

TOKIO MARINE
INSURANCE GROUP

Claim Form / Borang Tuntutan

Medical Insurance

Information collected in this claim form shall be used in connection with the Company's purposes and course of business only. This form must be completed to avoid any delay in the settlement of claim.
Maklumat yang terdapat di dalam borang tuntutan ini hendaklah digunakan untuk tujuan dan menjalankan perniagaan Syarikat sahaja. Borang ini harus diisi dengan lengkap untuk mengelakkan sebarang kelewatan dalam penyelesaian tuntutan.

Part 1: Insured Person Information

Bahagian 1: Maklumat Orang Yang Diinsuranskan

Policy Number:
Nombor Polisi:

H0178386

Name of Insured Person:
Orang Yang Diinsuranskan:

Lau Loon Sin

NRIC/Passport No:
No KP/Pasport:

Telephone No:
No Telefon:

Company Name
Nama Syarikat

(if Insured is covered under a Group Policy):

(jika Orang Yang Diinsuranskan dilindungi di bawah Polisi Berkumpulan):

Part 2: Patient Information (If other than Insured)

Bahagian 2: Maklumat Pesakit (selain daripada Orang Yang Diinsuranskan)

Name of Patient:
Nama Pesakit:

Lau Loon Sin

Gender: ☒ Male ☐ Female
Jantina: ☒ Lelaki ☐ Perempuan

NRIC/ Passport/ BC:

No KP/ Pasport/ Sijil Kelahiran:

510516-02-5277

Date of Birth:

Tarikh Lahir:

16 05 1951

Relationship to Insured Person:

Hubungan Dengan Orang Yang Diinsuranskan:

Insured.

Part 3: Claim Details

Bahagian 3: Maklumat Tuntutan

Important Note:

Nota Penting:

- Certified true diagnosis is required for all claims amounting to RM500 and below.**
Diagnosis yang disahkan benar diperlukan untuk semua tuntutan berjumlah RM500 dan ke bawah.
- Detail itemized bill is required for incurred amount above RM100 in a single receipt / visitation.**
Bil terperinci diperlukan jika jumlah yang dibayar melebihi RM100 dalam satu resit/lawatan.
- For Death Claim, a copy of Death Certificate is required.
Untuk Tuntutan Kematian, salinan Sijil Kematian diperlukan.
- For Hospital Cash Allowance Claim, discharge summary/medical report of admission at Government Hospital is required.
Untuk Tuntutan Elaun Tunai Hospital, ringkasan discaj/laporan perubatan kemasukan ke Hospital Kerajaan diperlukan.
- For Group Policy only - Maternity and Outpatient claim (GP/SP/Optical/Dental (not due to accidental) and Medical Examination) kindly complete the **Outpatient Reimbursement Claim Form**.
Untuk Polisi Berkumpulan sahaja - Tuntutan Bersalin dan Pesakit Luar (GP/SP/Optikal/Pergigian (bukan disebabkan kemalangan) dan Pemeriksaan Perubatan) sila lengkapkan **Borang Tuntutan Bayaran Balik Pesakit Luar**.



Please (✓) Type of Claim and answer accordingly

Sila (✓) Jenis Tuntutan dan isi jawapan sewajarnya

☐ Pre & Post Hospitalisation / Follow up for Outpatient Accidental Injury/Dental Injury Treatment
Pra & Pos Kemasukan ke Hospital / Rawatan Susulan untuk Kecederaan Kemalangan/Kecederaan Gigi Pesakit Luar

☐ Outpatient Cancer Treatment / Outpatient Kidney Dialysis Treatment Claim
Tuntutan Rawatan Kanser Pesakit Luar / Rawatan Dialisis Buah Pinggang Pesakit Luar

Is this the first treatment or a continuous treatment?
Adakah ini rawatan pertama atau rawatan berterusan?

☐ First treatment
Rawatan Pertama

☐ Continuous treatment
Rawatan Berterusan

☐ Emergency Sickness Treatment
Rawatan Penyakit Kecemasan

Date of Visit

Tarikh Lawatan

D D M M Y Y Y Y

(b) Time of Visit

Waktu Lawatan

H H M M

☐ am ☐ pm

pagi petang

☒ New Claim - Hospitalisation / Daycare Surgery / Outpatient Accident Injury / Dental Injury / Hospital Cash Allowance / Death Claim
Tuntutan Baru - Kemasukan ke Hospital / Pembedahan / Kecelakaan Akibat Kemalangan Pesakit Luar / Kecelakaan Pergigian /
Elaun Tunai Hospital / Tuntutan Kematian

Is this new claim due to Accident?
Adakah ini tuntutan baru akibat kemalangan?

☐ Yes (Please complete Q1)
Ya (Sila isi Q1)

☒ No (Please complete Q2)
Tidak (Sila isi Q2)

Q1. Accident Details / Maklumat Kemalangan

a) Date

D	D	M	M	Y	Y	Y	Y		

 Time

H	H	M	M		

Tarikh Waktu

b) Date of first consultation with doctor/hospital:

D	D	M	M	Y	Y	Y	Y		

Tarikh rundingan pertama dengan doktor/hospital:

Clinic / Hospital Name

Nama Klinik / Hospital

c) Please describe briefly how the Accident happened and extent of injury (ies) sustained?
Sila terangkan secara ringkas bagaimana Kemalangan itu berlaku dan tahap kecederaan yang dialami

Q2. Illness Details/ Maklumat Penyakit

a) First treatment sought date

D	D	M	M	Y	Y	Y	Y		

Tarikh Rawatan Pertama Diterima

b) i. Name of first Doctor consulted Tan Chyang Soo
Nama Doktor perunding pertama

ii. Name & Address of Clinic / Hospital:
Nama dan Alamat Klinik / Hospital:

Northern Aest Hospital Penang

Part 4: Payee Information

Bahagian 4: Maklumat Penerima Bayaran

Claim Payment in Favor of? (Please specify name of payee)

Bayaran Tuntutan untuk? (Sila nyatakan nama penerima bayaran secara terperinci)

☐ Policy Owner: _____
Pemegang Polisi:

☐ Insured Person / Claimant:
Orang Yang Dilindungi/ Pembuat Tuntutan:

☒ Others (Please specify relationship): Lau Wei Soon (Son).
Lain-lain (Sila nyatakan hubungan):

Note: For first time payee (applicable to individual payee only), kindly complete the E-Payment Form to facilitate payment via E-Banking.
Nota: Untuk penerima bayaran kali pertama (khusus untuk penerima bayaran individu sahaja), sila lengkapkan Borang E-Pembayaran untuk memudahkan pembayaran melalui E-Banking.

