Assunta
Heart & Art of Care

INVOICE

PAYOR: 3121
TENAGA NASIONAL BERHAD

KETUA (TNB HEALTHCARE), BAHAGIAN TENAGA GLOBAL BUSINESS SOLUTION,
TENAGA NASIONAL BERHAD, ARAS 9, BANGUNAN WARISAN TNB,
NO : 129, JALAN BANGSAR,
59200, KUALA LUMPUR , WILAYAH PERSEKUTUAN, MALAYSIA.

SERVICE RECIPIENT

Patient Name : NAGAMMAL A/P M GOVINDAN
Patient Mailing Address : 709 JALAN MEDAN 30
TAMAN BUANA PERDANA
46000, PETALING JAYA, SELANGOR, MALAYSIA.
IC No / Passport : 540721085858
MRN : 00303562

Invoice No : S-250117361
Date : 19/08/2025 01:38 PM
Billed By : balqis.roslan
Visit Type : INPATIENT
Visit ID : A25008926
Admission Date / Time : 09/08/2025 12:55 PM
Discharge Date / Time : 18/08/2025 03:11 PM
Admitting Doc : DATO SRI DR SURESH RAJ LACHMANAN
Bed Type : MAR / MAR-4301-4 / 4 Bedded - (RM95/day)
GL Ref No : -
Policy No : -

CODE	DESCRIPTION	DATE	QTY	UNIT PRICE	AMOUNT	DISCOUNT	TOTAL
HOSPITAL CHARGES							
01	**DRUGS & MEDICINE**				**4,855.28**	**0.00**	**4,855.28**
DN5505	# (SP) MIDAZOLAM INJ 5MG/ML		2	22.45	44.90	0.00	44.90
DM4715	#**IRON(III) POLYMALTOSE CO/ FOLATE CHEW TAB 100/0.35MG [MALTOFER FOL]		10	1.90	19.00	0.00	19.00
DM4514	**ALPHA LIPOIC ACID + VITAMIN B1, B6 & B12 (BIONERV) (10'S)		1	31.90	31.90	0.00	31.90
DZ9858	@ TERUMO NANOPASS NEEDLE FOR INSULIN PEN 32.5GX4MM		35	1.10	38.50	0.00	38.50
DB0673	AMOXYCILLIN TRIHYDRATE TAB 500MG [OSPAMOX 500]		16	0.70	11.20	0.00	11.20
DB0631	AMOXYCILLIN/ CLAV K TAB 625MG [AUGMENTIN 625]		18	6.90	124.20	0.00	124.20
DR7055	BECLOMETHASONE/FORMOTEROL MDI 100/6MCG [FOSTER](120DS)		1	156.00	156.00	0.00	156.00
DS7802	CLOTRIMAZOLE CREAM 1% [CANESTEN] (10G)		1	27.60	27.60	0.00	27.60
DI3305	DEXTROSE INJ 10% (500ML)		2	17.54	35.08	0.00	35.08
DI3306	DEXTROSE INJ 50% (20ML)		1	14.70	14.70	0.00	14.70
DS7698	ESFLURBIPROFEN 40MG TRANSDERMAL PATCH [LOCOA] (7'S)		2	38.80	77.60	0.00	77.60
DG2555	ESOMEPRAZOLE TAB 40MG [NEXIUM 40]		8	13.20	105.60	0.00	105.60
DH3113	HYDROCORTISONE NA ^INJECTION^ 100MG/2ML [SOLU-CORTEF]		19	37.80	718.20	0.00	718.20
DB0850	LEVOFLOXACIN 500MG TABLET [CRAVIT]		4	20.90	83.60	0.00	83.60
DC1141	LOSARTAN K TAB 50MG [COZAAR 50]		5	5.00	25.00	0.00	25.00
DG2727	MACROGOL 4000/ NA SULFATE/ NA BICARB/ NACL/ KCL SACHET [FORTRANS]		3	28.60	85.80	0.00	85.80
DE2320	MOMETASONE N/SPRAY 50MCG [NASONEX] (140DS)		1	137.10	137.10	0.00	137.10
DB0672	MOXIFLOXACIN HCL ^INJECTION^ 400MG [AVELOX] LIFELINE		10	281.00	2,810.00	0.00	2,810.00
DT8116	POTASSIUM CHLORIDE TAB 600MG		5	0.50	2.50	0.00	2.50
DL4333	ROSUVASTATIN CA TAB 10MG [CRESTOR 10]		9	8.80	79.20	0.00	79.20
DI3339	SODIUM CHLORIDE (NACL) INJ 0.9% (100ML)		5	16.40	82.00	0.00	82.00
DT8422	SODIUM CHLORIDE (NACL) PREFILLED SYRINGE 0.9% (OMNIFLUSH) 10ML		15	3.90	58.50	0.00	58.50
DR7016	THEOPHYLLINE SR TAB 125MG [NUELIN SR 125]		17	1.20	20.40	0.00	20.40
DU8609	URAL EFFERVESCENT GRANULES (4G)		23	2.90	66.70	0.00	66.70

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02	**SURGICAL MATERIALS**				**658.62**	**0.00**	**658.62**
CD0127	3 WAY STOPCOCK WITH EXTENSION FOR INFUSION THERAPY & PRESSURE MONITORING WITH LUER LOCK 10CM TUBING (STOPCOCK W T EXTENSION-ADULT)		2	11.65	23.30	0.00	23.30
SS0235	ALCOHOL SWAB		15	0.10	1.50	0.00	1.50
SS0490	Cavilon No Sting Barrier Film 3ml wand (3M) #3345		2	20.96	41.92	0.00	41.92
SS0527	COTTON BALL STERILE 10'S/PKT		3	2.60	7.80	0.00	7.80
CD0035	FOLEY CATH 2 WAY 22FR 30-50ML SILICONE ELASTOMER COATED		1	14.15	14.15	0.00	14.15
SS6023	Intrafix Safeset P I. S. Y - N.F. Valve #4063004		9	15.95	143.55	0.00	143.55
SS0528	IV ADVANCED TRANSPARENT DRESSING WITH SECURING TAPE 7CMX6.5CM		12	5.40	64.80	0.00	64.80
SS0512	MICROCLAVE CONNECTOR # 011-C3300 / 12568		8	7.95	63.60	0.00	63.60
SS0246	NASAL OXYGEN CANULLA WITH TUBING 7FT		2	4.30	8.60	0.00	8.60
SS0168	NEBULIZER KIT C/W MASK & TUBING ADULT		1	19.25	19.25	0.00	19.25
SS0252	Peak Flow Meter Mouth Piece Adult Disposable		4	1.30	5.20	0.00	5.20
CD0044	PLAIN GAUZE STERILE 7.5CM X 7.5CM X 8PLY 5'S/PKT		1	1.60	1.60	0.00	1.60
SS0637	PRE-CUT ABSORBENT GAUZE SWAB PLAIN, STERILE, 10CM X 10CM - 8PLY (2'S/PKTS)		15	1.15	17.25	0.00	17.25
CDE015	SUPERSOFT STERILIZATION PAPERS 120CM X 180CM		1	11.00	11.00	0.00	11.00
CD0120	SYRINGE CATHETER TIP 50ML (TERUMO) #SS50CZ		1	6.90	6.90	0.00	6.90
SS0631	TERUMO INFUSION SET FOR PUMP #TI*PU300LY		6	17.05	102.30	0.00	102.30
SS0461	UNIVERSAL CLOSING STOPPER WITH MALE&FEMALE LUER LOCK (RED COMBI STOPPER)		11	0.35	3.85	0.00	3.85
SS0489	VACUTAINER WINGED BUTTERFLY 23G X 12"(TUBING) X 3/4"		1	6.90	6.90	0.00	6.90
SS6027	VASOFIX IV G20X33MM PINK I.V. CANNULA MADE OF FEP-TEFLON / PUR WITH INJECTION PORT (PINK) DIAMETER 1.0MM, LENGTH 33MM #4268113B / 4269110S-03		11	9.65	106.15	0.00	106.15
SS0259	YANKAUER SUCTION WITH OPEN TIP CROWN HEAD WITH VENT STERILE 20CM		2	4.50	9.00	0.00	9.00
04	**RADIOLOGY MATERIALS**				**327.50**	**0.00**	**327.50**
XR0424	WUXI YUSHOU MULTIPACK (NE-SHORT Y) (2 X 200ML SYRINGE +		1	132.75	132.75	0.00	132.75

