:       Image: Conditions requiring admission:         Provisional Diagnosis:       Image: Conditions respective of other problem?       Ves       Image: Conditions respective of the conditions of symptoms before?         If Yes, please provide doclor's name and address or referral letter)       Yes       No         If Yes, please provide doclor's name and address or referral letter)       Image: Conditions respective of the condition.         Has patient few rhad the same or similar related conditions or symptoms before?       Yes       No         If Yes, please state when)       Name and address of doclors previously consulted by patient for the condition.       How long in your protessional oprinon has the condition existed?       days       months       years         Final Diagnosis / ICD Coding:       Cause and patientory if applicabie/or investigations and Surgical procedure performed, if any (please provide docpy of results)       Any other medical / surgical conditions present?       Yes       No       If Yes, please provide dotalis         a.	1.	Name of Patient:		2.	Name	of Hospital:				
Symploms / Conditions requiring admission:       Pulse:       BP:         Provisional Diagnosis:       B.       Date you were first consulted:         Have you seen bits patient before for other problem?       Yes       No         (If Yes, piease provide date and type of problem?       Yes       No         (If Yes, piease provide dotod's name and address or referral letter)       Has patient even hat the same or similar related conditions or symptoms before?       Yes       No         (If Yes, piease state when)       Name and address of doctors previously consulted by patient for the condition.       How long in your protessional optrion has the condition existed?       days       months       years         Final Diagnosis / ICD Coding:       Cause and pathology (If applicable) for the above diagnosis:       is this admission primarity for investigation       Yes       No         is this admission primarity for investigation       Yes       No       if Yes, piease provide details         a.	3.	Admission Date and Time:		4.	Disch	arge Date ar	nd Time:			
Vital signs:       Temperature:       Pulse:       BP:         Provisional Diagnosis:       8.       Date you were first consulted:         Have you seen firs patient before for other problem?       Yes       No         (if Yes, please provide date and type of problem)       Yes       No         (if Yes, please provide doctor's name and address or referral letter)       Has patient dver had the same or similar related conditions or symptoms before?       Yes       No         (if Yes, please state when)       Name and address of doctors previously consulted by patient for the condition.       No       No         How long in your protessional opinion has the condition existed?       days       months       years         Final Diagnosis / ICD Coding:       Cause and pathology (if applicable) for the above diagnosis:       is this admission primarity for investigation       Yes       No         Medical treatment, investigations and Surgical procedure performed, if any (please provide copy of results)       Any other medical / surgical conditions present?       Yes       No       ddmm/yyyy         b.	5.	Symptoms / Conditions requiring admission:			-					
Provisional Diagnosis:       8.       Date you were this consulted:         Have you seen this patient before for other problem?       Yes       No         (If Yes, please provide doctor's name and address or reternal lefter)       No       No         Has patient referred to you?       Yes       No         (If Yes, please provide doctor's name and address or reternal lefter)       No       No         Has patient were had the same or similar related conditions or symptoms before?       Yes       No         (If Yes, please provide doctor's name and address or reternal lefter)       No       No         Has patient were had the same or similar related conditions or symptoms before?       Yes       No         (If Yes, please provide doctor's name and address of rotextile)       No       Cause and pathology if applicable) for the above diagnosis:         Is this administion primarity for investigation       Yes       No       No         Medical treatment, investigations and Surgical procedure performed, if any (please provide copy of results)       Any other medical / surgical conditions present?       Yes       No         Any other medical history (if any)       a.	6.	Vital signs: Temperature:	Put	se:			BP:			
