Eximius Medical Administration Solutions Sdn Bhd

Level 2, Bangunan MMA, 124 Jalan Pahang
53000 Kuala Lumpur, Wilayah Persekutuan , Malaysia
Tel : +6 03-4041 3627 Fax : +6 03-4041 8627
www.emastpa.com.my
reimbursements@emastpa.com.my

eMAS REIMBURSEMENT CLAIM FORM

Personal Detail

Please use capital letters only

Company Name : ____________________ **Employee ID** : ____________________

Employee Name : ____________________ **Employee NRIC** : ____________________

Patient Name : ____________________ **Patient NRIC** : ____________________

Contact Number : ____________________ **Self** : [ ] **Dependant** : [ ]

Mailling Address : ____________________

Email Address : ____________________

Bank Detail

Payee Name : ____________________

Bank Name : ____________________

Bank Account Number (IMPORTANT) : ____________________

Medical Detail

Claim Type*	Clinic / Hospital	Date	Diagnosis	Bill No. / Receipt No	(RM)

Please select your claim type

Claim Type : GP Panel / GP Non Panel / Out Patient Specialist/ Inpatient / Maternity / Optical / Dental

Kindly attach your medical bills with this form. Claim forms received without any supporting documents shall be considered as incomplete

Kindly scan & email this form along with supporting documents to reimbursements@emastpa.com.my

REASON / REMARK : ____________________

MC Given : Yes [ ] No [ ] Start Date : __________ Duration : __________ Day(s)

Claimed by:

I solemnly and sincerely declare that the information provided is full, complete and true.

I hereby authorise any physician, nurse or medical staff of the hospital/ GP clinic who has observed or treated me/ my above named spouse/ my above named child to release my/ my above named spouse/ my above named child's medical information and medical history to my employer and Eximius Medical Administration Solutions Sdn Bhd for the purpose of processing my medical claim.

I hereby undertake to reimburse my employer or Eximius Medical Administration Solutions Sdn Bhd in the event that my/ my above named spouse/ my above named child's hospitalisation/ clinical cost are not covered by the medical policy of my employer due to any reason whatsoever.

Signature of Employee/ Patient
Name :
Relationship :

Date

Received by:

Signature of Employer / HR
Name :
Date :

Company Stamp

For e-MAS use only

Remark:

Claims Status : Approved [ ] : Rejected [ ]

Approval Amount : RM ____________________

Reason for Rejection : ____________________

Processed by :

Signature
Name :
Date :

Approved by ;

Signature
Name :
Date :