



## MEDICAL CLAIMS AUTHORISATION FORM (SINGLE INSTITUTION)

<b>A - Particulars of Patient</b>																											
Name:		Date of Birth: (DD-MM-YYYY)	<input type="checkbox"/> Singapore Citizen (SC)																								
NRIC / CPF Account No:	FIN / Passport No: (for foreigners only)		<input type="checkbox"/> Permanent Resident (PR)																								
			<input type="checkbox"/> Foreigner																								
<b>B - Particulars of the Additional MediSave Payer</b>																											
Name:		Date of Birth: (DD-MM-YYYY)	NRIC / CPF Account No:																								
The Patient is the Additional MediSave Payer's:	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Parent																								
	<input type="checkbox"/> Grandparent (Patient must be SC/PR)	<input type="checkbox"/> Sibling (Patient must be SC/PR)																									
<b>C - Purpose</b>																											
(For the <b>Patient</b> )		(For the <b>Additional MediSave Payer</b> )																									
I authorise the Medical Institution to:		I authorise the Medical Institution to:																									
<input type="checkbox"/> Y <input type="checkbox"/> N	Check my healthcare financing coverage;	<input type="checkbox"/> Y <input type="checkbox"/> N	Check my healthcare financing coverage;																								
<input type="checkbox"/> Y <input type="checkbox"/> N	Withdraw from my MediSave;	<input type="checkbox"/> Y <input type="checkbox"/> N	Withdraw from my MediSave;																								
<input type="checkbox"/> Y <input type="checkbox"/> N	Claim from my Health Insurance Policy;																										
for the Patient's treatment charges incurred at:		Name of the <b>Medical Institution</b> : <b>Changi General Hospital</b>																									
<input type="checkbox"/> Y <input type="checkbox"/> N	for hospitalisation <sup>1</sup> / day surgery / treatment period starting on / from:	Date: (DD-MM-YYYY)																									
<input type="checkbox"/> Y <input type="checkbox"/> N	for all outpatient treatments																										
<div style="border: 1px dashed black; padding: 5px;"> <p>(a) claimable under</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>Renal dialysis</td> <td><input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>Flexi-MediSave</td> <td><input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>Cancer scans</td> </tr> <tr> <td><input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>Chemotherapy</td> <td><input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>Radiotherapy</td> <td><input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>Anti-Retroviral Drugs</td> </tr> <tr> <td><input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>Outpatient scans</td> <td><input type="checkbox"/> Y <input type="checkbox"/> N</td> <td colspan="3">Approved chronic diseases, vaccinations, screenings</td> </tr> <tr> <td><input type="checkbox"/> Y <input type="checkbox"/> N</td> <td colspan="5">Other schemes (please specify):</td> </tr> </table> </div>				<input type="checkbox"/> Y <input type="checkbox"/> N	Renal dialysis	<input type="checkbox"/> Y <input type="checkbox"/> N	Flexi-MediSave	<input type="checkbox"/> Y <input type="checkbox"/> N	Cancer scans	<input type="checkbox"/> Y <input type="checkbox"/> N	Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N	Radiotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N	Anti-Retroviral Drugs	<input type="checkbox"/> Y <input type="checkbox"/> N	Outpatient scans	<input type="checkbox"/> Y <input type="checkbox"/> N	Approved chronic diseases, vaccinations, screenings			<input type="checkbox"/> Y <input type="checkbox"/> N	Other schemes (please specify):				
