

APPOINTMENT BOOKING FORM
MEMBER PARTICULARS

Subscription ID

Name

Contact No. (H) Fax No.

Contact No. (H)

Email _____

APPOINTMENT BOOKING DETAILS

Patient's Name

NRIC - - Age: _____ Gender: M F

Contact No. Email: _____

Health Screening

 1st choice: Date (_ / _ / _ _)

 2nd choice: Date (_ / _ / _ _)

 3rd choice: Date (_ / _ / _ _)

Time: _____ Hospital Choice: _____ Language(s) Preferred: _____

Date: _____ Signature: _____

FOR OFFICE USE ONLY

Installment Paid Yes No Due _____

Re-enrollment Fee Paid Yes No Due _____

Appointment Booking No. _____

Remarks Enrolment No.: _____ D.O.J.: _____ HC: _____

% Paid: _____

Processed by _____ Authorized by _____

Name: _____ Name: _____

Date: _____ Date: _____

IMPORTANT:

1. A minimum of seven (07) days of notice is required for this booking, failing which it will not be entertained.
2. To avoid forfeiture of your health screening benefit, cancellation of confirmed booking(s) should be done at least three (3) days prior to health screening date.
3. Please assure that the Re-enrollment fee and your Account status are current.