Anzen Health
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International Medicare Group Sdn Bhd
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TOP-UP / ADD-ON GUARANTEE REQUEST FORM

PATIENT ADMISSION DETAILS	
PATIENT NAME	HOSPITAL NAME
PATIENT ID (NRIC/ PASSPORT)	ADMISSION DATE AND TIME
MRN/ ADMISSION NUMBER	SPECIALIST/ PHYSICIAN'S NAME
GUARANTEE LETTER NUMBER	PROVISIONAL DIAGNOSIS

SECTION 1: INTERIM BILL AMOUNT

1. Interim bill amount

   MYR ☐☐☐☐☐☐ . ☐☐

   Please provide a copy of the interim bill summary and itemised breakdown

2. Additional Treatments / Invesgations done (MMA/ PHFSR coding recommended)

Treatments / Investigations Description	Estimated cost (MYR)	Date (DD/MM/YYYY)

Please provide copies of all investigation reports (CT scans, X-ray, etc.) and other relevant hospital reports

3. Additional Surgical Procedures to be performed (MMA/ PHFSR coding recommended)

Surgical Procedures Description	Esmated cost (RM)	Date (DD/MM/YYYY)

SECTION 2: PATIENT'S DIAGNOSIS AND HISTORY

1. a) Has the patient's provisional diagnosis changed?

☐ Yes ☐ No

b) If 'YES', please elaborate on complications

Updated Diagnosis Description	ICD-10 Code

2. a) In your professional opinion, is this a pre-exisng illness/condition?

☐ Yes ☐ No

b) If 'YES', how long has the patient had or is reasonably aware of the illness/condition?

☐☐ Years ☐☐ Months

3. Please confirm if the final diagnosis was caused directly or indirectly by the following conditions:

☐ Pregnancy/Childbirth/Caesarean section/Miscarriage/Prenatal/Postnatal/Sterilisation/Infertility
If pregnancy related, please state gestation period: _____ weeks

☐ Congenial/Hereditary Disease

☐ Influence of Drugs/Alcohol

☐ Nervous/Mental/Emotional/Sleeping Disorder

☐ Cosmectic surgery/Dental care/Refractive errors connection

☐ AIDS/HIV/STD/VD

☐ Self-inflicted Injuries/Violation of Laws/Strike/Riots

☐ None of the above

SECTION 3: ADD-ON SPECIALIST DOCTORS

1. a) Any other surgical/medical specialist(s) involved in the treatment of the patient?

☐ Yes ☐ No

b) If 'YES', please state their names and reason for referral

Doctor/ Specialist/ Surgeon Name	Referral Reason

Please provide copies of completed and signed admission forms for all additional specialist doctors.

SECTION 4: ATTENDING DOCTOR'S DECLARATION

I hereby certify that I have personally examined and treated the Patient for the injuries/illness described above and that the facts as stated above represent my medical opinion of their condition.

Attending doctor's stamp and signature:

_____

Name:
Date: