

# Formulir Klaim SmartCare Executive

## Claim Form SmartCare Executive

**AdMedika**

**Important**

- Harap lengkapi formulir klaim ini dan lengkapi seluruh dokumen klaim merujuk pada Syarat Kelengkapan Dokumen pada halaman 2 sesuai dengan jenis klaim Anda  
*Please complete this claim form and attached all related claim document refer to Claims Document Requirement on page 2.*
- Harap lengkapi formulir ini kemudian kirim ke Pengelola Program kami berikut ini dalam waktu paling lambat 30 hari setelah mendapatkan pelayanan kesehatan.  
*Submit to the SmartCare Executive program administrator within 30 days after discharged from hospital or medical treatment.*

**PT Administrasi Medika, Jl. Balikpapan Raya No. 11B, Kelurahan Petojo Selatan, Kecamatan Gambir, Jakarta Pusat 10160**  
**UP. CLAIM DEPT. Tel. (6221) 500 353 Fax. (+6221) 3483 0903**

### Data Peserta/Personal Data

Nama Peserta : ..... <i>Insured's Name</i>	Nomor Kartu Peserta : ..... <i>Card member no</i>
Tanggal Lahir : ..... <i>Date of Birth</i>	Plan : ..... <i>Plan</i>
Jenis Kelamin : <input type="checkbox"/> Male <input type="checkbox"/> Female <i>Gender</i>	Pekerjaan/Jabatan : ..... <i>Occupation/Job Title</i>
Alamat : ..... <i>Address</i>	Telepon : ..... <i>Telephone</i>
Nama Perusahaan : ..... <i>Company Name</i>	
Alamat : ..... <i>Address</i>	Telepon : ..... <i>Telephone</i>

Untuk tujuan pembayaran klaim, mohon lengkapi data di bawah ini  
*For claim payment purposes, please complete the data below*

Nama Bank : ..... <i>Bank Name</i>	Atas Nama : ..... <i>In the name of</i>
Cabang : ..... <i>Branch</i>	Nomor Rekening : ..... <i>A/C No.</i>
Jumlah yang ditagihkan : ..... <i>Total paid</i>	

**Pernyataan Pemberian Kuasa dari Pasien**

Bersama ini saya memberi kuasa yang tidak terbatas waktu kepada Pengelola Program untuk mendapatkan segala keterangan/catatan medis lisan/tertulis dari rumah sakit atau pihak lain sehubungan dengan diagnosis, perawatan atau pelayanan yang diberikan kepada saya atau keluarga saya. Saya setuju untuk memberikan data catatan medis kami kepada Pengelola Program **SmartCare Executive** untuk keperluan medis & administrasi. Foto copy Pernyataan dan Surat Kuasa ini sama absahnya dengan yang asli yang tidak dapat dicabut kembali selama berlangsungnya pelaksanaan Program **SmartCare Executive** ini. Saya menyatakan bahwa segala keterangan yang tercantum dalam formulir ini adalah benar.

**Authorisation to Release Information**

I hereby authorise the Administrator Program without any time limit to release any information/medical records from hospital/clinic providers or other party acquired in the course of my examination or treatment or my family's medical history according to the applicable law and regulation. I agree to provide my medical records to **SmartCare Executive Program Administrator** for medical and administration purposes. Copy of this statement and letter of authority has the same validity with its original which is irrevocable during the enforcement of this **SmartCare Executive Programme**. I declare that the best of my knowledge and belief, all information under this true and correct.

\_\_\_\_\_  
Nama & Tanda tangan  
Name & Signature

\_\_\_\_\_  
Tempat & Tanggal (tgl/bln/thn)  
Place & Date (D/M/Y)

