



## Dental Reimbursement Claim Cover Form

(This form is to be completed by the Employee only, please click on the grey highlighted area and start typing, press Tab to proceed to the next grey area or click on the next grey highlighted area)

Employee Name: \_\_\_\_\_

Dr Name : \_\_\_\_\_

Employee No: \_\_\_\_\_

Receipt number : \_\_\_\_\_

Claimant Name (if not employee) : \_\_\_\_\_

Treatment Date : \_\_\_\_\_

Contact No : \_\_\_\_\_

Amount : RM \_\_\_\_\_

Clinic Name : \_\_\_\_\_

Take note if you have done Category II, III, IV or V treatment, please ensure that the necessary prerequisites are fulfilled (i.e x-rays enclosed and/or pre-approval from Micare, please refer to the bottom of each section of the Schedule of Benefits for the relevant prerequisites or contact Micare at **1800-88-2678** if you require further clarification)

If you are seeking reimbursement for excess amount after receiving reimbursement from another insurer, please provide a full set of copies of all documents provided to the original insurer including proof of payment invoice and amount. Documents should include:

- a) Copy of the dental receipt with breakdown of charges/fees
- b) Claim form submitted to the other insurer
- c) Proof of payment from the other insurer

Please ensure receipts that is provided to Micare has an address and contact no. If it does not, please fill in the space below. This will reduce the time taken to process the claim.

Clinic Address : \_\_\_\_\_

Clinic Telephone No : \_\_\_\_\_

**I, as named above hereby authorize Micare to contact the clinic/s concerned and obtain all my and/or my dependants treatment details and/or supporting documents (x-rays etc) to verify and approve my/my dependants' dental receipts for reimbursement.**

Employee Name : \_\_\_\_\_

Date : \_\_\_\_\_

Signature : \_\_\_\_\_

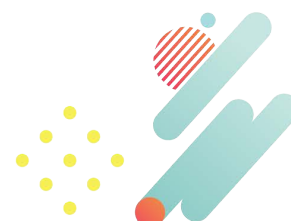
### TUNE PROTECT MALAYSIA

Tune Insurance Malaysia Berhad

COMPANY NO.: 197601004719 (30686-K)

Level 9 Wisma Capital A 19 Lorong Dungun Damansara Heights 50490 Kuala Lumpur

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### AUTHORISATION BY EMPLOYEE FOR E-PAYMENT REIMBURSEMENT

I, as named below hereby authorize Tune Insurance Malaysia Bhd (Insurance Company) to reimburse my claims as approved by them directly to my personal account, the details of which I have provided below.

Bank Name: \_\_\_\_\_

Bank Acc Name: \_\_\_\_\_

Bank Acc Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Full name: \_\_\_\_\_

I/C \ Passport number: \_\_\_\_\_

Signature : \_\_\_\_\_

\* Please note that the Approved Amount is subject to final confirmation and payment by Tune Insurance Malaysia Berhad 2022

### Dental Visit Slip Confirmation by Attending Dentist

I certify having examined \_\_\_\_\_ on \_\_\_\_\_ Treatment description  
(to include the tooth number treated) and breakdown of costs are as follow:

No	Treatment Description	Tooth Number	Treatment Cost (MYR)

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of dentist / rubber stamp of clinic

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