Declaration and Authorisation To Physician, Clinic or Hospital

Pengisytiharan dan Kebenaran Kepada Pakar Perubatan, Klinik atau Hospital

By signing this Claim Form:

Dengan menandatangani Borang Tuntutan ini:

i) I/We hereby declare that the answers provided above are true and complete to the best of my/our knowledge and belief.
Saya/Kami dengan ini mengaku bahawa jawapan yang diberikan di atas adalah benar dan lengkap sepanjang pengetahuan dan kepercayaan saya/kami.

ii) I/We 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 disability, to fully disclose to TOKIO MARINE INSURANS (MALAYSIA) BERHAD or its authorized representative such information in relation to this claim.

Saya/Kami dengan ini memberi kuasa mutlak kepada mana-mana organisasi, institusi atau individu yang mempunyai apa-apa rekod atau pengetahuan tentang kesihatan saya dan sejarah perubatan atau rawatan atau nasihat yang telah atau mungkin selepas ini dirujuk, maklumat peribadi lain atau butiran ketidakupayaan yang berkaitan, untuk mendedahkan sepenuhnya kepada TOKIO MARINE INSURANS (MALAYSIA) BERHAD atau wakilnya yang diberi kuasa maklumat tersebut berhubung dengan tuntutan ini.

This authorization is irrevocable and a photocopy of it will have the same effect and validity as the original.

Kebenaran ini tidak boleh ditarik balik dan salinan fotokopi akan mempunyai kesan dan kesahihan yang sama seperti dokumen yang asal.

Acknowledgement & Declaration
Pengakuan & Pengisytiharan

Personal Data Protection Act 2010/ Akta Perlindungan Data Peribadi 2010

- i. I/We acknowledge and consent that the personal data, including any sensitive personal data, collected herein be used and processed for the purpose of this claim and be disclosed to reinsurers; individuals or organizations associated with Tokio Marine Group, or involve in any claim settlement; or PIAM/ISM
Saya/Kami mengaku dan bersetuju bahawa data peribadi, termasuk apa-apa data peribadi yang sensitif, yang dikumpulkan di sini digunakan dan diproses untuk tujuan cadangan ini dan dizahirkan kepada penanggung insurans individu atau pertubuhan yang berkaitan dengan Kumpulan Tokio Marine, atau terlibat dalam apa-apa penyelesaian tuntutan atau PIAM/ISM;
- ii. I/We confirm that I/we have obtained the consent of the person(s) and/or nominee(s) named herein, where applicable, and that he/she/they has/have authorized me/us to disclose their personal data and to give consent on their behalf for the above collection, use, process and disclosure
Saya/Kami mengesahkan bahawa saya/kami telah mendapat persetujuan orang yang dinamakan dan/atau penama yang dinamakan di sini, jika berkenaan, dan bahawa dia/mereka telah memberi kuasa kepada saya/kami untuk menzahirkan data peribadi dia/mereka dan untuk memberi kebenaran bagi pihak dia/mereka untuk pengumpulan, penggunaan, pemprosesan, dan penzahiran di atas;
- iii. I/We acknowledge that I/we am/are obligated to provide the above personal data failing which my/our claim could not be processed and that I/we am/are entitled to obtain access to, request for correction of or limit the processing of my/our personal data; and
Saya/Kami mengaku bahawa saya/kami adalah diwajibkan untuk memberikan data peribadi di atas, jika gagal berbuat demikian, cadangan saya/kami tidak dapat di proses, dan saya/kami berhak untuk mendapatkan akses kepada, meminta pembetulan atau mengehaskan pemprosesan data peribadi saya/kami; dan
- iv. I/We acknowledge the detail Privacy Policy Statement, governing the above, posted at www.tokiomarine.com and that I/we could also make enquiry with regard to the PDPA through email send to enquiry@tokiomarine.com.my
Saya/Kami mengaku Pernyataan Dasar Privasi terperinci, yang mengawal perkara yang tersebut di atas, yang dipaparkan di www.tokiomarine.com, bahawa Notis Privasi memaklumkan perkara di atas akan dihantar bersama-sama dengan polisi saya/kami, dan saya/kami juga boleh membuat pertanyaan berkenaan dengan PDPA melalui emel kepada enquiry@tokiomarine.com.my.

Declaration/ Pengisytiharan

I/We understand that it is my/our duty to take reasonable care not to make a misrepresentation in answering the questions in this Claim Form and I/we hereby declare that I/we have fully and accurately answered the questions above.

Saya/Kami faham bahawa menjadi tanggungjawab saya/kami untuk mengambil langkah yang munasabah untuk tidak salah nyata semasa menjawab soalan-soalan dalam Barang Tuntutan dan saya/kami dengan ini mengaku bahawa saya/kami telah menjawab dengan sepenuhnya dan dengan tepat soalan di atas.

