HOSPITAL FATIMAH (125542-U)

1, Lebuh Chew Peng Loon, Off Jalan Dato' Lau Pak Khuan,
Ipoh Garden, 31400 Ipoh,Perak, Malaysia
Tel: 605-5455777, 5455713, 5455725, 5456622.
Fax: 6 (05)-5477050 (General Line), 6 (05)-5499237 (Admission/Accounts & Billing Department)
E-mail: enquiry@fatimah.com.my

INVOICE

Payor : ALLIANZ LIFE INSURANCE MALAYSIA BERHAD

: UNIT 6-5 & 6-7 & 8, LEVEL 6
WISMA UOA DAMANSARA II
NO.6 CHANGKAT SEMANTAN
DAMANSARA HEIGHTS,
50490 KUALA LUMPUR

Payor Code : A0165
Patient's name : LAU MOON THO

Invoice number : IP0000294946
Date : 04/03/2019 10:53:02
Page : 1 of 2
Patient's number : 0251347
Episode No : I0000207771-3
Date of admit/ward : 26/02/2019 12:37:00 W4C 411-B
Date of discharge/ward : 03/03/2019 11:32:00 W2C 202-A
Length of stay (days) : 5.0

DESCRIPTION		Amount Due (RM)	Discount (RM)	Payable (RM)
HOSPITAL'S CHARGES				
ACCOMMODATION		500.00	0.00	500.00
DRUGS AND MEDICINE		654.00	0.00	654.00
ECG		40.00	0.00	40.00
IMPLANTS		3,750.00	0.00	3,750.00
LABORATORY CHARGES		162.00	0.00	162.00
MEDICAL / SURGICAL SUPPLIES		1,009.89	0.00	1,009.89
MEDICAL EQUIPMENT		120.00	0.00	120.00
OPERATING THEATRE ACCESSORIES & EQUIPMENT		891.20	0.00	891.20
OPERATING THEATRE CHARGES		1,090.00	0.00	1,090.00
PHYSIOTHERAPY		90.00	0.00	90.00
PROCEDURE		28.00	0.00	28.00
PROCEDURE SETS		53.54	0.00	53.54
X-RAY		426.70	0.00	426.70
Sub total		8,815.33	0.00	8,815.33
DOCTOR'S CHARGES				
ANAESTHETIC FEE	DR. YIP KIN SOON	760.00	0.00	760.00
CONSULTATION FEE	DR. RAVEENDRAN A/L S. KANDIAH	235.00	0.00	235.00
OPERATION FEE	DR. RAVEENDRAN A/L S. KANDIAH	1,890.00	0.00	1,890.00
OTHER FEE	DR. YIP KIN SOON	50.00	0.00	50.00
PRE-OP ASSESSMENT	DR. YIP KIN SOON	150.00	0.00	150.00
PROCEDURE FEE	DR. YIP KIN SOON	50.00	0.00	50.00
RADIOLOGIST FEE	DATO' DR. MOHAMAD BIN ABDUL KADIR	33.30	0.00	33.30
RADIOLOGIST FEE	DR. MINSYEH @ BOUNAH BINTI KIMIN	21.00	0.00	21.00
VISIT/MANAGEMENT FEES	DR. RAVEENDRAN A/L S. KANDIAH	1,100.00	0.00	1,100.00
Sub total		4,289.30	0.00	4,289.30
Total		13,104.63	0.00	13,104.63
Rounding Adjustment				0.02
Total Payable				**13,104.65**
Deposit				
Less : Total Deposit				**0.00**

RECEIVED
06 MAR 2019
CHA-Ops Unit

RECEIVED
06 MAR 2019
CHA-Ops Unit

Charges omitted at the time of discharge will be billed separately

User ID :SERJIT
HOSPITAL FATIMAH
ADM(Bill)14

HOSPITAL FATIMAH (125542-U)

1, Lebuh Chew Peng Loon, Off Jalan Dato' Lau Pak Khuan,
Ipoh Garden, 31400 Ipoh,Perak, Malaysia
Tel: 605-5455777, 5455713, 5455725, 5456622.
Fax: 6 (05)-5477050 (General Line), 6 (05)-5499237 (Admission/Accounts & Billing Department)
E-mail: enquiry@fatimah.com.my

