PT Mandiri AXA General Insurance
Customer Care Center
AXA Tower lt. GF
Jl. Prof. Dr. Satrio Kav.18, Kuningan City
Jakarta 12940, Indonesia
Tel : 1500733 (24 Jam)
Email : customer.general@axa-mandiri.co.id
Website : www.axa-mandiri.co.id

Formulir Klaim Smart*Care Executive*
Claim Form Smart*Care Executive*

Fullerton Health Indonesia

Important
1. 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.
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. Fullerton Health Indonesia Group CIBIS Nine (CIBIS Business Park) Building 5th Floor
Jl. TB Simatupang No. 2 Rt.001 Rw. 05 Kelurahan Cilandak Timur Kecamatan Pasar Minggu Jakarta Selatan 12560
UP. CLAIM DEPT. Tel (+62 21) 2997 8997 Fax (+62 21) 2997 8955

Data Peserta/Personal Data

Nama Peserta : .....
Insured's Name

Nomor Kartu Peserta : .....
Card Member no

Tanggal Lahir : .....
Date of Birth

Plan : .....
Plan

Jenis Kelamin : ☐ Male ☐ Female
Gender

Pekerjaan/Jabatan : .....
Job Title

Alamat : .....
Address
.....

Telepon : .....
Telephone

Nama Perusahaan : .....
Company Name

Alamat : .....
Address

Telepon
Telephone : .....

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

Nama Bank : .....
Bank Name

Atas Nama :.....
In the name of

Cabang : .....
Branch

Nomor Rekening :.....
A/C No.

Jumlah yang ditagihkan : .....
Total paid

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 **Smart**Care 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 **Smart**Care 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 **Smart**Care Executive Program Administrator for medical and administration purposes. Copy of this statement and letter of authority has the same validity with is original which is irrevocable during the enforcement of this **Smart**Care Executive Programe. 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
Type of treatment :
☐ Rawat Inap/*Inpatient*
☐ 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 until 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 *(filled by client)*	□	□	□	□	□	□
2	Completed medical resume *(filled by treating doctor, signed & stamped by Hospital)*	□	□	□	□	□	□
3	Copy of laboratory examination result & radiology/ other diagnostic examination	□	□	□	□	□	–
4	Original receipt with details of medication fee, treatment fee & copy of prescriptions *(for the claim amount 1mio and above must be stamp IDR 6000)*	□	□	□	–	–	–
5	Photocopy of Passport (*if treatment/dies at overseas*)	□	□	□	–	□	–
6	Copy of Insured / Participant ID Card (*for Group)*	□	□	□	□	□	□
7	Power of Attorney to request medical data	□	–	–	□	–	–
8	Photocopy of driver license & investigation report from the Local Police (*if an accident)*	□	□	□	–	□	–
9	Original receipt with details of medication fee, treatment fee, copy of prescriptions & copy of examination diagnostic result *(only if there is a coordination of benefit & hospital cash plan)*	–	–	–	□	–	□
10	Copy of insurable Interest between Insured and Beneficiary(s)	–	–	–	□	□	–
11	Copy Beneficiary(s) ID *(only for death claim allowance)*	–	–	–	–	□	–
12	Power of Attorney from Beneficiaries if Beneficiaries more than one person / Certificate of heirs	–	–	–	–	□	–
13	Legalized of Death Certificate from authorized institution	–	–	–	–	□	–
14	Legalized of Death Certificate from General Consul of RI *(if dies at overseas)*	–	–	–	–	□	–
15	Death of Chronology *(if dies at home or when go to Hospital)*	–	–	–	–	□	–
16	Bank account Power of Attorney *(if the account owner is not the Benefit Receiver)*	–	–	–	–	□	–
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	–	–	–	–	□	–
18	Result Visum Repertum and investigation report fromLocal Police *(if dies due to accident)*	–	–	–	–	□	–
19	Original receipt of the excess of the treatment *(only if there is a coordination of benefit and for claim amount 1mio and above must be stamp IDR 6000)*	–	–	–	–	–	□
20	Statement letter with detail of claim payment from another Insurer/BPJSK *(only for coordination of benefit)*	–	–	–	–	–	□

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.