Signature of Patient/Tandatangan Pesakit

(Note: Insured should sign if patient is a child below 18 years of age)

(Nota: Orang diinsuranskan harus menandatangani jika pesakit adalah kanak-kanak dibawah umur 18 tahun)

Name: Lau Leon Sin
Nama: Lau Leon Sin
NRIC: 510516025277
No KP: 510516025277
Date: 11/11/24
Tarikh: 11/11/24

Signature of Policy Owner

Tandatangan Pemegang Polisi

Name: Lau Leon Sin
Nama: Lau Leon Sin
Date: 11/11/24
Tarikh: 11/11/24

Company Stamp:
Cop Syarikat:

(Company Stamp is compulsory for Group Policy)
(Cop Syarikat adalah wajib untuk Polisi Berkumpulan)



Medical Report

(To be completed by Attending Physician / Surgeon)

TOKIO MARINE
INSURANCE GROUP

1. a. Patient's Name: Lau Lorn Sin b. Age: _____
c. NRIC: _____ d. Gender: ☐ Male ☐ Female

2. This report is regarding of patient's: ☒ Admission ☐ Day Care Surgery ☐ Others, please specify: _____

3. Admission Date and Time: 16/10/2024 (Time) _____ ☐ am ☐ pm
D D M M Y Y Y Y

4. Discharge Date and Time: _____ (Time) _____ ☐ am ☐ pm
D D M M Y Y Y Y

5. a. Symptoms / Conditions requiring admission: Chest pain
b. Patient's BP / Temp. / Pulse: 145/77, PR 62, T-36.7°C
c. How long is patient aware of the condition: 16/10/24
d. Date symptoms first appeared: 16/10/2024
U U M M Y Y Y Y
e. Date first consulted: 16/10/2024
D D M M Y Y Y Y

6. a. Any previous consultation / treatment / hospitalisation for this symptom / illness or related conditions, or other disorders whether in this hospital or any other facilities? ☐ Yes ☒ No
Name and Address of doctors previously consulted by the patient for the condition: _____

b. Was this patient referred to you? If yes, please provide details below: 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: 16/10/24

d. Can the condition be managed under the Outpatient basis: ☐ Yes ☒ No
If no, please provide reasons of admission: ICU / HDU care. PCZ

7. a. Final Diagnosis: Nm ST elevation myocardial infarction
b. Cause and pathology underlying the present diagnosis: atherosclerotic plaque rupture

c. Any possibility of relapse: ☒ Yes ☐ No
Is follow up required? ☐ Yes ☒ No

8. 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"/> Cosmetic Reason / Dental Care / Refractive Errors Correction
<input type="checkbox"/> Congenital / Hereditary Diseases	<input type="checkbox"/> AIDS / STD / VD / HIV
<input type="checkbox"/> Influence of Drugs / Alcohol	<input type="checkbox"/> Self-inflicted Injuries / Violation of Laws / Strike / Riots
<input type="checkbox"/> Nervous / Mental / Emotional / Sleeping Disorder	<input checked="" type="checkbox"/> None of the above

Please provide details: _____

9. a. Treatment given / investigation done (please supply copy of all investigation results):

MDU care. IV Nitrates. Blood: raised troponin T. ECHO.
416.

b. Surgical procedures performed: coronary artery / intravascular ultrasound / percutaneous coronary intervention

c. MMA code / PHFSR code: 37.22 / 00.22 / 00.66

d. Date of surgery / procedure: 11/7/10 2014
D D M M Y Y Y Y

10. Any other medical / surgical conditions present:

☒ Yes, details below ☐ No

a. ischemic heart disease - PLZ by Dr Gan HW, Gleneagles 2019
b. Hypertension - 2019 ↓ Dr Gan

11. a. Was the patient pregnant at the time of hospitalisation? (For Female only)

☐ Yes, _____ months ☐ No

b. Was the illness caused directly or indirectly by pregnancy/child birth/caesarian section/
abortion miscarriage and all complications arising therefrom?

☐ Yes, details below ☐ No

12. a. If hospitalisation was due to injury, please describe circumstances and cause of injury:

☐ Yes, details below ☒ No

b. Please indicate date/time of accident: _____ (Time) _____ ☐ am ☐ pm
D D M M Y Y Y Y


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

NIL

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

24/10/20

Date


Name & Signature of Attending Doctor



DR TAN CHIANG SOO
CONSULTANT CARDIOLOGIST
MBBS (Hons) (Aus), MRCP (UK), FAMS Cardiology (Singapore),
FSCAI (USA)
MMC No.: 29901 NSR No.: 123676
NORTHERN HEART HOSPITAL PENANG

Doctor / Hospital Stamp

INVOICE-DETAIL

PAYOR

LAU LOON SIN
B11, JALAN CEMARA 12,
TAMAN CEMARA,
ALOR SETAR, KEDAH,
05050, ALOR SETAR, KEDAH, MALAYSIA.

SERVICE RECIPIENT

Patient Name : LAU LOON SIN
Patient Mailing : B11, JALAN CEMARA 12,
Address TAMAN CEMARA,
ALOR SETAR, KEDAH,
05050, ALOR SETAR, KEDAH, MALAYSIA.

IC No / Passport : 510516025277

MRN : 2405100

Invoice No : S-240008106
Date : 17/10/2024 11:25 AM
Billed By : therasa.premi
Visit Type : INPATIENT
Visit ID : A24000520
Admission Date / Time : 16/10/2024 02:28 PM
Discharge Date / Time : 17/10/2024 10:37 AM
Admitting Doc : DR TAN CHIANG SOO
Bed Type : HDU / HDU 5 / -
GL Ref No : -
Policy No : -

