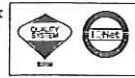




HOSPITAL FATIMAH (125542-U)

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

HOSPITAL'S CHARGES

DESCRIPTION	Amount Due (RM)	Discount (RM)	Payable (RM)
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

Charges omitted at the time of discharge will be billed separately



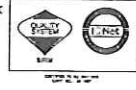
User ID :SERJIT
HOSPITAL FATIMAH
ADM(Bill)14



HOSPITAL FATIMAH (125542-U)

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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

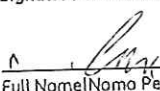
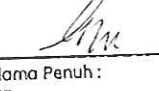
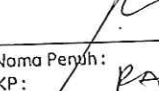
Invoice number : IP0000294946
Date : 04/03/2019 10:53:02
Page : 2 of 2
Patient's number : 0251347
Episode No : I0000207771-3
Date of admit/ward : 26/02/2019 12:37:00 W4C 411-B
Date of discharge/ward : 03/03/2019 11:32:00 W2C 202-A
Length of stay (days) : 5.0

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

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	LNU MOON THO		
2. NRIC No. No. K.P.	520202-08-539	3. Date of Birth Tarikh Lahir	2/2/1957
4. Age Umur	62 years	5. Sex Jantina	<input type="checkbox"/> Male Laki-laki <input type="checkbox"/> 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 kemasukan 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	<input type="checkbox"/> Accident Kemalangan Occurred On Berlaku pada: Date Tarikh: _____ Time Masa: _____ Details of Accident Butir-butir kemalangan: _____ <input type="checkbox"/> Illness Penyakit Symptoms first appeared on Tarikh simptom tersebut bermula: Date Tarikh: _____ Doctor(s) consulted for this condition Doktor-doktor yang dilawati bagi penyakit ini: _____ Doctor's or Clinic Contact (Address & Telephone) Alamat & Telefon Doktor: _____		
Declaration and Authorization Pengisytiharan dan Pemberkuasa 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/Assured 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 oman 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 mengguna 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, penylosot tuntutan dan pertubuhan/persekutuan industri dll) berkaitan dengan tuntutan ini. Pengesahan ini hendaklah mengikat waris-waris dan penama saya/Assured/Insured dan kekal sah meskipun setelah kematian saya/Assured/Insured setakat yang dibenarkan di sisi undang-undang. Solnon 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	
 Full Name Nama Penuh: LNU MOON THO IC No. No. KP: 520202-08-539 Date Tarikh: 7/2/19 Contact No. No. Telefon: 011-2345678		 Full Name Nama Penuh: _____ IC No. No. KP: _____ Date Tarikh: _____ Contact No. No. Telefon: _____ Relationship to Patient Hubungan dengan Pesakit: _____	
		Signature of Witness Tandatangan Saksi	
		 Full Name Nama Penuh: PASMA IC No. No. KP: 080 Date Tarikh: 08/2/19 Contact No. No. Telefon: 05-5455777	

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

Part 2 Admission Section: To be completed upon admission by Doctor			
1. Patient Name	LAU MOON THO		
2. NRIC No.	570202-08-53	3. Age	62y
4. Sex	<input checked="" type="checkbox"/> Male <input type="checkbox"/> 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	Can not say yet here		
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? (b) Was this patient referred? If Yes, please provide details. (c) If this condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed (d) Can the condition be managed under the Outpatient basis	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 15/2/15 NO Date Disease/Disorder Treatment/hospitalization details Doctor/Hospital/Clinic 2008 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If No, please provide reason for admission:		
11. <input checked="" type="checkbox"/> Admitting Diagnosis OR <input type="checkbox"/> Provisional Diagnosis Supraventricular premature beats	Diagnosis confirmed on 15/2/15 Advised patient on 15/2/15 Cause and pathology underlying the present diagnosis: JAW Any possibility of relapse? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
12. Estimated Total Cost (RM)			
13. Admission Required	<input checked="" type="checkbox"/> Hospitalization <input type="checkbox"/> Day Care <input type="checkbox"/> On Patient's Request		
14. Is the illness/condition related to: Please tick ✓ if YES	<input type="checkbox"/> Pregnancy/Childbirth/Infertility/Caesarean section/miscarriage OR any complications arising therefrom. <input type="checkbox"/> Congenital / Hereditary diseases <input type="checkbox"/> Influence of Drugs / Alcohol <input type="checkbox"/> Nervous / Mental / Emotional / Sleeping Disorder <input type="checkbox"/> Cosmetic reason / Dental care / refractive errors correction <input type="checkbox"/> AIDS / STD / VD / HIV <input type="checkbox"/> Self-inflicted injuries / Violation of laws / Strike / Riots <input checked="" type="checkbox"/> None of the above		
15. Medical treatment, Investigations and Surgical procedure to be performed, if any (please supply copy of all investigation results)	15/2/15 15/2/15 Locking of leg		
16. Any other medical/surgical conditions present?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, details below: a. _____ since ____/____/____ b. _____ since ____/____/____		
17. Was the patient pregnant at the time of hospitalization? (For Female Only)	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, _____ months		
18. (a) If hospitalization was due to injury, please describe circumstances and cause of injury (b) Please indicate date/time of accident	2008 at home 15/2/15		
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 the condition. 26 FEB 2015 DR. RAVELINDRAN A/L S. KANDIAH M.B.B.S. (Malaysia), F.A.C.C. (USA) M.D. (Orthopedics), F.A.M.S. Certificate of Specialization (M.S.M.) Date: _____ Name & Signature of Attending Doctor: _____ Doctor/Hospital Stamp: _____ HOSPITAL FATIMAH-IPCH			

Part 3 Discharge Section: To be completed upon discharge by Doctor	
1. Undertaking Letter Ref No. (If available)	
2. Date of Discharge	3/3/18
3. (a) Final Diagnosis (b) Cause and pathology of the diagnosis ICD code	Supracondylar fracture of femur 241
4. Treatment given / Investigation done: (Please supply copy of all investigation results)	Xr. / Blood test
5. (a) Surgical procedures performed (b) Date of surgery / procedure MMA code / PHFSR code	Locking plate 22/11/18 N 2110
6. (a) Recovery complication that arose (if any): (b) In the case of DEATH, please advise Date/ Time and Cause of death	NR

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.

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

Date: _____ Name & Signature of Attending Doctor: _____