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	J-TUBE + SPIKE, Y ADAPTOR WITH 2 CHECK VALVE AND 150CM COILED TUBING) #300200B						
XR0382	XENETIC 350 100ML, GUERBET (CT SCAN CONTRAST)		1	194.75	194.75	0.00	194.75
D0001	**PHARMACY SUPPLIES**				**340.70**	**0.00**	**340.70**
DI7005	COMBIVENT INHALATION		24	11.80	283.20	0.00	283.20
DST8122	NACL INJ 0.9% (UP TO 10ML)		12	2.50	30.00	0.00	30.00
DSZ9901	Sterile Water For Inj (10mL)		25	1.10	27.50	0.00	27.50
S01	**ACCOMMODATION**				**902.50**	**90.25**	**812.25**
AC0116	Four Bedded Room		9	85.50	855.00	85.50	769.50
ACH0116	Four Bedded Room: Half Day		1	42.75	47.50	4.75	42.75
S02	**LABORATORY SERVICES**				**1,334.94**	**0.00**	**1,334.94**
LM7204	BLOOD CULTURE (AEROBIC AND ANAEROBIC)		1	85.00	85.00	0.00	85.00
LC8276	BUSE		2	46.00	92.00	0.00	92.00
LS6325	C REACTIVE PROTEIN (CRP)		3	60.32	180.96	0.00	180.96
LT2201	CERVICAL SMEAR/VAULT SMEAR		1	33.00	33.00	0.00	33.00
LM7205	CULTURE AND SENTIVITY (PUS,CSF,URINE,SPUTUM ETC)		1	59.50	59.50	0.00	59.50
LP8236	DIABETES MONITORING PROFILE (DMP)		1	44.00	44.00	0.00	44.00
LT3208	ERYTHROCYTE SEDIMENTATION RATE (ESR)		1	11.50	11.50	0.00	11.50
LT3235	FULL BLOOD COUNT (FBC)		2	31.36	62.72	0.00	62.72
LC8203	GLUCOSE FASTING/RANDOM		1	17.00	17.00	0.00	17.00
LP0212	LIPID PROFILE (P12)		1	50.50	50.50	0.00	50.50
LP0201	LIVER FUNCTION TEST (LFT)		2	55.63	111.26	0.00	111.26
LP0515	RENAL FUNCTION TEST C		2	61.00	122.00	0.00	122.00
LS6446	RESPIRATORY TRACT INFECTION (6 IN 1) TEST		1	146.00	146.00	0.00	146.00
LT2221	TRUCUT/SMALL BIOPSIES		1	91.50	91.50	0.00	91.50
LP0406	TUMOR MARKER PANEL FEMALE (TMF)		1	228.00	228.00	0.00	228.00
S03	**RADIOLOGY SERVICES**				**592.00**	**0.00**	**592.00**
XR2260	CT SCAN SURCHARGE		1	60.00	60.00	0.00	60.00
CT0006	CT Scan: Abdomen/Pelvis: Pelvis - pre & post contrast		1	309.00	309.00	0.00	309.00

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CODE	DESCRIPTION	DATE	QTY	UNIT PRICE	AMOUNT	DISCOUNT	TOTAL
XR2259	GENERAL XRAY SURCHARGE		1	15.00	15.00	0.00	15.00
XR0862	ULTRASOUND: ABDOMEN/PELVIS: ABDOMEN & PELVIS		1	125.00	125.00	0.00	125.00
XR0801	X-RAY: THORAX: CHEST		2	41.50	83.00	0.00	83.00
S030	**OPERATING THEATRE SERVICES & INSTRUMENTS**				**22.00**	**0.00**	**22.00**
OX0011	OT GASES- OXYGEN		2	11.00	22.00	0.00	22.00
S04_15	**PROCEDURE FEES**				**98.00**	**0.00**	**98.00**
MF0017	HP CHARGES: INTRAVENOUS DRIP (BY M/O)		7	14.00	98.00	0.00	98.00
S05	**OPERATING THEATRE FEES**				**50.00**	**0.00**	**50.00**
OT0014	USE OF RECOVERY ROOM		1	50.00	50.00	0.00	50.00
S17	**HOSPITAL FEES & CHARGES**				**35.00**	**0.00**	**35.00**
MF0233	CLINICAL WASTE DISPOSAL		1	35.00	35.00	0.00	35.00
S19	**MEDICAL OFFICER CONSULTATION FEES**				**152.50**	**0.00**	**152.50**
WR0001	ED PATIENT VISIT OFFICE HOURS		2	21.25	42.50	0.00	42.50
WR0004	HP: MO REVIEW PATIENT AM		5	22.00	110.00	0.00	110.00
S29	**DAY SURGERY UNIT CHARGES**				**1,190.00**	**0.00**	**1,190.00**
EDSU1317	Endoscopy charges - Minor - 1 mins till 30 mins		2	135.00	270.00	0.00	270.00
EDSU2004	Endoscopy Report		2	30.00	60.00	0.00	60.00
EDSU2005	SCOPE FACILITY CHARGES		2	30.00	60.00	0.00	60.00
OEV0061	Video Colonoscope		1	400.00	400.00	0.00	400.00
OEV0052	Video Gastroscope		1	400.00	400.00	0.00	400.00
S38	**ADMINISTRATIVE FEE**				**25.00**	**0.00**	**25.00**
RF1005	ADMISSION FEE		1	20.00	20.00	0.00	20.00
RF1019	REGISTRATION FEES		1	5.00	5.00	0.00	5.00
S41	**NURSING PROCEDURE**				**895.00**	**0.00**	**895.00**
MF0208	Nursing Procedure - Pap Smear		1	15.00	15.00	0.00	15.00
MF0023	NURSING SERVICE (H)		10	80.00	800.00	0.00	800.00

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MF0213	Toilet Bath		4	20.00	80.00	0.00	80.00
S42	**EQUIPMENT CHARGES**				**1,293.89**	**0.00**	**1,293.89**
SB9331	BLOOD GLUCOSE TEST		31	9.70	300.70	0.00	300.70
SQ9859	IV Infusion Pump		10	28.44	284.40	0.00	284.40
SQ9851	NIBP (PER DAY) - OBSERVATION		10	50.00	500.00	0.00	500.00
SQ5016	P.V.Speculum		1	7.61	7.61	0.00	7.61
SQ9876	Peak flow meter		26	1.98	51.48	0.00	51.48
SQ9860	Pulse Oximeter		2	19.85	39.70	0.00	39.70
EC0001	Resting 12 lead ECG		1	35.00	35.00	0.00	35.00
EC0114	ULTRASOUND BY CONSULTANT IN SS - NEW CASES		1	75.00	75.00	0.00	75.00
S43	**MEDICAL SUPPLIES**				**97.26**	**0.00**	**97.26**
MS0037	ALCOHOL SWABS (PER PC)		40	0.10	4.00	0.00	4.00
MS0150	DISPOSABLE GOWN APRON PVC		4	0.45	1.80	0.00	1.80
MS0013	LATEX EXAMINATION GLOVE (XS/S/M/L/XL) (PER PC)		100	0.40	40.00	0.00	40.00
MS0147	Micropore 3" Tape (per metre)		3	2.00	6.00	0.00	6.00
MS9999	MISCELLANEOUS - OTHERS		1	2.00	2.00	0.00	2.00
MS0015	SYRINGE 10CC WITH NEEDLE		30	1.22	36.60	0.00	36.60
MS0023	SYRINGE 5CC WITH NEEDLE		7	0.98	6.86	0.00	6.86
TOTAL HOSPITAL CHARGES (RM):					**12,870.19**	**90.25**	**12,779.94**