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<div style="border: 1px dashed black; padding: 5px;"> <p>(b) and sought</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>on:</td> <td colspan="2">Date: (DD-MM-YYYY)</td> </tr> <tr> <td><input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>within the limited period<sup>2</sup> from:</td> <td>Date: (DD-MM-YYYY)</td> <td>to Date: (DD-MM-YYYY)</td> </tr> <tr> <td><input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>for an indefinite period<sup>2</sup>, until revoked in writing, starting from:</td> <td colspan="2">Date: (DD-MM-YYYY)</td> </tr> </table> </div>				<input type="checkbox"/> Y <input type="checkbox"/> N	on:	Date: (DD-MM-YYYY)		<input type="checkbox"/> Y <input type="checkbox"/> N	within the limited period <sup>2</sup> from:	Date: (DD-MM-YYYY)	to Date: (DD-MM-YYYY)	<input type="checkbox"/> Y <input type="checkbox"/> N	for an indefinite period <sup>2</sup> , until revoked in writing, starting from:	Date: (DD-MM-YYYY)													
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<p>1: If the Patient authorises use of MediSave and passes away during this hospitalisation, the Patient's MediSave balance will be used to pay the last hospitalisation bill first before any withdrawal can be made from the MediSave Account of any Additional MediSave Payer(s).</p> <p>2: Please inform the staff at the Medical Institution during your visit how you would like the bill to be claimed. If you do not do so, the Medical Institution may, as authorised, claim the bill in full from the Patient's and/or the Additional MediSave Payer's MediSave and Health Insurance Policy.</p>																											
<b>D - Authorisation on Behalf of Patient / Additional MediSave Payer</b>																											
(Please complete this part <u>only</u> if you are signing on behalf of the Patient or the Additional MediSave Payer.)																											
Name:		Date of Birth: (DD-MM-YYYY)	NRIC / FIN / Passport Number:																								
I am signing this form on behalf of (please tick):																											
<input type="checkbox"/> <b>the Patient</b> , because: <ul style="list-style-type: none"> <li><input type="checkbox"/> I am the parent / legal guardian<sup>3</sup> of the Patient who is under 21 years of age.</li> <li><input type="checkbox"/> he/she lacks capacity<sup>4</sup>, and I am his/her:             <ul style="list-style-type: none"> <li><input type="checkbox"/> donee / deputy<sup>5</sup>.</li> <li><input type="checkbox"/> family member<sup>6</sup>.</li> </ul> </li> <li><input type="checkbox"/> he/she is deceased, and I am his/her:             <ul style="list-style-type: none"> <li><input type="checkbox"/> donee / deputy<sup>5</sup>.</li> <li><input type="checkbox"/> family member<sup>6</sup>.</li> </ul> </li> </ul>		<input type="checkbox"/> <b>the Additional MediSave Payer</b> , because: <ul style="list-style-type: none"> <li><input type="checkbox"/> I am the parent / legal guardian<sup>3</sup> of the Additional MediSave Payer who is under 21 years of age.</li> </ul> <p>3: You are lawfully appointed as a legal guardian by a court or under a will/deed.</p> <p>4: A person lacks capacity as set out in Section 4 of the Mental Capacity Act (Cap. 177A) ("MCA").</p> <p>5: You are acting under a Lasting Power of Attorney registered under the MCA with power to act on behalf of the Patient, or are appointed by the Court under the MCA to act on behalf of the Patient.</p> <p>6: You are the spouse, child, or parent of the Patient, are 21 years old and above, and do not lack capacity.</p>																									
<p>(The section below must be completed by a doctor if the Patient lacks capacity and a doctor's certification or court order has not already been obtained.)</p> <p><b>Doctor's Certification</b></p> <p>I certify that the Patient lacks capacity and is unable to sign this form.</p> <table style="width: 100%;"> <tr> <td>Name of Doctor:</td> <td>Doctor's MCR:</td> <td rowspan="2">Clinic / Hospital Stamp:</td> </tr> <tr> <td>Doctor's Signature:</td> <td>Date of Signature (DD-MM-YYYY):</td> </tr> </table>				Name of Doctor:	Doctor's MCR:	Clinic / Hospital Stamp:	Doctor's Signature:	Date of Signature (DD-MM-YYYY):																			
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## Consent to Data-Sharing & Use of Information

