KPJ HEALTHCARE BERHAD
CHARGE CODE REQUEST FORM

HOSPITAL / COMPANY: _____ SERVICE: _____

No.	(1) Fill up by requester				(5) Fill up by KPJ BODIV
	Description of the procedure/test/product *	Charge type	Proposed price		Assigned charge code
			Inpatient	Outpatient	

** Note: Please provide detail information using supplement form as attached:*
Supplement form I : Medical Supplies/Pharmacy/Dietetic Product/Services/Nursing

REQUESTED BY,	**(2) HOSPITAL MANAGEMENT & EVALUATION COMMITTEE**	**(3)APPROVED BY,**
Name : **Position:** **Date:**	**APPROVAL DATE:**	**Executive Director/Chief Executive Officer/ General Manager** **Name :** **Date:**

For KPJ use

KPJ Business Operation Division (BODIV)		
(4) DATE RECEIVED **RECEIVED BY,**	(6) **EXECUTIVE DIRECTOR / SENIOR GENERAL MANAGER** **APPROVED / NOT APPROVED**	**(7) INSTALLED BY:** **Name:** **Date :**
(9) NOTIFY REQUESTER/HOSPITAL **Name:** **Date:**	_____ **Name:** **Date :**	**(8) VERIFIED BY:** **Name:** **Date :**