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COLLECTION ON BEHALF OF DOCTORS							
DATO SRI DR SURESH RAJ LACHMANAN (2005-2500006127)							**4,028.00**
S40	**INDEPENDENT DOCTOR - COLLECTION ON BEHALF**				**445.00**	**0.00**	**445.00**
CF0026	SPECIALIST FEE - FIRST/INITIAL CONSULTATION (DAY / WORKING HOURS) (WARD): A1	09/08/2025	1	235.00	235.00	0.00	235.00
CF0029	SPECIALIST FEE - FOLLOW UP VISIT DURING CLINIC HOUR (CLINIC): A1	09/08/2025	1	105.00	105.00	0.00	105.00
CF0024	SPECIALIST FEE - WARD ROUND (DAY / WORKING HOURS) (WARD): A1	09/08/2025	1	105.00	105.00	0.00	105.00
S40	**INDEPENDENT DOCTOR - COLLECTION ON BEHALF**				**314.00**	**0.00**	**314.00**
CF0025	SPECIALIST FEE - WARD ROUND (HOLIDAY / SUNDAY / NIGHT) (WARD): A1	10/08/2025	2	157.00	314.00	0.00	314.00
S40	**INDEPENDENT DOCTOR - COLLECTION ON BEHALF**				**210.00**	**0.00**	**210.00**
CF0024	SPECIALIST FEE - WARD ROUND (DAY / WORKING HOURS) (WARD): A1	11/08/2025	2	105.00	210.00	0.00	210.00
S40	**INDEPENDENT DOCTOR - COLLECTION ON BEHALF**				**210.00**	**0.00**	**210.00**
CF0024	SPECIALIST FEE - WARD ROUND (DAY / WORKING HOURS) (WARD): A1	12/08/2025	2	105.00	210.00	0.00	210.00
S40	**INDEPENDENT DOCTOR - COLLECTION ON BEHALF**				**210.00**	**0.00**	**210.00**
CF0024	SPECIALIST FEE - WARD ROUND (DAY / WORKING HOURS) (WARD): A1	13/08/2025	2	105.00	210.00	0.00	210.00
S40	**INDEPENDENT DOCTOR - COLLECTION ON BEHALF**				**615.00**	**0.00**	**615.00**
VG6500	DIAGNOSTIC OESOPHAGO-GASTRO-DUODENOSCOPY INCLUDING BIOPSY: 100%	14/08/2025	1	405.00	405.00	0.00	405.00
CF0024	SPECIALIST FEE - WARD ROUND (DAY / WORKING HOURS) (WARD): A1	14/08/2025	2	105.00	210.00	0.00	210.00
S40	**INDEPENDENT DOCTOR - COLLECTION ON BEHALF**				**210.00**	**0.00**	**210.00**
CF0024	SPECIALIST FEE - WARD ROUND (DAY / WORKING HOURS) (WARD): A1	15/08/2025	2	105.00	210.00	0.00	210.00
S40	**INDEPENDENT DOCTOR - COLLECTION ON BEHALF**				**1,210.00**	**0.00**	**1,210.00**
VH2000	FIBREOPTIC COLONOSCOPY +/- EXCISION BIOPSY/DESTRUCTION OF LESION: 100%	16/08/2025	1	1,000.00	1,000.00	0.00	1,000.00
CF0024	SPECIALIST FEE - WARD ROUND (DAY / WORKING HOURS)	16/08/2025	2	105.00	210.00	0.00	210.00

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Jalan Templer, 46990 PJ, Selangor Darul Ehsan
Tel : +603 7872 3000 Fax : +603 7781 4933 www.assunta.com.my

Assunta
Heart & Art of Care

INVOICE

PAYOR: 3121
TENAGA NASIONAL BERHAD

KETUA (TNB HEALTHCARE), BAHAGIAN TENAGA GLOBAL BUSINESS SOLUTION,
TENAGA NASIONAL BERHAD, ARAS 9, BANGUNAN WARISAN TNB,
NO : 129, JALAN BANGSAR,
59200, KUALA LUMPUR , WILAYAH PERSEKUTUAN, MALAYSIA.

SERVICE RECIPIENT

Patient Name : NAGAMMAL A/P M GOVINDAN
Patient Mailing Address : 709 JALAN MEDAN 30
TAMAN BUANA PERDANA
46000, PETALING JAYA, SELANGOR, MALAYSIA.
IC No / Passport : 540721085858
MRN : 00303562

Invoice No : S-250117361
Date : 19/08/2025 01:38 PM
Billed By : balqis.roslan
Visit Type : INPATIENT
Visit ID : A25008926
Admission Date / Time : 09/08/2025 12:55 PM
Discharge Date / Time : 18/08/2025 03:11 PM
Admitting Doc : DATO SRI DR SURESH RAJ LACHMANAN
Bed Type : MAR / MAR-4301-4 / 4 Bedded - (RM95/day)
GL Ref No : -
Policy No : -

CODE	DESCRIPTION	DATE	QTY	UNIT PRICE	AMOUNT	DISCOUNT	TOTAL
	(WARD): A1						
S40	**INDEPENDENT DOCTOR - COLLECTION ON BEHALF**				**314.00**	**0.00**	**314.00**
CF0025	SPECIALIST FEE - WARD ROUND (HOLIDAY / SUNDAY / NIGHT) (WARD): A1	17/08/2025	2	157.00	314.00	0.00	314.00
S40	**INDEPENDENT DOCTOR - COLLECTION ON BEHALF**				**290.00**	**0.00**	**290.00**
PF0049	DOCTOR'S READING FEE - ECG (BY CONSULTANTS)	18/08/2025	1	80.00	80.00	0.00	80.00
CF0024	SPECIALIST FEE - WARD ROUND (DAY / WORKING HOURS) (WARD): A1	18/08/2025	2	105.00	210.00	0.00	210.00
DR. CHIN MUN KIN (11326-2500001522)							**10.00**
S04_15	**PROCEDURE FEES**				**4.00**	**0.00**	**4.00**
MFF0017	MO CHARGES: INTRAVENEOUS DRIP/VENEPUNCTURE/VENESECTION (ORDER SET: INTRAVENOUS DRIP (BY M/O))	10/08/2025	1	4.00	4.00	0.00	4.00
S19	**MEDICAL OFFICER CONSULTATION FEES**				**6.00**	**0.00**	**6.00**
WRF0004	MO CHARGES: MO VISIT (ORDER SET: MO VISIT)	10/08/2025	1	6.00	6.00	0.00	6.00
DR. FAUZAH ABD GHANI (3212-2500000587)							**125.00**
S40	**INDEPENDENT DOCTOR - COLLECTION ON BEHALF**				**125.00**	**0.00**	**125.00**
LPF121	Professional Fee: Trucut/Small Bx	16/08/2025	1	125.00	125.00	0.00	125.00
DR. FOO CHEW YING (3233-2500006976)							**115.00**
S40	**INDEPENDENT DOCTOR - COLLECTION ON BEHALF**				**115.00**	**0.00**	**115.00**
XRF0862	Radiologist Fee - Ultrasound: Abdomen/Pelvis: Abdomen & Pelvis	15/08/2025	1	115.00	115.00	0.00	115.00
DR. JULIA MUNCHAR BTE MUNCHAR JAJULI (3132-2500001379)							**35.00**
S40	**INDEPENDENT DOCTOR - COLLECTION ON BEHALF**				**35.00**	**0.00**	**35.00**
LPF106	Professional Fee: Cervical Or Vaginal Smear Pap Smear	15/08/2025	1	35.00	35.00	0.00	35.00
DR. KISHOKANTH A/L SUBRAMANIAN (900362-2500002636)							**20.00**
S04_15	**PROCEDURE FEES**				**8.00**	**0.00**	**8.00**
MFF0017	MO CHARGES: INTRAVENEOUS DRIP/VENEPUNCTURE/VENESECTION (ORDER SET: INTRAVENOUS DRIP (BY M/O))	15/08/2025	1	4.00	4.00	0.00	4.00

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Jalan Templer, 46990 PJ, Selangor Darul Ehsan
Tel : +603 7872 3000 Fax : +603 7781 4933 www.assunta.com.my

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PAYOR: 3121
TENAGA NASIONAL BERHAD
KETUA (TNB HEALTHCARE), BAHAGIAN TENAGA GLOBAL BUSINESS SOLUTION,
TENAGA NASIONAL BERHAD, ARAS 9, BANGUNAN WARISAN TNB,
NO : 129, JALAN BANGSAR,
59200, KUALA LUMPUR , WILAYAH PERSEKUTUAN, MALAYSIA.