DATE	DESCRIPTION	QTY	UOM	UNIT PRICE	AMOUNT	DISCOUNT	TOTAL
HOSPITAL CHARGES							
	ADMINISTRATIVE CHARGE				30.00	0.00	30.00
16/10/2024	IP REGISTRATION	1	EACH	30.00	30.00	0.00	30.00
	CATHLAB				4,550.00	0.00	4,550.00
16/10/2024	CATHLAB EQUIPMENTS B	2	HOURL	1,200.00	2,400.00	0.00	2,400.00
16/10/2024	CATHLAB ROOM CHARGES B	2	HOURL	1,000.00	2,000.00	0.00	2,000.00
16/10/2024	HEMODYNAMIC MONITORING	1	EACH	150.00	150.00	0.00	150.00
	CATHLAB				859.84	0.00	859.84
17/10/2024	DISPOSABLE TR CLOSURE BAND (S), SM-TB-S-TP	1	EACH	106.40	106.40	0.00	106.40
17/10/2024	HAEMOSTATIC VALVE SET, Y CLICK, AA-HV-7CPLCR-TB	1	EACH	204.00	204.00	0.00	204.00
17/10/2024	INTRODUCER II RADIAL SHEATH, 6 Fr x 10cm, RM-RF6F10PQ	1	EACH	288.00	288.00	0.00	288.00
17/10/2024	MANIFOLD 3 CORE RIGHT ON, BMN 3RN	1	EACH	55.44	55.44	0.00	55.44
17/10/2024	TERUMO RADIFOCUS OPTITORQUE BRACHIAL TYPE (TIG) CATHETERS (DIAGNOSTIC CATHETER), 5FR X 100CM	1	EACH	206.00	206.00	0.00	206.00
	DIETETICS				80.00	0.00	80.00
17/10/2024	MEDICAL NUTRITION CONSULTATION_INITIAL	1	EACH	80.00	80.00	0.00	80.00
	EQUIPMENT CHARGES				285.00	0.00	285.00
16/10/2024	ICU/HDU MONITOR	1	EACH	250.00	250.00	0.00	250.00
16/10/2024	SYRINGE PUMP	1	EACH	35.00	35.00	0.00	35.00
	EQUIPMENT CHARGES				390.00	0.00	390.00
17/10/2024	ICU/HDU MONITOR	1	EACH	250.00	250.00	0.00	250.00
17/10/2024	SYRINGE PUMP	4	EACH	35.00	140.00	0.00	140.00
	LABORATORY				842.00	0.00	842.00
16/10/2024	ABG TESTING	1	EACH	132.00	132.00	0.00	132.00
16/10/2024	CARDIAC ENZYMES	1	EACH	134.00	134.00	0.00	134.00

NORTHERN HEART HOSPITAL PENANG
Peel Healthcare Sdn Bhd
201601001986 (1172912-P)
No. 2, Lebuhraya Peel, 10350 Georgetown,
Penang, Malaysia.

PRINT DATE/TIME/USER : 17/10/2024 11:25:28 THERASA.PREMI

INVOICE-DETAIL

PAYOR : LAU LOON SIN

Invoice No : S-240008106

DATE	DESCRIPTION	QTY	UOM	UNIT PRICE	AMOUNT	DISCOUNT	TOTAL
16/10/2024	CARDIAC SCREENING 4 MALE	1	EACH	378.00	378.00	0.00	378.00
16/10/2024	TROPONIN T	1	EACH	198.00	198.00	0.00	198.00
	MEDICAL & SURGICAL SUPPLIES				475.20	0.00	475.20
16/10/2024	10ML SYRINGE LUER LOCK	2	PIECE	2.60	5.20	0.00	5.20
16/10/2024	3M TEGADERM I.V. ADVANCED SECUREMENT	1	EACH	6.30	6.30	0.00	6.30
16/10/2024	3M TEGADERM I.V. ADVANCED SECUREMENT	1	EACH	6.30	6.30	0.00	6.30
16/10/2024	3M TEGADERM I.V. ADVANCED SECUREMENT	1	EACH	6.30	6.30	0.00	6.30
16/10/2024	3ML SYRINGE LUER LOCK	2	PIECE	1.80	3.60	0.00	3.60
16/10/2024	50ML SYRINGE LUER LOCK	1	PIECE	8.00	8.00	0.00	8.00
16/10/2024	9680 SINGLE USE BLADE ASSEMBLY FOR 9681	1	PIECE	52.00	52.00	0.00	52.00
16/10/2024	CD AND PHOTO IMAGE	1	EACH	30.00	30.00	0.00	30.00
16/10/2024	CLINICAL WASTE DISPOSAL - IP	1	EACH	35.00	35.00	0.00	35.00
16/10/2024	CLINICAL WASTE DISPOSAL-PROCEDURE MAJOR	1	EACH	80.00	80.00	0.00	80.00
16/10/2024	COMBIDYN PVC PRESS. TUBING TRANSP. 200CM 1.0 X 2.0MM	1	PIECE	17.80	17.80	0.00	17.80
16/10/2024	COTTON BALLS 0.5GM (S) 10'S SP	1	PACK	1.80	1.80	0.00	1.80
16/10/2024	DRIHEP A-LINE, SLIP TIP, 1ML	1	PIECE	6.50	6.50	0.00	6.50
16/10/2024	ECG ELECTRODE, ADULT	10	EACH	1.20	12.00	0.00	12.00
16/10/2024	ECG ELECTRODE, ADULT	15	EACH	1.20	18.00	0.00	18.00
16/10/2024	EXAMINATION NITRILE POWDER FREE GLOVES, BLUE (5 PAIRS)	1	EACH	5.00	5.00	0.00	5.00
16/10/2024	MEDICAL SUPPLIES - CATHLAB	1	EACH	40.00	40.00	0.00	40.00
16/10/2024	MEDICAL SUPPLIES A	2	EACH	12.00	24.00	0.00	24.00
16/10/2024	PERFUSOR LINE, PVC, LL, 150CM	1	PIECE	8.00	8.00	0.00	8.00
16/10/2024	SAFEFLOW VALVE BBRAUN #409100H	1	PIECE	11.90	11.90	0.00	11.90
16/10/2024	SAFEFLOW VALVE BBRAUN #409100H	1	PIECE	11.90	11.90	0.00	11.90
16/10/2024	STERICAN NEEDLE G20 X 1 1/2"	3	PIECE	0.60	1.80	0.00	1.80
16/10/2024	STERILE GAUZE SWABS 10X10CMX16PLY (5S), GS(S)-10.10.16(5)	1	EACH	7.50	7.50	0.00	7.50
16/10/2024	UNISEX URINAL 1000ML	1	PIECE	23.80	23.80	0.00	23.80
16/10/2024	VASOF.SAFETY FEP 18G,1.25 IN.,1.3X33MM-AP	1	PIECE	10.50	10.50	0.00	10.50
16/10/2024	VASOF.SAFETY FEP 20G,1.25 IN.,1.1X33MM-AP	2	PIECE	10.50	21.00	0.00	21.00
16/10/2024	VASOF.SAFETY FEP 20G,1.25 IN.,1.1X33MM-AP	1	PIECE	10.50	10.50	0.00	10.50
16/10/2024	VASOF.SAFETY FEP 22G,1 IN.,0.9X25MM-AP	1	PIECE	10.50	10.50	0.00	10.50
	MEDICAL & SURGICAL SUPPLIES				949.80	0.00	949.80
17/10/2024	10ML SYRINGE LUER LOCK	1	PIECE	2.60	2.60	0.00	2.60
17/10/2024	ADHESIVE OP-TOWEL 75X75CM 35'S	1	EACH	17.80	17.80	0.00	17.80
17/10/2024	ANSELL GAMMEX P/FREE LATEX SURGICAL GLOVE SIZE 7.0	2	PAIR	7.90	15.80	0.00	15.80
17/10/2024	CLINICAL WASTE DISPOSAL - IP	1	EACH	35.00	35.00	0.00	35.00
17/10/2024	DISPOSABLE HYGIENE SHEET, 80CMX180CM, CARTON OF 10BAGS	1	PIECE	11.00	11.00	0.00	11.00
17/10/2024	DISPOSABLE UNDERPADS, 76CMX76CM, CARTON OF 10BAGS	1	PIECE	6.30	6.30	0.00	6.30
17/10/2024	DISPOSABLE UNDERPADS, 76CMX76CM, CARTON OF 10BAGS	1	PIECE	6.30	6.30	0.00	6.30
17/10/2024	ECG ELECTRODE, ADULT	10	EACH	1.20	12.00	0.00	12.00
17/10/2024	ECG ELECTRODE, ADULT	10	EACH	1.20	12.00	0.00	12.00
17/10/2024	EXAMINATION NITRILE POWDER FREE GLOVES, BLUE (5 PAIRS)	5	EACH	5.00	25.00	0.00	25.00