Have you seen this patient before for other problem?       Yes       No         (if Yes, please provide date and type of problem)       Was this patient referred to you?       Yes       No         (if Yes, please provide date and type of problem)       Yes       No       No         (if Yes, please provide date and type of problem)       Yes       No         (if Yes, please provide date and type of problem)       Yes       No         (if Yes, please provide date and type of problem)       No       (if Yes, please provide date and other set of the above of approximation or symptoms before?       Yes       No         Has patient were thad the same or similar related conditions or symptoms before?       days       months       year         Final Diagnosis / ICO Coding:       Cause and pathology (if applicable) for the above diagnosis:       is this administion primarily for investigation       Yes       No         Medical treatment, investigations and Surgical procedure performed, if any (please provide copy of results)       Any other medical / surgical conditions present?       Yes       No       if Yes, please provide details         a.	7.	Provisional Diagnosis:	-	8.	Date	you were firs	t consulte	d:		
(If Yes, please provide date and type of problem)         Was this patient vertered to you?	9.	Have you seen this patient before for other prol	blem?		Yes			2		
Was this patient reterred to you?       Yes       No         (If Yes, please provide doctor's name and address or referral letter)       No         Has patient wer had the same or similar related conditions or symptoms before?       Yes       No         (If Yes, please state when)       Name and address of doctors previously consulted by patient for the condition.       How long in your protessional optrion has the condition existed?       days       months       years         Final Diagnosis / ICD Coding:       Cause and pathology (if applicable) for the above diagnosis:       Is this admission primarily for investigation       Yes       No       Medical treatment, investigations and Surgical procedure performed, if any (please provide copy of results)         Any other medical / surgical conditions present?       Yes       No       if Yes, please provide details since       dd/mm/yyyy         a.		(If Yes, please provide date and type of problem	n)							
(If Yes, please provide doctor's name and address or referral letter)         Has patient ever had the same or similar related conditions or symptoms before?       Yes       No         (If Yes, please state when)       Name and address of doctors previously consulted by patient for the condition.       No         How long in your professional opirion has the condition existed?       days       months       years         Final Diagnosis / ICD Coding:       Cause and pathology (if applicable) for the above diagnosis:       Is this admission primarity for investigation       Yes       No         Is this admission primarity for investigation       Yes       No       If Yes, please provide details       a.         a.	0.	Was this patient referred to you?			Yes					
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Name and address of doctors previously consulted by patient for the condition.         How long in your professional optrion has the condition existed?		(If Yes, please state when)								
How long in your professional opinion has the condition existed?	2.	Name and address of doctors previously consu	ited by patient f	or the c	ndition.					
Final Diagnosis / ICD Coding:         Cause and pathology (if applicable) for the above diagnosis:         Is this admission primarily for investigation       Yes         Medical treatment, Investigations and Surgical procedure performed, if any (please provide copy of results)         Any other medical / surgical conditions present?       Yes         B.       Since         C.       since         B.       Since         C.       since         Since       dd/mm/yyyy         c.       since         C.       since         Since       dd/mm/yyyy         c.       dd/mm/yyyy         dd/mm/yyy       dd/mm/yyyy         dd/mm/yyyy       dd/mm/yyyy         s.       Congenital / Hereatlary       e.         Set-Inflicted injuries / Violation of laws / Strike / Riots       dd/mm/yyyy         b.       Influence of Drugs / Alcohol       f.         C.       Congenital / Hereatlary       e.       Setf-Inflicted injuries / Violation of laws / Strike / Riots         disorder       g.       Dental care / refractive errors correction       IIII         disorder       n.       No Errogenary / Childichi' Infertility / Caesarean section / Miscarriage or any complications arising therefrom         Can this sickness o	3.	How long in your professional opinion has the o	condition existed	1?		days		months		years