SERVICE RECIPIENT

Patient Name : NAGAMMAL A/P M GOVINDAN
Patient Mailing Address : 709 JALAN MEDAN 30
TAMAN BUANA PERDANA
46000, PETALING JAYA, SELANGOR, MALAYSIA.
IC No / Passport : 540721085858
MRN : 00303562

Invoice No : S-250117361
Date : 19/08/2025 01:38 PM
Billed By : balqis.roslan
Visit Type : INPATIENT
Visit ID : A25008926
Admission Date / Time : 09/08/2025 12:55 PM
Discharge Date / Time : 18/08/2025 03:11 PM
Admitting Doc : DATO SRI DR SURESH RAJ LACHMANAN
Bed Type : MAR / MAR-4301-4 / 4 Bedded - (RM95/day)
GL Ref No : -
Policy No : -

CODE	DESCRIPTION	DATE	QTY	UNIT PRICE	AMOUNT	DISCOUNT	TOTAL
MFF0017	MO CHARGES: INTRAVENEOUS DRIP/VENEPUNCTURE/VENESECTION (ORDER SET: INTRAVENOUS DRIP (BY M/O))	15/08/2025	1	4.00	4.00	0.00	4.00
S19	**MEDICAL OFFICER CONSULTATION FEES**				**12.00**	**0.00**	**12.00**
WRF0004	MO CHARGES: MO VISIT (ORDER SET: MO VISIT)	15/08/2025	1	6.00	6.00	0.00	6.00
WRF0004	MO CHARGES: MO VISIT (ORDER SET: MO VISIT)	15/08/2025	1	6.00	6.00	0.00	6.00
DR. LIEW FAH ONN (2008-2500000573)							**345.00**
S40	**INDEPENDENT DOCTOR - COLLECTION ON BEHALF**				**345.00**	**0.00**	**345.00**
PF0121	Doctor Procedure - Ultrasound in SC - new cases	15/08/2025	1	30.00	30.00	0.00	30.00
PF0127	PAP SMEAR PROCEDURE BY GYNAECOLOGIST	15/08/2025	1	80.00	80.00	0.00	80.00
CF0026	SPECIALIST FEE - FIRST/INITIAL CONSULTATION (DAY / WORKING HOURS) (WARD): A1	15/08/2025	1	235.00	235.00	0.00	235.00
DR. MOHD FARIQ BIN MOHD YUSOF (3251-2500006564)							**275.25**
S40	**INDEPENDENT DOCTOR - COLLECTION ON BEHALF**				**13.50**	**0.00**	**13.50**
XRF0801	Radiologist Fee - X-Ray: Thorax: Chest	11/08/2025	1	13.50	13.50	0.00	13.50
S40	**INDEPENDENT DOCTOR - COLLECTION ON BEHALF**				**322.00**	**80.50**	**241.50**
CTF0006	Radiologist Fee - CT Scan: Abdomen/Pelvis: Pelvis - pre & post contrast	15/08/2025	1	161.00	161.00	0.00	161.00
CTF0006	Radiologist Fee - CT Scan: Abdomen/Pelvis: Pelvis - pre & post contrast (ONCALL CHARGES)	15/08/2025	1	80.50	161.00	80.50	80.50
S40	**INDEPENDENT DOCTOR - COLLECTION ON BEHALF**				**27.00**	**6.75**	**20.25**
XRF0801	Radiologist Fee - X-Ray: Thorax: Chest	18/08/2025	1	13.50	13.50	0.00	13.50
XRF0801	Radiologist Fee - X-Ray: Thorax: Chest (ONCALL CHARGES)	18/08/2025	1	6.75	13.50	6.75	6.75
DR. NOR AZAH BINTI MOHAMAD JAMIL (900370-2500002151)							**20.00**
S04_15	**PROCEDURE FEES**				**4.00**	**0.00**	**4.00**
MFF0017	MO CHARGES: INTRAVENEOUS DRIP/VENEPUNCTURE/VENESECTION (ORDER SET: INTRAVENOUS DRIP (BY M/O))	09/08/2025	1	4.00	4.00	0.00	4.00
S19	**MEDICAL OFFICER CONSULTATION FEES**				**6.00**	**0.00**	**6.00**
WRF0001	MO CHARGES: OFFICE HOURS (ORDER SET: MO FEES OFFICE HOURS)	09/08/2025	1	6.00	6.00	0.00	6.00

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PAYOR: 3121
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TENAGA NASIONAL BERHAD, ARAS 9, BANGUNAN WARISAN TNB,
NO : 129, JALAN BANGSAR,
59200, KUALA LUMPUR , WILAYAH PERSEKUTUAN, MALAYSIA.

SERVICE RECIPIENT

Patient Name : NAGAMMAL A/P M GOVINDAN
Patient Mailing Address : 709 JALAN MEDAN 30
TAMAN BUANA PERDANA
46000, PETALING JAYA, SELANGOR, MALAYSIA.
IC No / Passport : 540721085858
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Invoice No : S-250117361
Date : 19/08/2025 01:38 PM
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Visit Type : INPATIENT
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Admitting Doc : DATO SRI DR SURESH RAJ LACHMANAN
Bed Type : MAR / MAR-4301-4 / 4 Bedded - (RM95/day)
GL Ref No : -
Policy No : -

CODE	DESCRIPTION	DATE	QTY	UNIT PRICE	AMOUNT	DISCOUNT	TOTAL
S04_15	**PROCEDURE FEES**				**4.00**	**0.00**	**4.00**
MFF0017	MO CHARGES: INTRAVENEOUS DRIP/VENEPUNCTURE/VENESECTION (ORDER SET: INTRAVENOUS DRIP (BY M/O))	17/08/2025	1	4.00	4.00	0.00	4.00
S19	**MEDICAL OFFICER CONSULTATION FEES**				**6.00**	**0.00**	**6.00**
WRF0001	MO CHARGES: OFFICE HOURS (ORDER SET: MO FEES OFFICE HOURS)	17/08/2025	1	6.00	6.00	0.00	6.00
DR. RAHAEL MATHEWS (900385-2500002080)							**10.00**
S04_15	**PROCEDURE FEES**				**4.00**	**0.00**	**4.00**
MFF0017	MO CHARGES: INTRAVENEOUS DRIP/VENEPUNCTURE/VENESECTION (ORDER SET: INTRAVENOUS DRIP (BY M/O))	11/08/2025	1	4.00	4.00	0.00	4.00
S19	**MEDICAL OFFICER CONSULTATION FEES**				**6.00**	**0.00**	**6.00**
WRF0004	MO CHARGES: MO VISIT (ORDER SET: MO VISIT)	11/08/2025	1	6.00	6.00	0.00	6.00
DR. ZUZAILA BINTI IBRAHIM (9174-2500001968)							**10.00**
S04_15	**PROCEDURE FEES**				**4.00**	**0.00**	**4.00**
MFF0017	MO CHARGES: INTRAVENEOUS DRIP/VENEPUNCTURE/VENESECTION (ORDER SET: INTRAVENOUS DRIP (BY M/O))	13/08/2025	1	4.00	4.00	0.00	4.00
S19	**MEDICAL OFFICER CONSULTATION FEES**				**6.00**	**0.00**	**6.00**
WRF0004	MO CHARGES: MO VISIT (ORDER SET: MO VISIT)	13/08/2025	1	6.00	6.00	0.00	6.00
TOTAL COLLECTION ON BEHALF OF DOCTORS:					**5,080.50**	**87.25**	**4,993.25**
ROUND OFF (RM):							0.01
TOTAL INVOICE FOR THIS BILL (RM):							**17,773.20**

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Tel : +603 7872 3000 Fax : +603 7781 4933 www.assunta.com.my

PAYMENT SUMMARY

Invoice No : S-250117361

Date : 19/08/2025 01:38 PM

PAYOR: 3121

TENAGA NASIONAL BERHAD

KETUA (TNB HEALTHCARE), BAHAGIAN TENAGA GLOBAL BUSINESS SOLUTION,
TENAGA NASIONAL BERHAD, ARAS 9, BANGUNAN WARISAN TNB,
NO : 129, JALAN BANGSAR,
59200, KUALA LUMPUR , WILAYAH PERSEKUTUAN, MALAYSIA.