INVOICE-DETAIL

PAYOR : LAU LOON SIN
Invoice No : S-240008106

DATE	DESCRIPTION	QTY	UOM	UNIT PRICE	AMOUNT	DISCOUNT	TOTAL
17/10/2024	EXAMINATION NITRILE POWDER FREE GLOVES, BLUE (5 PAIRS)	1	EACH	5.00	5.00	0.00	5.00
17/10/2024	HI-MEDITAPE PLASTER, WATERPROOF, 860061	2	EACH	0.40	0.80	0.00	0.80
17/10/2024	HI-MEDITAPE PLASTER, WATERPROOF, 860061	2	EACH	0.40	0.80	0.00	0.80
17/10/2024	HYPAFIX - PER USE (10CM)	1	EACH	3.50	3.50	0.00	3.50
17/10/2024	INTRAFIX PRIMELINE I.S. TYP BASIC	1	PIECE	6.50	6.50	0.00	6.50
17/10/2024	INTRAFIX PRIMELINE I.S. TYP BASIC	1	PIECE	6.50	6.50	0.00	6.50
17/10/2024	PENANG NORTHERN HEART EP PACK/ANGIOKIT	1	PIECE	649.00	649.00	0.00	649.00
17/10/2024	PILLOWCASE AAAA, 18.5 X 30	1	PIECE	6.60	6.60	0.00	6.60
17/10/2024	SINGLE PRESSURE TRANSDUCER	1	PIECE	123.80	123.80	0.00	123.80
17/10/2024	TENSOPLAST - PER USE (10CM)	1	EACH	3.50	3.50	0.00	3.50
	MEDICAL & SURGICAL SUPPLIES (c)				20,435.00	0.00	20,435.00
16/10/2024	BALLOON (EMERGE 3.00 X 12MM)	1	EACH	10.00	10.00	0.00	10.00
16/10/2024	BALLOON (NC EMERGE 3.50 X 12MM)	1	EACH	10.00	10.00	0.00	10.00
16/10/2024	BALLOON (NC EMERGE 3.75 X 12MM)	1	EACH	10.00	10.00	0.00	10.00
16/10/2024	CATHLAB CONSIGNMENT (AGENT 3.50 X 30MM)	1	EACH	4,500.00	4,500.00	0.00	4,500.00
16/10/2024	CATHLAB CONSIGNMENT (OPTICROSS HD)	1	EACH	6,000.00	6,000.00	0.00	6,000.00
16/10/2024	CATHLAB CONSIGNMENT (SLED BAG)	1	EACH	10.00	10.00	0.00	10.00
16/10/2024	CATHLAB CONSIGNMENT (SION BLACK)	1	EACH	855.00	855.00	0.00	855.00
16/10/2024	DES PKG 1S SYNERGY - BOSTON (SYNERGY 3.50 X 20MM)	1	EACH	9,000.00	9,000.00	0.00	9,000.00
16/10/2024	GUIDEWIRE 0.014 (MARVEL)	1	EACH	10.00	10.00	0.00	10.00
16/10/2024	GUIDEWIRE 0.035 (STARTER WIRE)	1	EACH	10.00	10.00	0.00	10.00
16/10/2024	GUIDING (MACH1 CLS3.5 6F)	1	EACH	10.00	10.00	0.00	10.00
16/10/2024	INFLATOR (ENCORE 26)	1	EACH	10.00	10.00	0.00	10.00
	MEDICAL OFFICER FEE				100.00	0.00	100.00
16/10/2024	MO - IV LINE INSERTION	1	EACH	50.00	50.00	0.00	50.00
16/10/2024	MO Consultation [Office Hrs]	1	EACH	50.00	50.00	0.00	50.00
	NON INVASIVE CARDIAC LAB				305.00	0.00	305.00
16/10/2024	ELECTROCARDIOGRAM (ECG) (16056 - SP Diagnostic)	1	EACH	45.00	45.00	0.00	45.00
16/10/2024	TRANSTHORACIC ECHOCARDIOGRAM (TTE)	1	EACH	260.00	260.00	0.00	260.00
	NON INVASIVE CARDIAC LAB				45.00	0.00	45.00
17/10/2024	ELECTROCARDIOGRAM (ECG) (16103 - SP Diagnostic)	1	EACH	45.00	45.00	0.00	45.00
	NURSING SERVICES				403.00	0.00	403.00
16/10/2024	NURSING CARE INTERMEDIATE	1	PER DAY	180.00	180.00	0.00	180.00
16/10/2024	NURSING PROCEDURE - CATHLAB	1	EACH	208.00	208.00	0.00	208.00
16/10/2024	SHEATH REMOVAL	1	EACH	15.00	15.00	0.00	15.00
	NURSING SERVICES				180.00	0.00	180.00
17/10/2024	NURSING CARE INTERMEDIATE	1	PER DAY	180.00	180.00	0.00	180.00
	PHARMACY				325.91	0.00	325.91
16/10/2024	ALCOHOL SWAB (ISOPROPYL ALCOHOL) 100S OTC	10	PIECE	0.80	8.00	0.00	8.00