Cause and pathology (if applicable) for the above diagnosis:         Is this admission primarily for investigation       Yes       No         Medical treatment, Investigations and Surgical procedure performed, if any (please provide copy of results)       Any other medical / surgical conditions present?       Yes       No       If Yes, please provide details         a.	4.	Final Diagnosis / ICD Coding:				,				. /
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Any other medical / surgical conditions present?       Yes       No       If Yes, please provide details         a.	·.	would reament, investigations and Surgical	procedure perio	nnieu, n	any (pice	ase provide c	opy of the	unsy		
a.       since       dd/mm/yyyy         b.       since       dd/mm/yyyy         c.       since       dd/mm/yyyy         insured's past medical history (if any)       a.       dd/mm/yyyy         a.	8.	Any other medical / surgical conditions present	? 🗆	Yes		D No	If Yes, p	lease provi	de details	
b.       since       dd*mm/yyyy         c.       since       dd*mm/yyyy         c.       since       dd*mm/yyyy         insured's past medical history (if any)       a.		a				since			dd/mm/y	WY
c.       since       dd/mm/yyyy         Insured's past medical Nistory (if any)       a.       dd/mm/yyyy         a.		b				since			dd/mm/y	ny -
Insured's past medical history (if any)       a.       dd/mm/yyyy         a.       dd/mm/yyyy         b.       dd/mm/yyyy         c.       dd/mm/yyyy         dd/mm/yyyy       dd/mm/yyyy         is the illness or condition related to: (please tick (v) if Yes       a.         a.       Congental / Hereatlary       e.         b.       Influence of Drugs / Alcohol       f.         c.       Antoxi / Mental / Nervous / Emotional       g.         c.       Antoxi / Nervous / Emotional       g.         c.       AlDS / STD / VD / HN       h.         Pregnancy / Childbirth / Infertitip / Casserase section       miscarriage or any complications arising therefrom         Can this sickness or injury be treated as:       a.       b.       Day surgery basis?       Yes       No         (if No, please provide details)       Was the patient pregnant at the time of hospitalization? (For female patient only)       Yes       months       No         If hospitalization was due to accident, please indicate:       Dale:       an/pm       an/pm         Nature of accident:       Extent of Injury:       I hereby certify that I have personally examined and treated Patient tor his / her injuries / liness described above and that the facts as stated above represent my medical opinion of his / her condition.		C				since			dd/mm/y	m
a.	9.	insured's past medical history (if any)								
b.		a							dd/mm/y	ny .
c		b.							dd/mm/y	WY .
Is the illness or condition related to: (please tick (\) if Yes a. Congential / Hercatiany b. influence of Drugs / Alcohol c. Arxikely / Mental / Nervous / Emotional c. Arxikely / Mental / Ne		с.							dd/mm/y	ny .
a. Congenital / Hereditay     a. Congenital / Hereditay     b. Influence of Drugs / Alcohol     c. Arxike/ / Mental / Nervous / Emotional     c. Arxike/ / Mental / Nervous / Emotional / Mental / Ment	0.	is the illness or condition related to: (please tick	k (√) If Yes			· · ·				