**RESUME MEDIS (Wajib diisi oleh Dokter yang merawat)  
MEDICAL RESUME (must be completed by Physician)**

- 1. Tanggal Pelayanan : ...../...../..... sampai ...../...../..... (tgl/bln/thn)  
Date of treatment to (dd/mm/yy)
- 2. No Registrasi Pasien : .....  
Registration No.
- 3. Nama Rumah Sakit/Klinik : .....  
Name of hospital/clinic
- 4. Apakah RS/Klinik termasuk dalam list provider kami?  Ya  Tidak  
Is the hospital/clinic listed as our provider?  Yes  No
- 5. Jenis Pelayanan :  Rawat Inap/Inpatient  
Type of treatment  Rawat Jalan dokter umum /Outpatient General Consultation  
 Rawat Jalan dokter Spesialis /Outpatient Specialist Consultation  
 Rawat Jalan Gigi/Dental Consultation  
 Kehamilan/Maternity  
 Optik (Khusus manfaat optik mohon diabaikan no. 4 s/d 9)/  
Optical (For optical benefit, please ignore item no. 4 till 9)
- 6. Anamnesis : .....  
Anamnesa
- 7. Pemeriksaan Fisik : .....  
Physical Check Up
- 8. Pemeriksaan Penunjang : .....  
Support Check Up
- 9. Diagnosa : .....  
Diagnosis
- 10. Tindakan : .....  
Therapy
- 11. Saran Pengobatan : .....  
Medical Advice

\_\_\_\_\_  
Nama & tanda tangan dokter & stempel RS/Klinik  
Physician's name, signature, and hospital/clinic stamp

\_\_\_\_\_  
Tempat  
Place

\_\_\_\_\_  
Tempat & Tanggal (tgl/bln/thn)  
Date/Month/Year

**Claims Document Requirement**

No	Document Requirement	Type of Claim					
		In patient	Out patient	Accident	Hospital Cash	Death	Coordination Benefit
1	Original completed claim form <i>(filled by client)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Completed medical resume <i>(filled by treating doctor, signed &amp; stamped by Hospital)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Copy of laboratory examination result & radiology/ other diagnostic examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-
4	Original receipt with details of medication fee, treatment fee & copy of prescriptions <i>(for the claim amount 1mio and above must be stamp IDR 6000)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	-	-
5	Photocopy of Passport <i>(if treatment/dies at overseas)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	<input type="checkbox"/>	-
6	Copy of Insured / Participant ID Card <i>(for Group)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Power of Attorney to request medical data	<input type="checkbox"/>	-	-	<input type="checkbox"/>	-	-
8	Photocopy of driver license & investigation report from the Local Police <i>(if an accident)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	<input type="checkbox"/>	-
9	Original receipt with details of medication fee, treatment fee, copy of prescriptions & copy of examination diagnostic result <i>(only if there is a coordination of benefit &amp; hospital cash plan)</i>	-	-	-	<input type="checkbox"/>	-	<input type="checkbox"/>
10	Copy of insurable Interest between Insured and Beneficiary(s)	-	-	-	<input type="checkbox"/>	<input type="checkbox"/>	-
11	Copy Beneficiary(s) ID <i>(only for death claim allowance)</i>	-	-	-	-	<input type="checkbox"/>	-
12	Power of Attorney from Beneficiaries if Beneficiaries more than one person / Certificate of heirs	-	-	-	-	<input type="checkbox"/>	-
13	Legalized of Death Certificate from authorized institution	-	-	-	-	<input type="checkbox"/>	-
14	Legalized of Death Certificate from General Consul of RI <i>(if dies at overseas)</i>	-	-	-	-	<input type="checkbox"/>	-
15	Death of Chronology <i>(if dies at home or when go to Hospital)</i>	-	-	-	-	<input type="checkbox"/>	-
16	Bank account Power of Attorney <i>(if the account owner is not the Benefit Receiver)</i>	-	-	-	-	<input type="checkbox"/>	-
17	Insured Death of Certificate which has been authorized by legal Institution, States the Insured has been died, if the Insured was miss in accident	-	-	-	-	<input type="checkbox"/>	-
18	• Result Visum Repertum and investigation report from Local Police <i>(if dies due to accident)</i>	-	-	-	-	<input type="checkbox"/>	-
19	Original receipt of the excess of the treatment <i>(only if there is a coordination of benefit and for claim amount 1mio and above must be stamp IDR 6000)</i>	-	-	-	-	-	<input type="checkbox"/>
20	Statement letter with detail of claim payment from another Insurer/BPJSK <i>(only for coordination of benefit)</i>	-	-	-	-	-	<input type="checkbox"/>

**Note:**  Required  
 - Not Required

Untuk klaim dengan nominal sampai dengan Rp. 1 juta dapat diajukan melalui WA di nomor 0815 8670 7637 atau aplikasi MyAXA Health. untuk keterangan lebih lanjut silahkan hubungi Customer Care kami.

*For claim amount up to Rp. 1 million can be submitted through WA at 0815 8670 7637 or MyAXA Health application.  
 For further information, please contact our Customer Care.*



