

Global Medical Plan

Guidelines/Checklist of Documentation Required from Insured

For Worldwide Coverage by Cashless Facility

No	Checklist	
1.	Overseas Admission Form	
2.	Identification Document/Passport Copy	
3.	Visa Requirements/Nationality Copy	
4.	Medical Report from a Qualified Medical Practitioner	
5.	All related Medical Documents (Please specify number of pages)	

Dear Insured Member for any enquiries please call

From Indonesia: Please call the number which is written on the back of your card.

From Singapore: +65 3157 9670

In Malaysia: Toll Free number 1800 22 0911

Worldwide: +603 7962 1814

Email: [ia.contact@international-assist.com](mailto:ia.contact@international-assist.com) or [i-assist@admedika.co.id](mailto:i-assist@admedika.co.id)

**IA International Assistance Sdn. Bhd.**

Unit I/J-5, Sunway PJ51a, Jalan SS9A/19, KG Baru Sungai Way, 47300 Petaling Jaya, Selangor, Malaysia.

Tel: +603-7962 1911 Fax: +603-7876 0911

[www.international-assist.com](http://www.international-assist.com)



**International Assistance Sdn. Bhd.**

Always there to Assist you



**AdMedika**  
preferred healthcare partner  
by Telkom Indonesia

**New Overseas Admission Form**

No	Details	
1.	Full Name of Patient	
2.	Date of Birth	
3.	Gender	
4.	Identification Document/Passport	Provide Copy
5.	Visa Requirements/Nationality	
6.	Insurance Name & Card Number	
7.	Location(Country) Of Hospital	
8.	Hospital Name	
9.	Name of Doctor	
10.	Illness	
11.	Admission Date	
12.	Patient Contact Number(Local No at the country of Admission)	
13.	Email	
14.	Name Of Referring Doctor & Hospital	
15.	Medical Report from a Qualified Medical Practitioner	Provide Copy
16.	All related Medical Documents	Provide Copy

The undersigned hereby gives his/her consent/power of attorney to medical service providers and treating physician(s) to release and share information about the state of health, medical treatment and report with the Insurance Company as stated above, International Assistance (other service providing partners) for the evaluation and assessment of above mentioned insurance event.

Note: This consent/power of attorney DOES NOT overrule the initial insurance agreement made between the insurance company and the policyholder/client.

**Date:** \_\_\_\_\_ **Signature** \_\_\_\_\_

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