Tenaga Nasional Berhad (200886-W)
Unit G-1, Ground Floor, Wisma UOA Pantai,
No. 11, Jalan Pantai Jaya (Jalan 4/83A)
59200 Kuala Lumpur

Tel : 1300-80-5656
Fax : 1300-22-5656
General Enquiry: tnbhealthcare@tnb.com.my
GL Request: gl@tnb.com.my

Patient Information:

Patient Name	:	AMIN NORDIN BIN MUSTAFA	Issued Date	:	11/09/2017
Patient NRIC	:	570103085639	Issued Time	:	15:52:33
Employee Name	:	AMIN NORDIN BIN MUSTAFA	Employee No	:	10042632
Employee NRIC	:	570103085639	Relationship	:	-

GUARANTEE LETTER REFERENCE NUMBER: 424559

Date of Visit : 11/09/2017
Attention : LIM CHOO GEE (NEPHROLOGIST;PHYSICIAN)
KPJ KLANG SPECIALIST HOSPITAL
NO 102 PERSIARAN RAJAWALI / KU1

Tel No :
Fax No :

Medical Service Requested

OUTPATIENT SPECIALIST CONSULTATION (ONE VISIT ONLY)
Medical Condition: Chronic ischemic heart disease , Diagnosis2: Type 2 diabetes mellitus

Initial GL limit: RM 500.00
MEDICAL PROVIDERS TO CALL TNB HEALTHCARE IF LIMIT IS INSUFFICIENT FOR INTERIM AND FINAL BILLS WITH CLEAR BREAKDOWN AND REASONS INDICATED

Expenses entitlement is only for or directly related to medical/surgical condition referred to the Medical Condition as per above mentioned.

TNB reserves the right not to honor payment for unnecessary admissions, services, investigations or treatment rendered.

TNB will not pay or be responsible for any expenses in excess of the above entitlement or incurred for non-entitlement as indicated above. The excess amount must be recovered by the hospital from the patient upon their discharge.

Payment of claim is subject to timely submission of complete documents, i.e. within 30 days from date of services or discharge.

This GL **DOES NOT COVER** the following services:

Birth Control & Infertility investigation or treatment; Circumcision; Cosmetic Surgery; Injuries due to illegal activities; Dental Care (except in injury cases); Refractive Error Treatment.

Referrals to other Specialists are not covered by this Guarantee Letter.

Medication: One month supply ONLY

Remarks:

This Guarantee Letter should be activated within 14 days from date of issue

To enable prompt payment, please forward **HOSPITAL ADMISSION AND SURGERY FORM, MEDICAL SUMMARY FORM, FINANCIAL GUARANTEE APPROVED LETTER**, which will be generated at time of discharge, and with your original bills to the following address within fourteen (14) days:

Medical Claim Unit
TNB Healthcare
Tenaga Nasional Berhad (200886-W)
Unit G-1, Ground Floor, Wisma UOA Pantai
No. 11, Jalan Pantai Jaya (Jalan 4/83A)
59200 Kuala Lumpur

Yours faithfully,

For and on behalf of
Tenaga Nasional Berhad

TNB HEALTHCARE CALL CENTER

Authorised Signatory

Tenaga Nasional Berhad (200886-W)
Unit G-1, Ground Floor, Wisma UOA Pantai,
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Part II: Patient's Consent and Information

Patient's Consent (to be signed by Patient or Guardian)
Please provide Tenaga Nasional Berhad with my medical treatment information as required by them to process this claim and other related visit(s), if any.
I understand that claims payment will only be made for all covered medical treatment and services under the program.

_____ _____
Date of Visit Signature of Patient/Guardian

This GL **DOES NOT COVER** the following services:

Birth Control & Infertility investigation or treatment; Circumcision; Cosmetic Surgery; Injuries due to illegal activities; Dental Care (except in injury cases); Refractive Error Treatment. For complete listing, please refer to the Working Guidelines.

Provisional Diagnosis:	Final Diagnosis: .....
Investigations Type:.....	Result:.....
Treatment: (Please attach reports) Procedures / Date:..... Surgery / Date:..... Medication (Name & Dosage):.....	
Progress Made & Prognosis Any follow-up / treatment: Yes / No	Reason & Number of visits required: .....
Is the hospitalization due to any of the following conditions: Routine examination, cosmetic surgery, alcohol / drug abuse related, AIDS related, sterilization / infertility / pregnancy / childbirth related, psychotic, self-inflicted injury / attempted suicide, congenital condition, unlawful act? Yes / No	Details:.....
I hereby certify the report true and correct to the best of my professional knowledge. Signature..... Name of admitting doctor..... Telephone/Contact No.....	..... Hospital Stamp Print