INVOICE-DETAIL

PAYOR : LAU LOON SIN

Invoice No : S-240008106

DATE	DESCRIPTION	QTY	UOM	UNIT PRICE	AMOUNT	DISCOUNT	TOTAL
16/10/2024	ALCOHOL SWAB (ISOPROPYL ALCOHOL) 100S OTC	1	PIECE	0.80	0.80	0.00	0.80
16/10/2024	ALCOHOL SWAB (ISOPROPYL ALCOHOL) 100S OTC	10	PIECE	0.80	8.00	0.00	8.00
16/10/2024	ALCOHOL SWAB (ISOPROPYL ALCOHOL) 100S OTC	3	PIECE	0.80	2.40	0.00	2.40
16/10/2024	APO-ALLOPURINOL 300MG TABLET (ALLOPURINOL) 500S B	1	TABLET	0.85	0.85	0.00	0.85
16/10/2024	BRAUNOL 10% SOLUTION (POVIDONE IODINE) 100ML NP	1	ORIGINAL PACK	15.65	15.65	0.00	15.65
16/10/2024	BRILINTA 90MG TABLET (TICAGRELOR) 168S B	2	TABLET	8.60	17.20	0.00	17.20
16/10/2024	BRILINTA 90MG TABLET (TICAGRELOR) 168S B	1	TABLET	8.60	8.60	0.00	8.60
16/10/2024	CARDIPRIN 100MG TABLET (ASPIRIN) 90S NP	1	TABLET	1.14	1.14	0.00	1.14
16/10/2024	CONCOR 2.5MG TABLET (BISOPROLOL FUMARATE) 100S B	1	TABLET	2.50	2.50	0.00	2.50
16/10/2024	GLYCERYL TRINITRATE 10MG/10ML INJECTION [HAMELN] 10S C	1	AMPOULE	38.00	38.00	0.00	38.00
16/10/2024	GLYCERYL TRINITRATE 10MG/10ML INJECTION [HAMELN] 10S C	1	AMPOULE	38.00	38.00	0.00	38.00
16/10/2024	INJECSOL LIG 2% PF INJECTION (LIGNOCAINE) 5ML 20S B	1	AMPOULE	5.85	5.85	0.00	5.85
16/10/2024	ISOCOR 5MG/2ML INJECTION (VERAPAMIL) 10S B	1	AMPOULE	39.60	39.60	0.00	39.60
16/10/2024	METOCLOPRAMIDE 10MG/2ML INJECTION [HAMELN] 10S B	1	AMPOULE	11.90	11.90	0.00	11.90
16/10/2024	MORPHINE 10MG/ML INJECTION [HAMELN] 10S PS	1	AMPOULE	11.50	11.50	0.00	11.50
16/10/2024	NORMAL SALINE 0.9% INJECTION [B BRAUN] 10ML 20S NP	5	AMPOULE	2.60	13.00	0.00	13.00
16/10/2024	OMNIFLUSH NORMAL SALINE 0.9% PRE-FILLED SYRINGE 10ML 100S NP	3	PRE-FILLED SYRINGE	6.85	20.55	0.00	20.55
16/10/2024	OMNIFLUSH NORMAL SALINE 0.9% PRE-FILLED SYRINGE 10ML 100S NP	1	PRE-FILLED SYRINGE	6.85	6.85	0.00	6.85
16/10/2024	OMNIFLUSH NORMAL SALINE 0.9% PRE-FILLED SYRINGE 10ML 100S NP	1	PRE-FILLED SYRINGE	6.85	6.85	0.00	6.85
16/10/2024	RACSER 5% CREAM (LIGNOCAINE) 5G C	1	TUBE	23.20	23.20	0.00	23.20
16/10/2024	RANEXA 375MG TABLET (RANOLAZINE) 60S B	1	TABLET	6.35	6.35	0.00	6.35
16/10/2024	RANEXA 375MG TABLET (RANOLAZINE) 60S B	1	TABLET	6.35	6.35	0.00	6.35
16/10/2024	UNIHEPA 25,000 IU/5ML INJECTION (HEPARIN NA) 10S B	1	VIAL	23.45	23.45	0.00	23.45
16/10/2024	VASTAREL MR 35MG TABLET (TRIMETAZIDINE) 60S C	1	TABLET	2.86	2.86	0.00	2.86
16/10/2024	VASTAREL MR 35MG TABLET (TRIMETAZIDINE) 60S C	1	TABLET	2.86	2.86	0.00	2.86
16/10/2024	ZETEZE 10MG TABLET (EZETIMIBE) 28S B	2	TABLET	1.80	3.60	0.00	3.60
	PHARMACY				1,569.40	0.00	1,569.40
17/10/2024	APO-ALLOPURINOL 300MG TABLET (ALLOPURINOL) 500S B (TTO)	30	TABLET	0.85	25.50	0.00	25.50 X
17/10/2024	BRILINTA 90MG TABLET (TICAGRELOR) 168S B (TTO)	60	TABLET	8.60	516.00	0.00	516.00 ✓
17/10/2024	CARDIPRIN 100MG TABLET (ASPIRIN) 90S NP (TTO)	30	TABLET	1.14	34.20	0.00	34.20 ✓
17/10/2024	CONCOR 2.5MG TABLET (BISOPROLOL FUMARATE) 100S B (TTO)	30	TABLET	2.50	75.00	0.00	75.00 ✓
17/10/2024	CONTROLOC 40MG TABLET (PANTOPRAZOLE) 14S B (TTO)	30	TABLET	9.55	286.50	0.00	286.50 ✓
17/10/2024	CONTROLOC 40MG TABLET (PANTOPRAZOLE) 14S B	1	TABLET	9.55	9.55	0.00	9.55
17/10/2024	INFLUVAC TETRA 0.5ML PRE-FILLED SYRINGE (INFLUENZA VACCINE) 1S B	1	PRE-FILLED SYRINGE	59.20	59.20	0.00	59.20 X
17/10/2024	NITROSOL 400MCG GTN SPRAY (GLYCERYL TRINITRATE) 200D C (TTO)	1	ORIGINAL PACK	78.05	78.05	0.00	78.05 ✓
17/10/2024	NORMAL SALINE 0.9% INJECTION [BAXTER] 500ML 18S NP (BAG)	4	BAG	16.05	64.20	0.00	64.20
17/10/2024	TULIP 40MG TABLET (ATORVASTATIN) 30S B (TTO)	30	TABLET	1.70	51.00	0.00	51.00 ✓
17/10/2024	ULTRAVIST 370MG/ML INJECTION (IOPROMIDE) 100ML 10S B	2	ORIGINAL	158.10	316.20	0.00	316.20

