HOSPITALIZATION & SURGICAL CLAIM FORM

TAKAFUL KELUARGA Life Insurance

Bismillaahirrahmaanirrahiim
Please fill in the form in block letters and with pen

I. REQUIRED DOCUMENTS

1.	This form must be completed and signed by the rightful employee/participant and is only valid for one employee/participant.
2.	This form must be filled in accordance with the actual data, signed by the Physician in charge and stamped by the hospital/clinic.
3.	This form must be submitted to the claim Department of PT. Asuransi Takaful Keluarga no later than 30 calendar days upon the treatment, along with the required documents. Claim can only be processed upon submission of completed documents.
4.	Checklist of required documents: ( ) Completed claim form ( ) Medical resume ( ) Expense detail ( ) Original payment receipt ( ) Copy of prescription from Physician in charge ( ) Statement letter from the first insurer in the case of COB claim ( ) Copy of diagnostic examination result (EKG, X-ray, USG, CT Scan, MRI, etc) and Laboratory test (blood test, etc)

II. DATA OF PARTICIPANT (MUST BE COMPLETED)

1.	Name of Company		
2.	Policy No.		
3.	Name of Primary Participant/Employee		
4.	Nama of Participant		
5.	Participant No.		
6.	Sex	( ) Male	( ) Female
7.	Date of Birth		
8.	Home Address	Phone/HP :	Email :
9.	Relation with primary participant/employee	( ) Participant/employee	( ) Spouse ( ) Children
10.	Transfer via	Bank Name	Branch :
		Account No.	Account holder :
11.	Total Claim Amount		
12.	Are there any other parties responsible for your injury/illness? if yes, please specify:		
13.	If there are any other insurance policies covering this case, please mention the name of the insurance company (address, phone no., and the name of policyholder) :		
14.	Claim type	( ) Hospitalization	( ) Maternity ( ) Pre/Post Hospitalization

III. STATEMENT

I hereby declare that :

1. I grant the power to PT. Asuransi Takaful Keluarga to obtain any information/medical record from physician/hospital or any other parties with diagnose, treatment or service provided to me, or to any other insured from my family in accordance with the prevailing law and regulation.
2. All statement given is true and i do not conceal any information required by this program. I agree that false statement shall result to the rejection of claim or cancellation of my participation.
3. I have received the above mentioned treatment/medication and i agree to pay part of uncovered treatment/medication expense by the insurance or due to treatment class above the chosen plan.

Participant/Attorney Signature

_____, __/__/____
place dt mo yr

_____
Full Name

FILLED IN BY PHYSICIAN (PLEASE COMPLETE THE FORM IN BLOCK LETTERS WITH PEN)

I. DATA OF HOSPITAL

1.	Hospital Name and Address	Phone :
2.	Date of Treatment : Admission Date ....., Discharge Date	
3.	Medical Record No.	
4.	In the case of referral case, please mention the name and address of referring physician	
	Physician Name :	Hospital/Clinic Name :

II. MEDICAL RESUME

	A. Anamneses	
1.	Primary symptoms	.....
2.	Additional symptoms	.....
3.	First time symptoms occurrence	Date .... Month .... Year .....
4.	History of previous related disease or injury	..... year .....(hospitalized/no) ..... year .....(hospitalized/no) ..... year .....(hospitalized/no)
5.	If it was caused by accident, when and how did the accident happen?	..... ., Date .... Month .... Year .....
6.	If it required hospitalization, what were the indications?	.....
7.	If due to pregnancy, please mention the starting date	Date .... Month .... Year .....
	B. Physical Examination	
1.	General Examination	.....
2.	Local Examination	.....
	C. Supporting Examination	
1.	Laboratory	.....
2.	Diagnostic (EKG, X-Ray, USG, CT Scan, MRI, etc)	.....
	D. Diagnosis	
1.	Primary Diagnosis	..... Kode ICD-10: .....
2.	Additional Diagnosis	..... Kode ICD-10: .....
	• What is the etiology from the above disease	.....
	• Is the diagnosis related to	( ) Congenital Hereditary ( ) Pregnancy ( ) *STD/HIV/AIDS* ( ) Fertility ( ) Accident ( ) Psychosomatics ( ) *Orthodentist* ( ) *Drug Abuse* ( ) Cosmetic ( ) *Tentamine Suicide* ( ) Others, specify : .....
	• Medically, is outpatient treatment possible for the patient	( ) outpatient is possible ( ) outpatient is not possible, due to .....
	E. THERAPY	
1.	Surgical Action (if performed):	
	• Name of surgery	.....
	• Indication of surgery	.....
	• Type of anesthesia	( ) local ( ) regional ( ) general, due to: .....
	F. PROGNOSIS	
1.	Possibility of recurrence	( ) minor possibility of recurrence ( ) major possibility of recurrence
2.	Advice & plan for following medication	.....

III. CLARIFICATION

I, the Physician in charge, hereby declare that the above statement is complete and correct

Name of Physician in charge :	Physician signature and hospital stamp
Phone No. :	