POLIKLINIK
Ar RAZI
PERUBATAN & X-RAY

PANEL APPLICATION FORM

Company Main Details

Company Name :____
Company Registration No :__________________ No. of Staff :__________
Type of Industry :__________________ Establish Year :__________

Company Contact Details

CEO/Manager :____
Address :____
:____
Tel. No :__________________ Fax No. :__________________
Email :____
Website :____

Applicant Details/Person Contact

**Please key in details of your company's representative for us to contact for verification & follow up purpose.*

(Admin/HR Dept)
Full Name :________________________
Designation :________________________
Email :________________________

(Finance Dept)
Full Name :____________________
Designation :____________________
Email :____________________

Please select which branch coverage that you require

☐ Sungai Isap ☐ Balok ☐ Pekan
☐ Malay Town ☐ Batu 11 ☐ Indera Mahkota (Poliklinik Shukri & Rakan-Rakan, IM8)

Please select medical coverage(s) which will be entitled to all your company's

☐ Employees only
☐ Employees' and dependants (family)

Remarks:____
**Please provide list of your employees and dependants for our kind reference.*

Entitlements

Common illness only	☐ Yes		
Vaccination / Immunization	☐ Yes	☐ No	☐ Call HR first
Minor surgery	☐ Yes	☐ No	☐ Call HR first
Essential laboratory / Urine test	☐ Yes	☐ No	☐ Call HR first
Chest X-Ray	☐ Yes	☐ No	☐ Call HR first
ECG	☐ Yes	☐ No	☐ Call HR first
Ultrasound	☐ Yes	☐ No	☐ Call HR first
Periodic health screening	☐ Yes	☐ No	☐ Call HR first
Maternity related cases	☐ Yes	☐ No	☐ Call HR first
Long term scheduled medication (Diabetes, HPT, etc.)	☐ Yes	☐ No	☐ Call HR first
Medical checkup, eg: pre-employment, pre-University	☐ Yes	☐ No	☐ Call HR first

Others:____________________________

Charges

☐ Please charge according to clinic rates
☐ Please limit charges to maximum of RM____________ per visit (except in emergency cases)

If the amount exceed this limit per visit:
☐ The employee (patient) to pay the diferrence
☐ To proceed and bill to company with itemized charges
☐ ____

All the medical bill will be paid via:

☐ IBG
☐ Cash - please provide us with transaction receipt as proof of payment.
☐ Cheque - physical cheque must be sent to our company by postal.

All cheque, transaction receipt and payment voucher must be sent to us by email / postal / fax to:

Poliklinik Ar Razi, Perubatan & X-Ray
No. 18, Jalan Putra Square 1,
Malay Town, 25200 Kuantan, Pahang.

Tel: 09-517 3477 Fax: 09-517 2447 Email: accarrazi@gmail.com

Effective Date:_________________________

I/We hereby agree to the terms and conditions mentioned in this letter. We shall pay all medical bills within 30 days from the date of receipt of invoice. Either party may terminate by giving 14 days written notice to the other party, and in such of event the outstanding bills shall be settled within 7 days from the date of such termination.

Authorized by:

Company Stamp:

Name:
Designation:

Date:

Please complete this form and return to us by email / fax to:
Email : hello@poliklinikarrazi.com / marketing@poliklinikarrazi.com
Fax : 09-517 2447

For more info, kindly please call us at **09-517 3477**