INVOICE-DETAIL

PAYOR : LAU LOON SIN

Invoice No : S-240008106

DATE	DESCRIPTION	QTY	UOM	UNIT PRICE	AMOUNT	DISCOUNT	TOTAL
			PACK				
17/10/2024	ZETEZE 10MG TABLET (EZETIMIBE) 28S B (TTO)	30	TABLET	1.80	54.00	0.00	54.00
	PHYSIOTHERAPY				77.00	0.00	77.00
17/10/2024	PHYSIOTHERAPY CONSULTATION	1	EACH	77.00	77.00	0.00	77.00
	RADIOLOGY				80.00	0.00	80.00
16/10/2024	XRAY CHEST PORTABLE	1	EACH	80.00	80.00	0.00	80.00
	ROOM & BOARD				280.00	0.00	280.00
16/10/2024	HIGH DEPENDENCY UNIT (HDU) - BAY	1	EACH	280.00	280.00	0.00	280.00
TOTAL HOSPITAL CHARGES:					32,262.15	0.00	32,262.15
COLLECTION ON BEHALF OF DOCTORS							
DR TAN CHIANG SOO (DTCS24002126)							7,370.00
	CONSULTANT CHARGES				7,235.00	0.00	7,235.00
16/10/2024	ADULT CARDIAC CATHETERISATION INCLUDING CORONARY ARTERIOGRAPHY/CATHETERISATION OF RIGHT/LEFT SIDE OF HEART/CONTRAST RADIOLOGY: 50% (K6510/TX110)	1	EACH	670.00	670.00	0.00	670.00
16/10/2024	ELECTROCARDIOGRAM (ECG) - PROFEE (16056 - SD Item)	1	EACH	30.00	30.00	0.00	30.00
16/10/2024	INTRAVASCULAR ULTRASOUND (IVUS), NOT INCLUDING ADJUNCTIVE PROCEDURES: 50% (XR1360)	1	EACH	670.00	670.00	0.00	670.00
16/10/2024	LOCAL SEDATION: 100%	1	EACH	125.00	125.00	0.00	125.00
16/10/2024	PERCUTANEOUS TRANSLUMINAL ANGIOPLASTY OF CORONARY ARTERIES INCLUDING LASER: 50% (K4900/TX097)	1	EACH	1,447.50	1,447.50	0.00	1,447.50
16/10/2024	PERCUTANEOUS TRANSLUMINAL ANGIOPLASTY WITH STENT INSERTION: 100% (K4910/TX098)	1	EACH	3,600.00	3,600.00	0.00	3,600.00
16/10/2024	SPECIALIST FIRST CONSULTATION/ ADMISSION CONSULTATION: 100% (20012)	1	EACH	235.00	235.00	0.00	235.00
16/10/2024	SPECIALIST WARD ROUND - EMERGENCY, AFTER STIPULATED CLINIC HOURS, SUNDAY & PUBLIC HOLIDAY: 100% (20042)	1	EACH	157.50	157.50	0.00	157.50
16/10/2024	TRANSTHORACIC ECHOCARDIOGRAM (TTE) - PROFEE: 100%	1	EACH	300.00	300.00	0.00	300.00
	CONSULTANT CHARGES				135.00	0.00	135.00
17/10/2024	ELECTROCARDIOGRAM (ECG) - PROFEE (16103 - SD Item)	1	EACH	30.00	30.00	0.00	30.00
17/10/2024	SPECIALIST WARD ROUND: 100% (20032)	1	EACH	105.00	105.00	0.00	105.00
TOTAL COLLECTION ON BEHALF OF DOCTORS:					7,370.00	0.00	7,370.00
ROUND OFF (RM):							0.00
TOTAL INVOICE FOR THIS BILL (RM):							39,632.15
REMARKS :							

Note:

This is a computer-generated document, no signature is required.
All payments to be payable to PEEL HEALTHCARE SDN BHD.
We reserve the right to bill you any omitted charges in due course.