INVOICE

Payor : ALLIANZ LIFE INSURANCE MALAYSIA BERHAD

: UNIT 6-5 & 6-7 & 8, LEVEL 6
WISMA UOA DAMANSARA II
NO.6 CHANGKAT SEMANTAN
DAMANSARA HEIGHTS,
50490 KUALA LUMPUR

Payor Code : A0165

Patient's name : LAU MOON THO

Invoice number	: IP0000294946
Date	: 04/03/2019 10:53:02
Page	: 2 of 2
Patient's number	: 0251347
Episode No	: I0000207771-3
Date of admit/ward	: 26/02/2019 12:37:00 W4C 411-B
Date of discharge/ward	: 03/03/2019 11:32:00 W2C 202-A
Length of stay (days)	: 5.0

DESCRIPTION	Amount Due (RM)	Discount (RM)	Payable (RM)
Total Due			**13,104.65**

Charges omitted at the time of discharge will be billed separately

User ID :SERJIT
HOSPITAL FATIMAH
ADM(Bill)14

Allianz Life Insurance Malaysia Berhad (104248-X)
Allianz General Insurance Company (Malaysia) Berhad (735426-V)

Allianz

PRE-AUTHORIZATION FORM | BORANG PRA-KEBENARAN

Part 1 | Bahagian 1
To be completed by Patient / Claimant | *Untuk diisi oleh Pesakit / Penuntut*

1. Patient Name | Nama Pesakit	LAU MOON THO		
2. NRIC No. | No. K.P.	570202-08-5397	3. Date of Birth | Tarikh Lahir	2/2/1957
4. Age | Umur	62 tahun	5. Sex | Jantina	☐ Male | Laki-laki ☐ Female | Perempuan
6. Mobile No. | Telefon Bimbit		7. Policy No./Member ID/Certificate No./Plan/Company Name | No. Polisi/ No. Ahli /No.Sijil /Pelan/Nama Syarikat	
8. Admission / Planned Admission Date | Tarikh kemosukan hospital	26/2/2019		
9. Hospital Name | Nama Hospital	HOSPITAL FATIMAH		
10. Name of Attending Doctor/ Specialty | Nama Doktor yang merawat/Kepakaran			

11. Admission Reason \| Sebab Kemasukan

☐ Accident \| Kemalangan
- Occurred On \| Berlaku pada: Date \| Tarikh: _____ Time \| Masa: _____
- Details of Accident \| Butir-butir kemalangan:

☐ Illness \|Penyakit
- Symptoms first appeared on \| Tarikh simptom tersebut bermula: Date \| Tarikh: _____
- Doctor(s) consulted for this condition \| Doktor-doktor yang ditawati bagi penyakit ini:
- Doctor's or Clinic Contact(Address & Telephone)| Alamat & Telefon Doktor