b.       Influence of Drugs / Alcohol       Image: Construction of Drugs / Alcohol       Image: Construction of Drugs / Alcohol         c.       Anckry / Mental / Nervous / Emotional       g.       Dental care / refractive errors correction         disorder       g.       Dental care / refractive errors correction       Image: Drugs / Alcohol         disorder       n.       Pregnancy / Chutkin'h / Infertility / Caesarean section / Miscarriage or any complications arising therefrom         Can this sickness or injury be treated as:       n.       Day surgery basis?       Yes       No         Can this sickness or injury be treated as:       n.       Day surgery basis?       Yes       No         (if No, please provide details)       Was the patient pregnant at the time of hospitalization? (For female patient only)       Yes       Months       No         If nospitalization was due to accident, please indicate:       Dale:		a. Congenital / Hereditary	□ e	). S	elf-inflicte	d injuries/ V	iolation of	laws / Strik	ke / Riots	
C. Alkkey' Mential / NetWork' Emilial / NetWork' Emilia / NetWork' Emili		<li>b. Influence of Drugs / Alcohol Amilabe / Manhal / Negroup / Emotional</li>	1	. C	osmetic /	Plastic surge	ery			
d.       AIDS/ STD / VD / HN       n.       Prognancy / Childbirth / Intertility / Caesarean section / Miscarriage or any complications arising therefrom         Can this sickness or injury be treated as:       .       .       .       .         a.       Outpatient basis?       Yes       No       b.       Day surgery basis?       Yes       No         (if No, please provide details)       Was the patient pregnant at the time of hospitalization? (For female patient only)       Yes       months       No         If hospitalization was due to accident, please indicate:       Date:		<ul> <li>Anderly / Mental / Nervous / Emotional disorder</li> </ul>	□ g	). D	ental care	e / refractive	errors cor	rection		
Can this sickness or injury be treated as: a. Outpatient basis?		d. AIDS/STD/VD/HN		L P M	egnancy iscarriag	/ Childbirth / e or any com	Infertility plications	/ Caesarea arising the	n section / refrom	
a. Outpatient basis?	1.	Can this sickness or injury be treated as:				-	-			
(If No, please provide details)         Was the patient pregnant at the time of hospitalization? (For female patient only)       YesmonthsNo         If hospitalization was due to accident, please indicate:		a. Outpatient basis?   Yes	D No	b	. Da	y surgery ba	sis?	Yes		No
Was the patient pregnant at the time of hospitalization? (For female patient only)       Yes       months       No         If hospitalization was due to accident, please indicate:       Date:       am/pm         Date:       dd/mm/yyyy       Time:       am/pm         Nature of accident:       Extent of injury:       am/pm         I horeby certify that I have personally examined and treated Patient for his / her injuries / liness described above and that the facts as stated above represent my medical opinion of his / her condition.         Date       Name & Signature of Attention Doctor       Doctor / Linesche Stame		(If No, please provide details)								
If hospitalization was due to accident, please indicate: Date: Date:dd/mm/yyyy Time:am/pm Nature of accident: Extent of injury: I hereby certify that I have personally examined and treated Patient for his / her injuries / liness described above and that the facts as stated above represent my medical opinion of his / her condition. Date Date Date Date Date Date Date Date	2.	Was the patient pregnant at the time of hospital	lization? (For fe	male pa	ient only		Yes	r	nonths [	No
Date:	3.	If hospitalization was due to accident, please in	dicate:							
Nature of accident:         Extent of injury:           I hereby certify that I have personally examined and treated Patient for his / her injuries / itness described above and that the facts as stated above represent my medical opinion of his / her condition.         Itness described above and that the facts as stated above represent my medical opinion of his / her condition.           Data         Name & Signature of Attending Doctor:         Doctor / Licensity States		Date: dd/mm/yyyy		Tim	e:		a	n/pm		
I hereby certify that I have personally examined and treated Patient for his / her injuries / illness described above and that the facts as stated above represent my medical opinion of his / her condition.  Data Data Data Data Data Data Data Da		Nature of accident:		Ext	ent of inji	iry:				
Data Nama & Signature of Attention Declar Declar / Licensisi Stame	4.	I hereby certify that I have personally examined stated above represent my medical opinion of h	I and treated Pa his / her conditio	itient for m.	his / her	injuries / Iline	ess descrit	ied above i	and that the	facts as
			amo 8 Cianalur	n of Att	odina Da	otor		Doctor	/ Linepitel C	tomo