NORTHERN HEART HOSPITAL PENANG
Peel Healthcare Sdn Bhd
201601001986 (1172912-P)
No. 2, Lebuhraya Peel, 10350 Georgetown,
Penang, Malaysia.

PAYMENT SUMMARY

Invoice No : S-240008106
Date : 17/10/2024 11:25 AM

PAYOR

LAU LOON SIN

B11, JALAN CEMARA 12,
TAMAN CEMARA,
ALOR SETAR, KEDAH,
05050, ALOR SETAR, KEDAH, MALAYSIA.

SERVICE RECIPIENT

Patient Name : LAU LOON SIN

Patient Address : B11, JALAN CEMARA 12,
TAMAN CEMARA,
ALOR SETAR, KEDAH,
05050, ALOR SETAR, KEDAH, MALAYSIA.

IC No / Passport : 510516025277

MRN : 2405100

DATE	DOC.TYPE	DOCUMENT NO	DEBTOR	DESCRIPTION	AMOUNT (RM)
17/10/2024 11:25 AM	RCP	R-2400009068		Receipt (DEPOSIT: LAU LOON SIN D-2400002186)	(10,000.00)
17/10/2024 11:25 AM	INV	S-240008106		Invoice Charges	39,632.15
OUTSTANDING BALANCE PAYABLE :					29,632.15

Balance Deposit

DATE	DOC.TYPE	DOCUMENT NO	DESCRIPTION	AMOUNT (RM)
16/10/2024 01:46 PM	DEP	D-2400002186	Deposit	10,000.00
17/10/2024 11:25 AM	RCP	R-2400009068	Payment for bill S-240008106 (visit no: A24000520)	(10,000.00)
				<u>0.00</u>

ORIGINALOFFICIAL RECEIPT**Received From :**LAU LOON SIN
B11, JALAN CEMARA 12
TAMAN CEMARA ALOR SETAR, KEDAH
05050 ALOR SETAR
KEDAH MALAYSIA**Printed On** : 17/10/2024
Receipt No : B-2400009073
Receipt Date/Time : 17/10/2024 11:53 AM
MRN : 2405100
Cashier ID : DURGAASHINIPayment Details**Payor** : LAU LOON SIN
Amount of : RINGGIT MALAYSIA TWENTY NINE THOUSAND SIX HUNDRED THIRTY TWO AND FIFTEEN CENTS ONLY
Being : PAYMENT RECEIVED - THANK YOU
Remarks : -
Paid By : CREDIT CARD
Amount : RM 29,632.15
Bank : CIMB CREDIT CARD
Card Type : VISA
Card No : **** * 0378
Card Expiry Date : 11/30
Approval Code : 023681INVOICES APPLIED

Invoice ID	Invoice Date	Visit ID	Patient Name	Amount
S-240008106	17/10/2024	A24000520	LAU LOON SIN	RM29,632.15

NORTHERN HEART HOSPITAL PENANG
Peel Healthcare Sdn Bhd
201601001986 (1172912-P)
No. 2, Lebuhraya Peel, 10350 Georgetown,
Penang, Malaysia.**Note:**This is a computer-generated document, no signature is required.
All payments to be payable to PEEL HEALTHCARE SDN BHD.
We reserve the right to bill you any omitted charges in due course.

Print date/time/user : 17/10/2024 11:53 Durgaashini A/P Ram Kumar

ORIGINALOFFICIAL RECEIPT**Received From :**

LAU LOON SIN

B11, JALAN CEMARA 12

TAMAN CEMARA ALOR SETAR, KEDAH

05050 ALOR SETAR

KEDAH MALAYSIA

Printed On : 17/10/2024**Receipt No** : R-2400009068**Receipt Date/Time** : 17/10/2024 11:25 AM**MRN** : 2405100**Cashier ID** : THERASA.PREMIPayment Details**Payor** : LAU LOON SIN**Amount of** : RINGGIT MALAYSIA TEN THOUSAND ONLY**Being** : PAYMENT RECEIVED - THANK YOU**Remarks** : -**Paid By** : DEPOSIT**Amount** : RM 10,000.00**Deposit Utilized** : D-2400002186INVOICES APPLIED

Invoice ID	Invoice Date	Visit ID	Patient Name	Amount
S-240008106	17/10/2024	A24000520	LAU LOON SIN	RM10,000.00

NORTHERN HEART HOSPITAL PENANG

Peel Healthcare Sdn Bhd

201601001986 (1172912-P)

No. 2, Lebuhraya Peel, 10350 Georgetown,
Penang, Malaysia.**Note:**

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Print date/time/user : 17/10/2024 11:44 Therasa Premi

LAU LOON SIN

MRN : 2405100

IC/PP : 510518025277

AGE/SEX : 73Y 5M 0D(M)

DOCTOR :

DR TAN CHIANG SOO

DOB

16/05/1951

VISIT NO : A24000520

DATE/TIME : 16/10/2024 (14:28)

WARD/BED : HDU / HDU 5

NORTHERN

HEART HOSPITAL PENANG

CARDIAC CATHETERIZATION & ANGIOGRAPHY

NAME _____ SEX _____ AGE _____
HOSP. NO. _____ DR. _____ RM _____ DATE 17/10/24

HISTORY

ACS E NSTGM1
PVC PL2 L LAD x 2 DES,
LCX x 1 DES

CONCLUSION

DR. TAN CHIANG SOO

CONSULTANT CARDIOLOGIST

MRCS (Hons) (Aus), MRCP (UK), FAMS Cardiology (S'pore), FSCAI (USA)

MMC No.: 29801 NSR No.: 123676

NORTHERN HEART HOSPITAL PENANG

RECOMMENDATIONS :

