Non-Direct Billing Claim Form - Part A
Patient Information

For a claim to be valid, the following two pages (Part A and B) must be completed and submitted to MSH CHINA ENTERPRISE SERVICES CO.,LTD. (hereinafter "Service Center") which is the appointed Service Provider appointed by your insurance company within 180 days after the date of service.

Patient Information	
Member ID:	Date of Birth (DD/MM/YY):
Name:	Gender:
Nationality:	ID/Passport No.:
Telephone:	Email:
Address:	
Ref. No. (As indicated on your insurance card):	
Policy Number:	

Primary Insured Inforamtion *Please skip this section if claim is for Primary Insured	
Name:	Date of Birth (DD/MM/YY):
Gender:	ID/Passport No.:
Telephone:	Email:
Address:	

1. Describe Injury or Illness		
Diagnosis/Chief Complaint:		
When did you first notice the condition(s)/symptom(s)?	DD/ MM/ /YY	
Please describe the condition(s)/symptom(s):		
When did you first seek a doctor's opinion regarding these condition(s)/symptom(s)?	DD/ MM/ /YY	
Are you covered by other insurance policy besides Medi+?	☐ Yes	☐ No
(If yes, please provide the following details)		
Name of insurance company:	Policy No.:	

2. Payment Information	
☐ Cash	
☐ Cheque - Payee's Name:	
☐ Bank Transfer	
Account Number:	Name on Account:
Swift Code/ Routing No./ ABA No.:	
Name of bank and branch:	
Bank Address:	
*Please ensure the name on your invoice is the same as that on your ID/ Passport	

The above answers are true and correct to the best of my knowledge and belief. I authorize any physician, medical institution, druggist, insurance company, employer, labor union, or association to release information to the Service Center including copies of records, concerning advice, care or treatment provided to me or my dependent's, if any, due me, or my dependent for this claim. If this claim is direct billed, I acknowledge that I am responsible for any fees that my insurance policy does not cover.
A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____

Primary Insured's signature Dependent's signature

Date DD/ MM/ /YY

Non-Direct Billing Claim Form - Part B
Medical Information

A photocopy of the medical record(s) from the outpatient visit(s) may replace Part B of this Claim Form. Please submit discharge summary if it is an inpatient claim.

3. Medical Information -To be completed by the Treating Physician

Doctor's Name:	Phone No.:
Hospital's Name:	Address:

Chief Complaint:

Physical Examination:

Lab Tests and Exams:

Lab Tests Results:

Exam Results:

Diagnosis/Impression:

Details of Treatment Provided:

Please state the name of drug(s) and dosage(s):

Treatment is related to (Please check box(es) if related to the following items)

- ☐ Maternity
- ☐ Therapy
- ☐ Acupuncture
- ☐ Checkup
- ☐ Immunization
- ☐ Dental
- ☐ Vision
- ☐ Others: _____

Date of Service (DD/MM/YY)	Description of Medical Procedure	Fees
	Consultation	
	Drugs	
	Lab Test(s)	
	Exam(s)	
	Acupuncture	
	Therapy	
	Others	
	Total	

_____

Signature of Treating Physician Date: DD/ MM/ /YY

Name and Title:

Checklist of documents to be submitted:

- ☐ Photocopy of patient's ID card/Passport
- ☐ Photocopy of insurance card
- ☐ Original Invoice(s)/Receipt(s)
- ☐ Photocopy of Medical Records
- ☐ Photocopy of Prescriptions (if any)
- ☐ Discharge Summary (for in-patient claims)