#### PART II: To be Completed by Attending Doctor

#### Part II: Medical report

• Attending doctor to complete this page (for claims amount that above RM500).

\*\*Disclaimer: BSIB reserve the right to request the medical report even if the claims amount is below RM500.



## Submission via Micare Apps or Web Portal

### **Submission via Micare Web Portal**

 Microsoft Edge or Google Chrome > <u>https://eclaims.micaresvc.com/</u> -> Click <u>LOGIN</u> button



BERJAYA SOMPO INSURANCE

### **Micare Web Portal**





- Top Features:
  - ✓ Request Outpatient GL
  - ✓ Claims Submission
  - ✓ View Claims History
  - ✓ View Claims Utilization
  - ✓ View Benefits
  - ✓ Update Personal Details

### **Inpatient Pre/ Post Claim Submission**



- Claim Submission > Pre/ Post > Submit Claim
- Select either employee or dependent to submit claim

Claim Submission	Inpatient Pre/Post Hosp Claim Subm	ission
Outpatient Clinical	Please enter all the fields that have (*)	
Outpatient Specialist	Employee Name	
<ul> <li>Print Claim</li> </ul>	Employee IC	
Update Personal Dotails	Admission Claim	*: Please Select V
Inpatient Claim	Claim Type	*: Pre Claim 🗸
Submit Claim	Visitation Date	*: Please Select
Claim	Remarks	Pre Claim
Ciaim		Post Claim
Guarantee Letter		Daily Cash Allowance at Malaysia Government Hospital
Enquiry		Emergency Sickness Treatment
<ul> <li>Change Password</li> </ul>	File to be uploaded	* Outpatient Physiotherapy (if applicable)
		Accidental Dental Treatment
		Outpatient Kidney Dialysis Save & New Claim 11 Cancell
Claim Submission	Inpatient Pre/Post Hosp Claim Subm	ission
Claim Submission Outpatient Clinical	Inpatient Pre/Post Hosp Claim Submi Please enter all the fields that have (*)	ission
Claim Submission Outpatient Clinical Outpatient Specialist Doutpatient Specialist	Inpatient Pre/Post Hosp Claim Submi Please enter all the fields that have (*) Employee Name	ission : [1
Claim Submission Outpatient Clinical Outpatient Specialist Dental/Optical/Others Print Claim	Inpatient Pre/Post Hosp Claim Submi Please enter all the fields that have (*) Employee Name Employee IC	ission : [1]
Claim Submission Outpatient Clinical Outpatient Specialist Dental/Optical/Others Print Claim Update Personal	Inpatient Pre/Post Hosp Claim Submi Please enter all the fields that have (*) Employee Name Employee IC Admission Claim	ission
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Claim Submission Outpatient Clinical Outpatient Specialist Dental/Optical/Others Print Claim Update Personal Decaus Inpatient Claim Submit Claim Outpatient Claim	Inpatient Pre/Post Hosp Claim Submi Please enter all the fields that have (*) Employee Name Employee IC Admission Claim Claim Type Visitation Date Remarks	ission : 1 : *: Please Select ✓ *: Pre Claim ✓ *: 09 JAN ✓ 2023 :
Claim Submission  Outpatient Clinical Outpatient Specialist Dental/Optical/Others  Print Claim  Update Personal  Persus Inpatient Claim  Submit Claim  Outstanting Claim	Inpatient Pre/Post Hosp Claim Submi Please enter all the fields that have (*) Employee Name Employee IC Admission Claim Claim Type Visitation Date Remarks	ission : [1
Claim Submission  Outpatient Clinical Outpatient Specialist Dental/Optical/Others  Print Claim Update Personal  Persans Inpatient Claim Submit Claim Submit Claim Claim Guarantee Letter	Inpatient Pre/Post Hosp Claim Submi Please enter all the fields that have (*) Employee Name Employee IC Admission Claim Claim Type Visitation Date Remarks	ission : [1
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Claim Submission   Outpatient Clinical Outpatient Specialist Dental/Optical/Others  Print Claim Update Personal Details Inpatient Claim  Submit Claim Guarantee Letter Enquiry Claim Change Password	Inpatient Pre/Post Hosp Claim Submi Please enter all the fields that have (*) Employee Name Employee IC Admission Claim Claim Type Visitation Date Remarks	ission
Claim Submission   Outpatient Clinical Outpatient Specialist Dental/Optical/Others	Inpatient Pre/Post Hosp Claim Submi Please enter all the fields that have (*) Employee Name Employee IC Admission Claim Claim Type Visitation Date Remarks File to be uploaded	ission  : 1  : Please Select ✓  *: Pre Claim  *: 09 JAN ✓ 2023  :  *: Choose File No file chosen (JPG, TIFF, PDF) Max filesize is 10 MB
Claim Submission   Outpatient Clinical  Outpatient Specialist  Dental/Optical/Others  Pint Claim  Outpate Personal  Decaus Inpatient Claim  Outpatient Claim  Outpatient Claim  Outpatient Claim  Guarantee Letter Enquiry Claim Change Password	Inpatient Pre/Post Hosp Claim Submi Please enter all the fields that have (*) Employee Name Employee IC Admission Claim Claim Type Visitation Date Remarks File to be uploaded	ission  : [

### **Check Claim History**



- Enquiry > Claim History
- To check utilization incurred for employee and dependents.

Welcome! You have logged	d in as		
<ul> <li>Claim Submission</li> <li>Guarantee Letter</li> <li>Enquiry         <ul> <li>Claim History</li> <li>Claim History</li> <li>Remoursement</li> <li>Utilization &amp; Balance Summary</li> <li>Document Listing</li> </ul> </li> <li>Change Password</li> </ul>	Claim History Consultation Start Date Consultation End Date Type of Claim	JAN V JAN V ALL V Search	

### **Check Reimbursement Status**



- Enquiry > Reimbursement
- Check reimbursement status whether Approved or Rejected.