Declaration and Authorization | Pengisytiharan dan Pemberikuasa

- I declare that the answers given above are true and complete to the best of my knowledge and belief. | Saya mengisytiharkan bahawa jawapan yang diberikan di atas adalah benar dan lengkap setakat pengetahuan dan kepercayaan saya.
- I understand the delivery of this form is in no way an admission of Allianz Life Insurance Malaysia Berhad's liability and payment to the hospital by Allianz Life Insurance Malaysia Berhad or its representative shall not be construed as final admission of Allianz Life Insurance Malaysia Berhad's liability and for this and any further claims arising, Allianz Life Insurance Malaysia Berhad reserves all rights for evaluation as appropriate. | Saya memahami bahawa penyerahan borang ini, tidak sama sekali boleh dianggap sebagai pengakuan liabiliti Allianz Life Insurance Malaysia Berhad ini ke atas tuntutan saya/Asured dan saya bersetuju bahawa bayaran kepada hospital oleh Allianz Life Insurance Malaysia Berhad atau wakilnya tidak akan ditafsirkan sebagai pengakuan muktamad liabiliti Allianz Life Insurance Malaysia Berhad dan Allianz Life Insurance Malaysia Berhad berhak menjalankan penilaian sewajarnya berhubung tuntutan ini atau apa-apa tuntutan yang timbul selanjutnya.
- I am fully aware of the limits as to my/Assured medical insurance under the above-mentioned policy. I hereby undertake to settle/reimburse any medical expenses exceeding my entitlement under the said policy contract, or that is not covered by the same. | Saya memahami sepenuhnya had-had insurans perubatan saya di bawah Polisi yang tersebut di atas. Saya dengan ini berjanji akan menyelesaikan sebarang amaun yang melebihi had kelayakan saya, yang tidak dilindungi oleh insurans berkenaan.
- I hereby irrevocably authorize any organization, institution, or individual that has any record or knowledge of my health and medical history or treatment or advice that has been or may hereafter be consulted, other personal information or details of related accident/injury, to disclose to Allianz Life Insurance Malaysia Berhad or its representative such information. I agree that Allianz Life Insurance Malaysia Berhad or its representative may use or disclose any of the information collected or held to third parties (within or outside Malaysia, including Allianz Life Insurance Malaysia Berhad's parent company, subsidiaries or any other associated companies within Allianz Life Insurance Malaysia Berhad's Group, reinsurers, medical examiners, claims investigators and industry associations/federations etc.) in relation to this claim. This authorization shall bind my/the Assured's/Insured's successors and assigns and remain valid notwithstanding my/Assured's/Insured's incapacity in so far as legally possible. A photocopy of this authorization shall be valid as the original. | Saya yang bertandatangan di bawah, dengan ini membenarkan pada setiap masa, mana-mana organisasi, institusi atau individu yang mempunyai apa-apa rekod atau pengetahuan tentang kesihatan dan latar belakang atau rawatan atau nasihat perubatan saya/Assured/Insured, yang telah atau mungkin kemudian dari ini dirujuk untuk mendedahkan kepada Allianz Life Insurance Malaysia Berhad atau wakilnya segala maklumat tersebut. Saya bersetuju membenarkan Allianz Life Insurance Malaysia Berhad atau wakilnya untuk menggunakan dan mendedahkan apa-apa maklumat yang dikumpul atau dipegang kepada pihak ketiga (di dalam atau di luar Malaysia, termasuk syarikat induk, anak Allianz Life Insurance Malaysia Berhad atau Allianz Life Insurance Malaysia Berhad berkait dalam Allianz Life Insurance Malaysia Berhad, reinsurer, pemeriksa perubatan, penyiasat tuntutan dan pertubuhan/persekutuan industri dll.) berkaitan dengan tuntutan ini. Pengesahan ini hendaklah mengikat waris-waris dan penama saya/Asured/Insured dan kekal sah meskipun setelah kematian saya/Assured/Insured setakat yang dibenarkan di sisi undang-undang. Salinan pengesahan ini adalah sah.
- I agree that in the event I make, or have in the past made, any false or untrue statement and/or suppressed and/or concealed any material facts in respect of my/the insured's condition, Allianz Life Insurance Malaysia Berhad shall absolutely forfeit my/the Insured's/ Assured's right to compensation and further reserves the right to recover any amounts paid earlier as a result thereof. | Saya bersetuju sekiranya saya membuat pengakuan palsu atau tidak mendedahkan maklumat yang berkaitan, Allianz Life Insurance Malaysia Berhad berhak membatalkan tuntutan saya dan menarik balik sebarang tuntutan awal yang telah dibayar.

Signature of Patient |Tandatangan Pesakit	Signature of Policyholder | Tandatangan Pemilik Polisi	Signature of Witness | Tandatangan Saksi
Full Name|Nama Penuh: LAU MOON THO IC No.| No. KP: Date|Tarikh: Contact No.| No. Telefon:	Full Name|Nama Penuh: IC No.| No. KP: Date|Tarikh: Contact No.| No. Telefon: Relationship to Patient |Hubungan dengan Pesakit:	Full Name|Nama Penuh: IC No.| No. KP: Date|Tarikh: Contact No.| No. Telefon: 05-5455777

NOTE: COMPLETION OF THIS PRE AUTHORISATION FORM DOES NOT GUARANTEE THE ISSUANCE OF GUARANTEE LETTER.| Melengkapkan borang permintaan ini tidak semestinya menjamin bahawa Surat Jaminan akan dikeluarkan.

Allianz Customer HealthCare: Suite 6-5, 6-7& 6-8, Level 6, Wisma UOA Damansara II, No. 6 Changkat Semantan, Damansara Heights, 50490 Kuala Lumpur.
Helpline: 1-300-88-8322 Fax: 603-8322 0881 Email : healthcare.guarantee@allianz.com.my

Allianz Life Insurance Malaysia Berhad (104248-X)
Allianz General Insurance Company (Malaysia) Berhad (735426-V)

Allianz

Part 2
Admission Section: To be completed upon admission by Doctor

1. Patient Name	LAU MOON THO		
2. NRIC No.	570202-08-5346	3. Age 624	
4. Sex	☐ Male ☐ Female	5. Policy No./Member ID/Certificate No./Plan/Company Name	
6. Admission No. / MRN and Hospital Name/ Hospital Contact and Fax No :	HOSPITAL FATIMAH 05-5455777 / 05-5499237	7. Admission Date and Time	
8. Expected days of stay / Discharge Date	5		

