HOSPITALISATION CLAIM FORM

Staff name : _____

Emp. No. : _____

Company : _____

Designation : _____

Div. / Dept. : _____

Date Joined : _____

Patient name : _____ Patient NRIC : _____

Relationship : _____ Patient age : _____

Hospital : _____ Room & Board : _____

Admission date : _____ Discharged date : _____

1st follow up : _____ 2nd follow up : _____

Date	Particulars	Cost Incurred
TOTAL		

Claimed by :	Approved by :	Verified for payment by :
(Staff)	(Head of Div./Dept.)	(Group Human Capital Division)

FOR GROUP HUMAN CAPITAL DIVISION USE
GHCD Remarks :

Note : Please submit this form together with Discharge Summary Report/Medical Report and original bills.
Cost for follow-up treatment (within 60 days from the discharged date) is included in the hospitalisation cost.