	Reimbursement												
ent Clain e Type	n Receipt No	Clinic/Hosp Name	Submission Date	Event Date	Diagnosis	Status	Process Date	Incurred Amt (RM)	Payable Amt (RM)	Excess Amt (RM)	<sup>s</sup> Payment Date	Remarks	Reason for Rejectin
SP			16 Aug 2018	01 Aug 2018	-	APPROVED		651.00	651.00	0.00			
Denta	131585	KLINIK PERGIGIAN MAXCARE	21 Nov 2018	07 Nov 2018	DENTAL	PAID	03 Dec 2018	435.00	435.00	0.00	06 Dec 2018	DENTAL	
	SP Denta	SP Dental 31585	Ent Claim Receipt       Clinic/Hosp Name         Image: SP       Clinic/Hosp Name         Dental 31585       KLINIK PERGIGIAN	Entrolaim Receipt       Clinic/Hosp Name       Submission Date         Type       No       Clinic/Hosp Name       Date         SP       Image: SP       Image: SP       Image: SP         Dental 31585       KLINIK PERGIGIAN 21 Nov 2018	PriceClaimReceipt NoClinic/Hosp NameSubmissionEvent DateSPSPImage: SP16 Aug 201801 Aug 2018Dental 31585KLINIK PERGIGIAN MAXCARE21 Nov 201807 Nov 2018	Ent Claim Receipt TypeClinic/Hosp NameSubmission DateEvent DateDiagnosisSPImage: SPImage: SP	Image: Security registerClinic/Hosp NameSubmission DateEvent DateDiagnosisStatusSPImage: SPImage: SP<	Process DateDiagnosisStatusProcess DateSPImage: SPImage: SPI	Process TypeNoClinic/Hosp NameSubmission DateDiagnosisStatusProcess DateAmt (RM)SPImage: SPImage:	Process TypeClinic/Hosp NameSubmission Event DateDiagnosisStatusProcess DateAmt (RM)Amt (RM)SPspaa16 Aug 201801 Aug 2018-APPROVED651.00651.00Dental 31585KLINIK PERGIGIAN MAXCARE21 Nov 201807 Nov 2018DENTALPAID03 Dec 2018435.00435.00	Ent Claim Receipt rypeClinic/Hosp NameSubmission Event DateDiagnosisStatusProcess DateAmt (RM)Amt (RM)Amt (RM)Amt (RM)SPspafragman16 Aug 201801 Aug 2018-APPROVEDa651.00651.000.00Dental 31585KLINIK PERGIGIAN MAXCARE21 Nov 201807 Nov 2018DENTALPAID03 Dec 2018435.00435.000.00	Process TypeAmt DateAmt Da	IntendictionReceipt TypeClinic/Hosp NameSubmission DateEvent DateDiagnosisStatusProcess DateAmt RM,Amt (RM)Amt RM,Amt DateAmt<

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### **Check Utilization & Balance Summary**



- Enquiry > Utilization & Balance Summary
- Check limit, amount used, and balance for employee and dependents.

Claim Submission Guarantee Letter	Utilization & Balance Summary								
Claim History	Employee Information								
Printmonent	Name	: Dummy Employee							
Utilization & Balance	IC/Passport	: 9999-99-9999							
A Demonst Listing	Benefit Year	: 01 APR 2018 - 31 MAR 201	9 🗸						
Change Password		View							
	Current Benefit Year: 01 Apr 201	8 - 31 Mar 2019							
	Benefit Type		Limit (RM)	Amount Used (RM)	Balance (RM)				
	Hospital Annual Limit (Limit Per Dis	sability)	60000.00	0.00	0.00				

### **Update Personal Details**



- Claim Submission > Update Personal Details
- Update your bank details, email address and contact no.
- This needed to be done only once and once updated, bank details cannot be amended
- Any amendment will require MiCare customer service support to assist.

### **Submission Via Micare Apps**





• For claims that allow to submit via Micare Apps, please log into MyMed Apps

### **Claim Submission**





- Utilization → Claim submission
- User can choose to submit claim type as below:
  - Pre/Post Hospital Claim (Inpatient)
  - Type of claims that can submit via MyMed:
    - Pre Claims (Pre-hospitalisation)
    - Post Claim (Post-hospitalisation)
    - Daily Cash Allowance at Malaysia GH
    - Emergency Outpatient Accidental Emergency
    - Emergency Sickness Treatment
    - Accidental Dental Treatment
    - Outpatient Kidney Dialysis

\*Note: Please take note that the allowable claim type submission is based on available benefit.





- After choose the claimant name, the name and passport no. will appear on this page
- User to select the claim type from the drop down list





- Admission Record, Admission Date and Discharge Date can leave as blank and these columns will be various choosing different claim type
- Choose the visitation date from the calendar that pop out
- Remarks is a free text column which you can type your preferred message or leave it blank
- Before submit, a copy of the claim documents need to be uploaded (file type: PDF and JPEG with total of 20MB file size).





- Once done, clicks <u>Submit.</u>
- System will pop out this message once user submit the claim successfully.

# Thank You

