PMCARE TNB GP VISIT AND CONSENT FORM

TENAGA NASIONAL BERHAD

PMCare

A. UNTUK DIISI OLEH AHLI / *FOR MEMBER TO FILL*

Nama Pesakit / *Name of Patient*

No. K/P Pesakit / *Patient's NRIC No.*

Nama Pekerja / *Name of Employee*

No. K/P Pekerja / *Employee's NRIC No.*

Sila keluarkan maklumat rawatan saya kepada PMCare Sdn Bhd dan/atau Majikan pekerja untuk memproses, membayar tuntutan, serta menghasilkan laporan.
Please release my information for this visit to PMCare Sdn Bhd and/or my Employer to process, pay this claim, and to produce report.

Tandatangan pesakit / ibubapa / penjaga
Signature of patient / parent / guardian
Tarikh / *Date*:

FOR GP CLINIC USE ONLY

B. VISIT DETAILS

Tarikh Lawatan / *Date of Visit*

H H B B T T T T

Waktu Lawatan / *Time of Visit*

am / pm

Types of Panelship:
- Open Panel ☐
- Closed Panel ☐ Please specify:_____

C. REASON FOR VISIT

To be filled by attending physician [please mark (X) in the appropriate box]

Code		Code		Code	
R1000	☐ Abdominal / Pelvic Pain	L0200	☐ Cutaneous Abcess, Furuncle, Warts and Carbuncle	H0103	☐ Disorders of the Eyelid (e.g. Stye, Chalazion)
J3000	☐ Allergic / VMR	I8400	☐ Heamorrhoids / Piles	T1519	☐ Foreign Body (please specify: .....)
M2025	☐ Arthralgia	G4400	☐ Headache / Migraine	Z2327	☐ Immunization (acc to KKM schedule)
J4546	☐ Asthma	E7800	☐ Hyperlipideemia	S0114	☐ Injury / Cuts (please specify:.....)
M5400	☐ Backache	I1015	☐ Hypertension	Z3435	☐ Maternal Healthcare (antenatal)
T2032	☐ Burns / Scalds	I258	☐ Ischaemic Heart Disease	Z3900	☐ Maternal Healthcare (postnatal)
B3700	☐ Candidiasis	L7200	☐ Cyst of Skin / Subcutaneous Tissue		☐ Others (please describe : .....)
H1000	☐ Conjunctivitis	N202	☐ Renal Calculus		.....
A9000	☐ Dengue Fever	J0100	☐ Sinusitis		
L2030	☐ Dermatitis / Eczema	J0300	☐ Tonsilitis		
B3536	☐ Dermatophytosis	J0006	☐ Upper Respiratory Tract Infection		
E1100	☐ Diabetes	N3000	☐ Urinary Tract Infection		
A0900	☐ Diarrhoea / Gaestroentritis	H8182	☐ Vertigo		
N946	☐ Dysmenorrhoea	B3334	☐ Viral Fever		
H6000	☐ Ear Infection	R1100	☐ Vomiting / Nausea		
K2900	☐ Gastritis / Duodenitis	N7700	☐ Vulvovaginal Diseases		
M1000	☐ Gout	K1300	☐ Disorders of Lips / Oral Mucosa (inc. Mouth Ulcer)		

- ☐ GDL (Good Driving Licence)*
- ☐ Health screening*
- ☐ Medical examination*

*Please confirm with PMCare if the treatment is covered to avoid non-payment.

FOR PMCARE OFFICE USE

- ☐ No authorisation
- ☐ Special arrangement

D. TREATMENT PROVIDED

		Cost (RM)
☐	Consultation	
☐	Medication (please specify drug, quantity & dosage)	
☐	Injection (please specify drug & dosage)	
☐	Nebuliser (please specify drug & dosage)	
☐	Surgical procedures e.g. I & D, T & S (please give details)	
☐	Lab / X- ray (please attach report)	
☐	Pap Smear (please attach report)	
	Total (RM)	

Referral Letter
Specialist & Name of Medical Centre / Hospital:

MC ☐☐ Days

CLINIC CODE ☐☐☐☐☐☐☐☐☐☐☐☐

I / We hereby confirm that all information given is true and complete.

Doctor's Signature & Clinic Stamp

All claims must be submitted to reach PMCare Sdn Bhd within 3 days from the service date. Claim form which is submitted late and / or incomplete shall not be paid.

PMCARE SDN BHD
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