SERVICE RECIPIENT

Patient Name : NAGAMMAL A/P M GOVINDAN

Patient Address : NO 18 JALAN SJ 7,
TAMAN SELAYANG JAYA,
68100, BATU CAVES, SELANGOR, MALAYSIA.

IC No / Passport : 540721085858

MRN : 00303562

DATE	DOC.TYPE	DOCUMENT NO	DESCRIPTION	AMOUNT (RM)
19/08/2025 01:38 PM	INV	S-250117361	Invoice Charges	17,773.20
OUTSTANDING BALANCE PAYABLE :				**17,773.20**

User: **BALQIS BINTI ROSLAN**
Printed on: 19/08/2025 01:38 PM

Tenaga Nasional Berhad (200866-W)
Bahagian TNB Global Business Solutions,
Tenaga Nasional Berhad,
Aras 9 Bangunan Warisan TNB,
No. 129 Jalan Bangsar,
59200 Kuala Lumpur.

Tel : 1300-80-5656
Fax : 1300-22-5656
General Enquiry: tnbhealthcare@tnb.com.my
GL Request: gl@tnb.com.my

FINAL GUARANTEE LETTER APPROVED

Patient Name	NAGAMMAL A/P GOVINDAN	**Claim Reference No.**	9783033
Patient NRIC	540721085858	**Admission Code**	783037
Employee Name	NADARAJAN A/L VENOGOBAL	**Print Date & Time**	19/08/2025 06:13:59
Employee NRIC	510105075245	**Bill No**	413006
Employee No	10034375	**Admission Date**	09/08/2025
Relationship	WIFE	**Discharge Date**	18/08/2025
Length of Stay	9.5	**No. of Days (ICU)**	0.0
Hospital	ASSUNTA HOSPITAL		

Description	Incurred (MYR)	Approved (MYR)	Non-Payable (MYR)
ROOM AND BOARD DAILY (RM),	812.25	812.25	0.00
HOSPITAL MISCELLANEOUS SERVICES,	11,652.70	11,313.43	339.27
IN-HOSPITAL PHYSICIAN FEES (RM),	2,862.50	2,862.50	0.00
SURGICAL FEES,	1,595.00	1,595.00	0.00
OPERATING THEATRE FEE,	1,190.00	1,190.00	0.00
Total	18,112.45	17,773.18	339.27

REMARKS :
Hospital to bear the following cost:

1)Multivitamin Inj: RM 253.80
2)Cetaphil moisturising lotion RM 85.47

(Do not collect from patient)

The amount guaranteed is not absolute and TENAGA NASIONAL BERHAD reserves the right to assess the final bill for payment in accordance to the agreed terms.

Enlisted are items where the hospital is allowed to charge:

i. Room & Board: Any excess can be collected with patients' prior consent (for ward admission).
ii. Uncovered procedures, medications, and items: To exclude from the Final Bill and charge separately upon prior consent from the patient.
iii. For Supplements apart from TNB Medical Guidelines: To obtain prior approval from TNB before dispensing and submit together with Final Bill.

For any appeals/inquiries: Please email to tnbhealthcare@tnb.com.my with valid justifications.
For any amended bills: Please send hardcopies of the bills directly to Claims Management Unit.

To enable prompt payment, please forward **HOSPITAL ADMISSION AND SURGERY FORM, MEDICAL SUMMARY FORM, FINAL GUARANTEE LETTER APPROVED,** which will be generated at time of discharge, and with your original bills to the following address within fourteen (14) days from the discharge date:

Claims Management Unit
TNB HealthCare
Tenaga Nasional Berhad (200866-W)
Aras 9 Bangunan Warisan TNB,
No. 129 Jalan Bangsar,
59200 Kuala Lumpur

Yours faithfully,

For and on behalf of
Tenaga Nasional Berhad

TNB HEALTHCARE CALL CENTRE

Authorised Signatory

Tenaga Nasional Berhad (200866-W)
Bahagian TNB Global Business Solutions,
Tenaga Nasional Berhad,
Aras 9 Bangunan Warisan TNB,
No. 129 Jalan Bangsar,
59200 Kuala Lumpur.

Tel : 1300-80-5656
Fax : 1300-22-5656
General Enquiry: tnbhealthcare@tnb.com.my
GL Request: gl@tnb.com.my

Patient Information:

Patient Name	: NAGAMMAL A/P GOVINDAN	Issued Date	: 09/08/2025
Patient NRIC	: 540721085858	Issued Time	: 12:13:57
Employee Name	: NADARAJAN A/L VENOGOBAL	Employee No	: 10034375
Employee NRIC	: 510105075245	Relationship	: WIFE

GUARANTEE LETTER REFERENCE NUMBER: 9783033

Date of Visit : 09/08/2025
Attention : DATO SRI SURESH RAJ LACHMANAN (PHYSICIAN AND GASTROENTEROLOGIST)
ASSUNTA HOSPITAL
JLN TEMPLER

Tel No : 0376807000
Fax No : 0377844415

Medical Service Requested : HOSPITALIZATION

Medical Condition: Other Sepsis

Hospital Room and Board 110.00 perday
Room and Board Inclusive of Meals and Nursing Care only
Initial GL limit: RM 2,500.00

MEDICAL PROVIDERS TO CALL TNB HEALTHCARE IF LIMIT IS INSUFFICIENT FOR INTERIM AND FINAL BILLS WITH CLEAR BREAKDOWN AND REASONS INDICATED

Expenses entitlement is only for or directly related to medical/surgical condition referred to the Medical Condition as per above mentioned.

TNB reserves the right not to honor payment for unnecessary admissions, services, investigations or treatment rendered.

TNB will not pay or be responsible for any expenses in excess of the above entitlement or incurred for non-entitlement as indicated above. The excess amount must be recovered by the hospital from the patient upon their discharge.

Payment of claim is subject to timely submission of complete documents, i.e. within 14 working days from date of services or discharge.

Hospital to complete the Pre-Admission Form (PAF) in full, including estimated total cost, as it is a medico-legal document.

This GL **DOES NOT COVER** the following services:

i. Supplements – Please refer to TNB Medical Guidelines dated June 2021.
ii. Birth Control & Infertility investigation or treatment; Circumcision; Cosmetic Surgery; Injuries due to illegal activities; Dental Care (except in injury cases); Refractive Error Treatment; Platelet-Rich Plasma; Robotic surgeries; Speech Therapy; Research Product/ Procedure.
iii. Referrals to other Specialists are not covered by this Guarantee Letter.

Medication: One month supply ONLY

Remarks :
Any Additional Procedure/Treatment Must Seek Approval From TNBHC In Advance

TNBHC Will Exclude All Charges/Fee By Consultants/Specialist Who Failed To Request Cross Referral From TNBHC After Consultation & Procedure Done After 48 Hours.

All Treatment Coverage Must Adhere To TNB Guidelines And Policies.