1. I allow the Government of the Republic of Singapore and its appointed agencies, the Central Provident Fund Board (“CPF Board”), my Insurer and its appointed agencies, the Medical Institution, and healthcare professionals at any medical institution who have cared for the Patient (“the Parties”), as applicable, to collect, share and use my Information (a) to facilitate the Patient’s treatment, (b) for the purposes I indicated in Part C, and (c) for data analysis, evaluation, and policy-making and review by the Government and CPF Board.
2. If I have also applied to withdraw from my MediSave or claim from my Health Insurance Policy in Part C, I agree to provide any information necessary to any of the Parties in paragraph 1 to process and administer the Claims. I further understand and agree that my Information may be collected, shared and used by any of the Parties to process and administer the Claims resulting from the Patient’s treatment charges, to assess and audit the Claims, and adjudicate Claims-related disputes.

## Claim Authorisation

3. If I have applied to withdraw from my MediSave or claim from my Health Insurance Policy to pay for the Patient’s treatment charges at the Medical Institution for the treatments indicated in Part C:
  - a) I authorise CPF Board and my Insurer to do all things necessary to process and administer the Claims;
  - b) I accept that the Claims will be subject to CPF Board’s and my Insurer’s approval, and the approved Claims amounts will depend on (i) the treatment charges submitted by the Medical Institution, (ii) my MediSave balance, (iii) the relevant Acts & Regulations, and (iv) the terms of my Health Insurance Policy, if applicable; and
4. I agree to immediately refund to my MediSave Account and my Insurer any payment which I receive as reimbursement for the treatment charges.
5. I agree that this authorisation will be valid for claims submitted (i) within 12 months after the date of signature, (ii) within 12 months after the end date indicated in Part C (for authorisations for a limited period), or (iii) by the revocation date (for authorisations for an indefinite period), whichever is later. I acknowledge that I may have to provide further authorisation if any Claims are submitted by the Medical Institution after this authorisation expires.

## General

6. I have read and understood this form fully, including the Definitions below, and I declare that the information that I have provided is accurate.

Signature / Thumbprint of Patient / Person signing on behalf of Patient
Date of Signature (DD-MM-YYYY):
Interpreted by (Name & NRIC):

Signature / Thumbprint of Additional MediSave Payer / Person signing on behalf of the Additional MediSave Payer
Date of Signature (DD-MM-YYYY):
Interpreted by (Name & NRIC):

Signature of Witness & Date of Signature
Name of Witness:
NRIC / Official Stamp:

## Definitions

I understand and agree that these phrases used in this form shall have the following meanings:

- a) **“Information”** refers to the following information in relation to both the Patient and the Additional MediSave Payer:
  - i) personal data (e.g. name, NRIC No, address, age, date of birth);
  - ii) MediSave balance and withdrawal limits;
  - iii) any other administrative information as the Government and its appointed agencies, CPF Board, the Insurer and its appointed agencies, the Medical Institution, and healthcare professionals at any medical institution who have cared for the Patient may consider necessary for the purpose of processing, administering, assessing, and auditing the Claim;and additionally the following healthcare information in relation to the Patient only:
  - iv) hospitalisation and bill records;
  - v) medical information and information relating to the Patient’s medical condition and treatment; and
  - vi) Health Insurance Policy information (e.g. policy details, benefits, exclusions, start and end dates);

For the avoidance of doubt, “Information” may relate to information on both past and present matters.

- b) **“Health Insurance Policy”** and the corresponding **“Insurer”** refer to the following:

Health Insurance Policy	Insurer		
MediShield & MediShield Life	Central Provident Fund Board		
MediSave-approved Integrated Shield Plan*	Income Insurance Limited	AIA Singapore Private Limited	Prudential Assurance Co
	Singapore Life Ltd.	Great Eastern Life Assurance Co	HSBC Life (Singapore) Pte. Ltd.
	Raffles Health Insurance	Any other insurer as approved by the Minister of Health	

\* MediSave-approved Integrated Shield Plan refers to the MediSave-approved integrated medical insurance plan as stated in the Central Provident Fund (MediShield Scheme) Regulations and the Central Provident Fund (Private Medical Insurance Scheme) Regulations, and the attached rider plans.

- c) **“Claims”** refers to all claims from the Health Insurance Policy or all withdrawals from MediSave, as authorised in Part C.
- d) **“Acts & Regulations”** refers to all relevant legislation governing the use of MediSave, MediShield and MediShield Life, including the Central Provident Fund Act, Central Provident Fund (Medisave Account Withdrawals) Regulations, Central Provident Fund (MediShield Scheme) Regulations, Central Provident Fund (Private Medical Insurance Scheme) Regulations, and the MediShield Life Scheme Act 2015 and its regulations, and any amendments or re-enactments thereof.