9. (a) Symptoms / Conditions requiring admission (b) How long is patient aware of the condition (c) Patient's BP/ Temp/ Pulse: (d) Date symptoms first appeared (e) Date first consulted	Pain and swelling
10. (a) Any previous consultation / treatment / hospitalization for this symptom / illness or related conditions, or other disorders whether in this hospital or any other facilities?	☐ Yes ☐ No
(b) Was this patient referred? If Yes, please provide details.	15/2/19 NO
(c) If this condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed	Date / Disease/Disorder / Treatment/ hospitalization details / Doctor/ Hospital/Clinic
(d) Can the condition be managed under the Outpatient basis	☐ Yes ☐ No If No, please provide reason for admission: for operation
11. ☐ Admitting Diagnosis OR ☐ Provisional Diagnosis	suspected fracture of the femur
	Diagnosis confirmed on 15/2/19 Advised patient on 15/2/19 Cause and pathology underlying the present diagnosis: fall Any possibility of relapse? ☐ Yes ☐ No
12. Estimated Total Cost (RM)	
13. Admission Required	☐ Hospitalization ☐ Day Care ☐ On Patient's Request
14. Is the illness/condition related to: Please tick ✓ if YES	☐ Pregnancy/Childbirth/Infertility/Caesarean section/miscarriage OR any complications arising therefrom. ☐ Congenital / Hereditary diseases ☐ Influence of Drugs / Alcohol ☐ Nervous / Mental / Emotional / Sleeping Disorder ☐ Cosmetic reason / Dental care / refractive errors correction ☐ AIDS / STD / VD/ HIV ☐ Self-inflicted Injuries / Violation of laws / Strike / Riots ☐ None of the above
15. Medical treatment, Investigations and Surgical procedure to be performed, if any (please supply copy of all investigation results)	X / Blood test / Locking plate right femur
16. Any other medical/surgical conditions present?	☐ No ☐ Yes, details below: a. _____ since ___/___/___ b. _____ since ___/___/___
17. Was the patient pregnant at the time of hospitalization? (For Female Only)	☐ No ☐ Yes, _____ months
18. (a) If hospitalization was due to injury, please describe circumstances and cause of injury	fall at home
(b) Please indicate date/time of accident	15/2/19

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

26 FEB 2019

DR. RAVEENDRAN A/L S. KANDIAH
M.B.B.S (Malaya), F.R.C.S. (Edin)
M.Ch. Orth (Liverpool), F.A.M.S.
Consultant Orthopaedic Surgeon (N.S.W.)
ORTHOPAEDIC & TRAUMA SURGEON
HOSPITAL FATIMAH IPOH
NSR NO.: 124458 MMC NO.: 21442

Date | Name & Signature of Attending Doctor | Doctor / Hospital Stamp

Allianz Life Insurance Malaysia Berhad (104248-X)
Allianz General Insurance Company (Malaysia) Berhad (735426-V)

Allianz

Part 3 Discharge Section: To be completed upon discharge by Doctor	
1. Undertaking Letter Ref No :(If available)	
2. Date of Discharge	3/3/15 bl
3. (a) Final Diagnosis (b) Cause and pathology of the diagnosis ICD code	Supracondylar fracture Rt femur Fall
4. Treatment given / Investigation done: (Please supply copy of all investigation results)	X-ray / Blood test
5. (a) Surgical procedures performed (b) Date of surgery / procedure MMA code / PHFSR code	Closed reduction Rt femur 27/2/15 N340
6. (a) Recovery complication that arose (if any): (b) In the case of DEATH, please advise Date/ Time and Cause of death	Nil

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

Date

Name & Signature of Attending Doctor

DR. K. RAVEENDRAN
(MMC NO. 21442)
M.B.B.S. (Malaya), F.R.C.S. (Edin)
M. Ch. Orth (Liverpool), F.A.M.M.
Doctor of Sports Medicine (N.S.W.)
CONSULTANT ORTHOPAEDIC & TRAUMA SURGEON
HOSPITAL FATIMAH, IPOH

Allianz Customer HealthCare: Suite 6-5, 6-7& 6-8, Level 6, Wisma UOA Damansara II, No. 6 Changkat Semantan, Damansara Heights, 50490 Kuala Lumpur.
Hotline: 1-300-88-8322 Fax : 603-8322 0881 Email : healthcare.guarantee@allianz.com.my