This Guarantee Letter should be activated within 14 days from date of issue

Yours faithfully,

For and on behalf of
Tenaga Nasional Berhad

TNB HEALTHCARE CALL CENTRE

Authorised Signatory

SCANNED
09 AUG 2025
ASSUNTA HOSPITAL
ADMISSION DEPARTMENT

Tenaga Nasional Berhad (200866-W)
Aras 9, Bangunan Warisan TNB,
No. 129 Jalan Bangsar,
59200 Kuala Lumpur

Tel: 1300-80-5656
Fax: 1300-22-5656
General Enquiry: tnbhealthcare@tnb.com
GL Request: gl@tnb.com.my

PRE-ADMISSION FORM / BORANG PRA-KEMASUKAN WAD

Private and Confidential/Sulit dan Persendirian

Part 1 (To be completed by patient)
Bahagian 1 (Untuk diisi oleh Pesakit)

1. Patient Name: *Nama Pesakit* Nagammal A/P M Govindan			2. NRIC (Old & New): *K.P. (Lama & Baru)* 540721 08 5285
3. a. Date of Birth: *Tarikh lahir* 21/7/1954.	b. Age: *Umur* 71	c. Sex: *Jantina*	☐Male *Laki-laki* ☑Female *Perempuan*
4. Employee/ Retiree Name: *Nama. Pekerja/Pesara:*	5. Employee No: *No. Pekerja:*		6. Admission / Planned Admission Date: *Tarikh kemasukan hospital*
7. Hospital Name: *Nama Hospital* Assunta Hospital			8. Name of Attending Doctor/ Speciality: *Nama Doktor yang merawat/ kepakaran:* Dr Liew

Admission Reason / Sebab Kemasukan. *Please tick (✓) and answer accordingly / Sila tanda (✓) dan jawab soalan yang berkenaan*

9. ☐ Accident *Kemalangan*	a. Occurred on: *Berlaku pada* Date ____/____/____ *Tarikh* Time _____ *Masa* ☐ am *pagi* ☐ pm *petang* b. Details of Accident: *Butir-butir kemalangan*
10. ☐ Illness *Penyakit*	a. Symptoms first appeared on: *Tarikh simptom tersebut bermula* Date ____/____/____ *Tarikh* b. Doctor(s) consulted for this condition: *Doktor-doktor yang dilawati bagi penyakit ini* c. Doctor's or Clinic Contact(Address & Telephone): *Alamat & Telefon Doktor*

Declaration and authorization

I declare that the answers given above are true and complete to the best of my knowledge and belief. I understand the delivery of this form is in no way an admission of TNB liability and payment to the hospital by TNB or its representative shall not be construed as final admission of TNB's liability and for this and any further claims arising, TNB reserves all rights for evaluation as appropriate. I am fully aware of the limits as to my medical benefit coverage under the above-mentioned benefit plan. I hereby undertake to settle/reimburse any medical expenses exceeding my entitlement under the said medical benefit plan, or that is not covered by the same. 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 condition, the TNB shall absolutely forfeit my right to compensation and further reserves the right to recover any amounts paid earlier as a result thereof.

I hereby consent for TNB to process my personal data including my sensitive personal data in accordance with the Personal Data Protection Act 2010, its subsidiary legislation and applicable personal data protection code of practice. In furtherance to the consent, I hereby authorize any party including any medical practitioner, medical institution, hospital, insurance company, company or individual, that has any record or knowledge of my medical information including and not limited to medical reports, medical records, background or medical history, treatment, advice or, other personal information or details of my medical condition, mental condition, physical condition and/ or related accident/injury, to disclose such information to TNB or its representative for the purpose of administration and execution of my employment contract with TNB including to obtain the medical benefit from TNB, as well as for other purpose(s) which is permissible under the laws. I also agree that TNB or its representative to use or disclose any of the information collected or held to third parties in relation to any of the above purpose(s). This consent and authorization shall bind my successors and beneficiaries and remain valid notwithstanding my death and/or incapacity in so far as legally possible. I also agree that my consent and authorization on a copy of this form is valid and binding as the original copy.

Pengisytiharan dan pemberikuasa

Saya memahami bahawa penyerahan borang ini, tidak sama sekali boleh dianggap sebagai pengakuan liabiliti TNB ke atas tuntutan saya dan saya bersetuju bahawa bayaran kepada hospital oleh TNB atau wakilnya tidak akan ditafsirkan sebagai pengakuan muktamad liabiliti TNB, dan TNB berhak menjalankan penilaian sewajarnya berhubung tuntutan ini atau apa-apa tuntutan yang timbul selanjutnya. Saya memahami sepenuhnya had-had kemudahan perubatan saya di bawah pelan yang tersebut di atas. Saya dengan ini berjanji akan menyelesaikan sebarang a maun yang melebihi had kelayakan saya, yang tidak dilindungi oleh kemudahan perubatan berkenaan. Saya bersetuju sekiranya saya membuat pengakuan palsu atau tidak mendedahkan maklumat yang berkaitan, TNB berhak membatalkan tuntutan saya dan menarik balik sebarang tuntutan awal yang telah dibayar.

Saya dengan ini memberikan persetujuan kepada TNB untuk memproses data peribadi saya termasuk data peribadi sensitif saya selaras dengan Akta Perlindungan Data Peribadi 2010, perundangan subsidiarinya dan tatacamalan perlindungan data peribadi yang terpakai. Lanjutan daripada persetujuan tersebut, saya dengan ini membenarkan mana-mana pihak termasuk mana-mana pengamal perubatan, institusi perubatan, hospital, syarikat insurans, syarikat atau individu, yang mempunyai sebarang rekod atau pengetahuan tentang maklumat perubatan saya termasuk dan tidak terhad kepada laporan perubatan, rekod perubatan, latar belakang atau sejarah perubatan, rawatan, nasihat atau maklumat peribadi lain atau butiran keadaan perubatan, keadaan mental, keadaan fizikal saya dan/ atau kemalangan/kecederaan yang berkaitan, untuk mendedahkan maklumat tersebut kepada TNB atau wakilnya bagi tujuan pentadbiran dan pelaksanaan kontrak pekerjaan saya dengan TNB termasuk untuk mendapatkan faedah perubatan daripada TNB, serta untuk tujuan mana-mana hal yang sah di sisi undang-undang. Saya juga bersetuju untuk TNB atau wakilnya menggunakan atau mendedahkan sebarang maklumat yang dikumpul atau dipegang kepada pihak ketiga yang berkaitan bagi mana-mana tujuan di atas. Persetujuan dan kebenaran ini adalah mengikat waris-waris dan benefisiari saya, dan kekal sah meskipun saya telah meninggal dunia dan/atau tidak berupaya setakat yang dibenarkan di sisi undang-undang. Saya juga bersetuju bahawa persetujuan dan kebenaran saya pada salinan borang ini adalah sah dan mengikat sebagaimana salinan asal.

Signature of Patient/ Guardian /*Tandatangan Pesakit/ Penjaga*	Signature of Employee/ Retiree / *Tandatangan Pekerja / Pesara*
x Nagammal Govindan	
Full Name/*Nama Penuh:*	Full Name/*Nama Penuh*:
IC No./*No. KP:*	IC No./*No. KP*:
Date/*Tarikh:*	Date/*Tarikh*:
Contact No / *No Telephone*:	Contact No / *No Telefon*:
	Relationship to Patient/ *Hubungan dengan Pesakit:*

NOTE: COMPLETION OF THIS PRE-ADMISSION FORM DOES NOT GUARANTEE THE ISSUANCE OF GUARANTEE LETTER.
NOTA: Melengkapkan borang Pra-Kemasukan Wad ini tidak semestinya menjamin bahawa Surat Jaminan akan dikeluarkan.

TENAGA NASIONAL BERHAD

Tenaga Nasional Berhad (200866-W)
Aras 9, Bangunan Warisan TNB,
No. 129 Jalan Bangsar,
59200 Kuala Lumpur

Tel: 1300-80-5656
Fax: 1300-22-5656
General Enquiry: tnbhealthcare@tnb.com.m
GL Request: gl@tnb.com.my

Part 2 ADMISSION SECTION ***(To be completed upon admission by Doctor)***

1.a. Patient name: Nagammal b. NRIC: 540710 08 5158 c. Age: 71 d. Sex: ☐ Male ☐ Female

2. Admission No. / MRN: 00303562

3. Hospital Contact and Fax No:

4. Admission Date and Time: 9/8/25.

5. Expected days of stay / Discharge Date: STILL IN

6. a. Symptoms / Conditions requiring admission: REFERRED FOR RIGHT OVARIAN CYST, THICKENED ENDOMETRIUM b. How long is patient aware of the condition:

c. Patient's BP/ Temp/ Pulse: NORMAL

d. Date symptoms first appeared: 27/5/2023 - CYST e. Date first consulted: 15/8/2025

7. 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 below: DATO'SRI DR SURESHRAJ LACHMANAN

c. If this condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed: UNKNOWN

Date	Disease / Disorder	Details of Treatment / Hospitalization	Doctor / Hospital/ Clinic

d. Can the condition be managed under the Outpatient basis? ~~Yes~~ ☐ No, If no, please provide reasons of admission:

e. Is this medical condition an EMERGENCY condition ~~Yes~~ ☐ No

8. a. ~~Admitting Diagnosis~~: RIGHT OVARIAN CYST → ULTRASOUND 15/8/2025
THICK ENDOMETRIUM b. ☐ Provisional Diagnosis

c. Diagnosis confirmed on 15/8/2025 or Advised patient on 15/8/2025

d. Cause and pathology underlying the present diagnosis: UNKNOWN

e. Any possibility of relapse? ~~Yes~~ ~~No~~

9. **Estimated Total Costs: RM**_____ ASK STAFF

10a. Admission requires:

~~☐ Hospitalisation~~
~~☐ Day Care~~
~~☐ On Patient's Request~~

11. Is the illness / condition related to: (please tick (☑) if YES) Please provide details:

a) ☐ Pregnancy / Childbirth / Infertility/ Caesarean section/ miscarriage or any complications rising therefrom
b) ☐ Congenital / Hereditary diseases
c) ☐ Influence of Drugs / Alcohol
d) ☐ Nervous / Mental / Emotional / Sleeping Disorder
e) ☐ Cosmetic reason / Dental care / refractive errors correction
f) ☐ AIDS / STD / VD/ HIV
g) ☐ Self-inflicted injuries / Violation of laws / Strike / Riots
h) ☑ None of the above

12. **Medical treatment, Investigations and Surgical procedure to be performed, if any (please supply copy of all investigation results):**
NEED CT SCAN OF PELVIS

13. Any other medical/surgical conditions present? ☐ No ☑ Yes, details below:

a. HYPERTENSION since __/__/2004
b. DIABETES MELLITUS since __/__/__

14. Was the patient pregnant at the time of Hospitalization? (For Female Only)

☑ No ~~Yes~~, _____ months

15. a. If hospitalization was due to injury, please describe circumstances and cause of injury:
NO

b. Please indicate date/time of accident: (dd/mm/yy) __/__/__ (hrs) _____ ☐ am ☐ pm

16. *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 me opinion of his/her condition.*

15/8/2024
Date

Name & Signature of Attending Doctor
DR's Contact no and Email addresss:

DR. LIEW FAH ONN
MBBS (Mal), MRCOG (UK)
LLB (Hons)(London), CLP (Mal)
MMC-Full Registration No. 23716
Consultant Obstetrician & Gynaecologist
Assunta Hospital
Doctor / Hospital (DR. CODE 2008)

TENAGA NASIONAL BERHAD

Tenaga Nasional Berhad (200866-W)
Aras 9, Bangunan Warisan TNB,
No. 129 Jalan Bangsar,
59200 Kuala Lumpur

Tel: 1300-80-5656
Fax: 1300-22-5656
General Enquiry: tnbhealthcare@tnb.com.m
GL Request: gl@tnb.com.my

DISCHARGE SECTION ***(To Be Completed Upon Discharge by Doctor)***

17. Undertaking Letter Ref No: (If available):

18. Date of Discharge: 18/8/2025

19. a. Final Diagnosis: RIGHT OVARIAN CYST

ICD code:

b. Cause and pathology of the diagnosis: UNKNOWN ?

20. Treatment given / investigation done: (Please supply copy of all investigation results). ① ULTRA-SOUND ② CT SCAN ABDOMEN / PELVIS

FOR SURGERY = SHE DECLINED

21. a. Surgical procedures performed: NIL

b. Date of surgery / procedure:

MMA code / PHFSR code

22. a. Recovery complication that arose (If any):
b. In the case of **DEATH**, please advise Date/ Time and Cause of death: NIL

23. *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.*

18/8/2025
Date

Name & Signature of Attending Doctor
MMC Registration No.

DR. LIEW [illegible] AH ONN
MBBS (Mal), MRCOG (UK)
Doctor [illegible] (London), CLP (Mal)
MMC-Full Registration No. 2371[illegible]
Consultant Obstetrician & Gynaecologist
Assunta Hospital
(DR. CODE 2008)

Tenaga Nasional Berhad (200866-W)
Aras 9, Bangunan Warisan TNB,
No. 129 Jalan Bangsar,
59200 Kuala Lumpur

Tel: 1300-80-5656
Fax: 1300-22-5656
General Enquiry: tnbhealthcare@tnb.com.my
GL Request: gl@tnb.com.my

PRE-ADMISSION FORM / BORANG PRA-KEMASUKAN WAD

Private and Confidential/Sulit dan Persendirian

Part 1 (To be completed by patient)
***Bahagian 1** (Untuk diisi oleh Pesakit)*

1. Patient Name: *Nama Pesakit* Nagammal A/P M gounden	2. NRIC (Old & New): *K.P. (Lama & Baru)* 540721085858
3. a. Date of Birth: *Tarikh lahir* 21-07-1954 b. Age: *Umur* 71 c. Sex: *Jantina*	☐Male *Laki-laki* ~~☐~~Female *Perempuan*
4. Employee/ Retiree Name: *Nama. Pekerja/Pesara:*	5. Employee No: *No. Pekerja:*
6. Admission / Planned Admission Date: *Tarikh kemasukan hospital* 09/08/2025	
7. Hospital Name: *Nama Hospital* Assunta Hospital	8. Name of Attending Doctor/ Speciality: *Nama Doktor yang merawat/ kepakaran:* Dato Sri Dr. Suresh Ear Ledmonan

Admission Reason / Sebab Kemasukan. ***Please tick (✓) and answer accordingly / Sila tanda (✓) dan jawab soalan yang berkenaan***

9. ☐ Accident *Kemalangan*	a. Occurred on: *Berlaku pada* Date ____/____/____ *Tarikh* Time _____ *Masa* ☐ am *pagi* ☐ pm *petang* b. Details of Accident: *Butir-butir kemalangan*
10. ☐ Illness *Penyakit*	a. Symptoms first appeared on: *Tarikh simptom tersebut bermula* Date ____/____/____ *Tarikh* b. Doctor(s) consulted for this condition: *Doktor-doktor yang dilawati bagi penyakit ini* c. Doctor's or Clinic Contact(Address & Telephone): *Alamat & Telefon Doktor*

Declaration and authorization

I declare that the answers given above are true and complete to the best of my knowledge and belief. I understand the delivery of this form is in no way an admission of TNB liability and payment to the hospital by TNB or its representative shall not be construed as final admission of TNB's liability and for this and any further claims arising, TNB reserves all rights for evaluation as appropriate. I am fully aware of the limits as to my medical benefit coverage under the above-mentioned benefit plan. I hereby undertake to settle/reimburse any medical expenses exceeding my entitlement under the said medical benefit plan, or that is not covered by the same. 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 condition, the TNB shall absolutely forfeit my right to compensation and further reserves the right to recover any amounts paid earlier as a result thereof.

I hereby consent for TNB to process my personal data including my sensitive personal data in accordance with the Personal Data Protection Act 2010, its subsidiary legislation and applicable personal data protection code of practice. In furtherance to the consent, I hereby authorize any party including any medical practitioner, medical institution, hospital, insurance company, company or individual, that has any record or knowledge of my medical information including and not limited to medical reports, medical records, background or medical history, treatment, advice or, other personal information or details of my medical condition, mental condition, physical condition and/ or related accident/injury, to disclose such information to TNB or its representative for the purpose of administration and execution of my employment contract with TNB including to obtain the medical benefit from TNB, as well as for other purpose(s) which is permissible under the laws. I also agree that TNB or its representative to use or disclose any of the information collected or held to third parties in relation to any of the above purpose(s). This consent and authorization shall bind my successors and beneficiaries and remain valid notwithstanding my death and/or incapacity in so far as legally possible. I also agree that my consent and authorization on a copy of this form is valid and binding as the original copy.

Pengisytiharan dan pemberikuasa

Saya memahami bahawa penyerahan borang ini, tidak sama sekali boleh dianggap sebagai pengakuan liabiliti TNB ke atas tuntutan saya dan saya bersetuju bahawa bayaran kepada hospital oleh TNB atau wakilnya tidak akan ditafsirkan sebagai pengakuan muktamad liabiliti TNB, dan TNB berhak menjalankan penilaian sewajarnya berhubung tuntutan ini atau apa-apa tuntutan yang timbul selanjutnya. Saya memahami sepenuhnya had-had kemudahan perubatan saya di bawah pelan yang tersebut di atas. Saya dengan ini berjanji akan menyelesaikan sebarang a maun yang melebihi had kelayakan saya, yang tidak dilindungi oleh kemudahan perubatan berkenaan. Saya bersetuju sekiranya saya membuat pengakuan palsu atau tidak mendedahkan maklumat yang berkaitan, TNB berhak membatalkan tuntutan saya dan menarik balik sebarang tuntutan awal yang telah dibayar.

Saya dengan ini memberikan persetujuan kepada TNB untuk memproses data peribadi saya termasuk data peribadi sensitif saya seloras dengan Akta Perlindungan Data Peribadi 2010, perundangan subsidiarinya dan tataamalan perlindungan data peribadi yang terpakai. Lanjutan daripada persetujuan tersebut, saya dengan ini membenarkan mana-mana pihak termasuk mana-mana pengamal perubatan, institusi perubatan, hospital, syarikat insurans, syarikat atau individu, yang mempunyai sebarang rekod atau pengetahuan tentang maklumat perubatan saya termasuk dan tidak terhad kepada laporan perubatan, rekod perubatan, latar belakang atau sejarah perubatan, rawatan, nasihat atau maklumat peribadi lain atau butiran keadaan perubatan, keadaan mental, keadaan fizikal saya dan/ atau kemalangan/kecederaan yang berkaitan, untuk mendedahkan maklumat tersebut kepada TNB atau wakilnya bagi tujuan pentadbiran dan pelaksanaan kontrak pekerjaan saya dengan TNB termasuk untuk mendapatkan faedah perubatan daripada TNB, serta untuk tujuan mana-mana hal yang sah di sisi undang-undang. Saya juga bersetuju untuk TNB atau wakilnya menggunakan atau mendedahkan sebarang maklumat yang dikumpul atau dipegang kepada pihak ketiga yang berkaitan bagi mana-mana tujuan di atas. Persetujuan dan kebenaran ini adalah mengikat waris-waris dan benefisiari saya, dan kekal sah meskipun saya telah meninggal dunia dan/atau tidak berupaya setakat yang dibenarkan di sisi undang-undang. Saya juga bersetuju bahawa persetujuan dan kebenaran saya pada salinan borang ini adalah sah dan mengikat sebagaimana salinan asal.

Signature of Patient/ Guardian /*Tandatangan Pesakit/ Penjaga* 9/8/25 Full Name/*Nama Penuh*: IC No./*No. KP*: Rafi Uddin Date/*Tarikh*: Contact No / *No Telephone*: 6011 8-06 4-5543	Signature of Employee/ Retiree / *Tandatangan Pekerja / Pesara* Full Name/*Nama Penuh*: IC No./*No. KP*: Date/*Tarikh*: Contact No / *No Telefon*: Relationship to Patient/ *Hubungan dengan Pesakit:*

NOTE: COMPLETION OF THIS PRE-ADMISSION FORM DOES NOT GUARANTEE THE ISSUANCE OF GUARANTEE LETTER.
NOTA: Melengkapkan borang Pra-Kemasukan Wad ini tidak semestinya menjamin bahawa Surat Jaminan akan dikeluarkan.

TENAGA NASIONAL BERHAD

Tenaga Nasional Berhad (200866-W)
Aras 9, Bangunan Warisan TNB,
No. 129 Jalan Bangsar,
59200 Kuala Lumpur

Tel: 1300-80-5656
Fax: 1300-22-5656
General Enquiry: tnbhealthcare@tnb.com.my
GL Request: gl@tnb.com.my

Part 2 ADMISSION SECTION ***(To be completed upon admission by Doctor)***

1.a. Patient name: naggmmal b. NRIC: 560721085858 c. Age: d. Sex: □ Male ☑ Female

2. Admission No. / MRN: 00303562

3. Hospital Contact and Fax No:

4. Admission Date and Time: 9/8/25

5. Expected days of stay / Discharge Date: few

6. a. Symptoms / Conditions requiring admission: Abdominal pain / indigestion / altered bowel / heartburn / [illegible]

b. How long is patient aware of the condition: 2/52

c. Patient's BP/ Temp/ Pulse:

d. Date symptoms first appeared: ___/___/___ 2/52 e. Date first consulted: 09/08/2025

7. 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 below: —

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	Details of Treatment / Hospitalization	Doctor / Hospital/ Clinic
		—	

d. Can the condition be managed under the Outpatient basis: □ Yes ☑ No. If no, please provide reasons of admission: Sepsis / chest infection

e. Is this medical condition an EMERGENCY condition ☑ Yes □ No

8. a. □Admitting Diagnosis: b. ☑ Provisional Diagnosis LRTI / sepsis / dyspepsia / GERD / [illegible]

c. Diagnosis confirmed on ___/___/___ or Advised patient on ___/___/___

d. Cause and pathology underlying the present diagnosis: infective

e. Any possibility of relapse? □Yes ☑No

9. Estimated Total Costs: RM 10,000 [illegible]

10a. Admission requires:
- ☑ **Hospitalisation**
- □ **Day Care**
- □ **On Patient's Request**

11. Is the illness / condition related to: (please tick (☑) if YES) — Please provide details:

a) □ Pregnancy / Childbirth / Infertility/ Caesarean section/ miscarriage or any complications rising therefrom
b) □ Congenital / Hereditary diseases
c) □ Influence of Drugs / Alcohol
d) □ Nervous / Mental / Emotional / Sleeping Disorder
e) □ Cosmetic reason / Dental care / refractive errors correction
f) □ AIDS / STD / VD/ HIV
g) □ Self-inflicted injuries / Violation of laws / Strike / Riots
h) ☑ None of the above

12. Medical treatment, Investigations and Surgical procedure to be performed, if any (please supply copy of all investigation results): Bloods / IV meds / IV [illegible] / [illegible] / CXR / IV meds / neb / oral meds

13. Any other medical/surgical conditions present? □ No ☑ Yes, details below: —
a. ___ since ___/___/___
b. ___ since ___/___/___

14. Was the patient pregnant at the time of Hospitalization? (For Female Only) □ No □ Yes, — months

15. a. If hospitalization was due to injury, please describe circumstances and cause of injury: —

b. Please indicate date/time of accident: (dd/mm/yy) ___/___/___ (hrs) ___ □ am □ pm

16. *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 med opinion of his/her condition.*

Date: 09/08/25

Name & Signature of Attending Doctor
DR's Contact no and Email addresss:

Doctor / Hospital Stamp:
DATO' PROF. DR. SURESH RAJ LACHMANAN
[illegible]
MBBS (Mal), MRCP [illegible]
RACGP (Aust) [illegible]
MBA (Aust), FAMM, FRCP (Edin), FRCP (Glasgow)
MMC [illegible]
Consultant Physician & Gastroenterologist
Assunta Hospital (7026-H)
(DR. CODE 2005)

TENAGA NASIONAL BERHAD

Tenaga Nasional Berhad (200866-W)
Aras 9, Bangunan Warisan TNB,
No. 129 Jalan Bangsar,
59200 Kuala Lumpur

Tel: 1300-80-5656
Fax: 1300-22-5656
General Enquiry: tnbhealthcare@tnb.com.my
GL Request: gl@tnb.com.my

DISCHARGE SECTION ***(To Be Completed Upon Discharge by Doctor)***

17. Undertaking Letter Ref No: (If available):

18. Date of Discharge: 18/ 08/ 2025

19. a. Final Diagnosis: [illegible handwriting] / Ovarian cyst

ICD code:

b. Cause and pathology of the diagnosis:

20. Treatment given / Investigation done: (Please supply copy of all investigation results). See [illegible] / [illegible] attach

21. a. Surgical procedures performed: —

MMA code / PHFSR code

b. Date of surgery / procedure:

22. a. Recovery complication that arose (if any):

b. In the case of **DEATH**, please advise Date/ Time and Cause of death: —

23. *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: 18/08/25

Name & Signature of Attending Doctor
MMC Registration No.

Doctor / Hospital Stamp
DATO' SRI DR. SURESH RAJ LACHMANAN D.S.P., D.K.S.D.