



PT Prudential Life Assurance  
 Prudential Tower  
 Jl. Jend. Sudirman Kav. 79, Jakarta 12910  
 Customer Care: 1500085/ customer.idn@prudential.co.id  
 www.prudential.co.id

PT Prudential Life Assurance terdaftar dan diawasi oleh Otoritas Jasa Keuangan

**DOCUMENT LIST TO SEND TO PRU MEDICAL NETWORK (PMN)**  
**DAFTAR DOKUMEN YANG DIKIRIM KE PRU MEDICAL NETWORK (PMN)**

Policy number :  
 Nomor Polis

Policy holder name :  
 Nama Pemegang Polis

Phone Number :  
 Nomor telepon

E-mail :  
 E-mail

Documents submitted : (Please put a check mark ✓ on the documents submitted)  
 Dokumen yang diserahkan (mohon berikan tanda ✓ pada dokumen yang diserahkan)

No. No.	Document Dokumen	Nasabah Customer	Singapore General Hospital (SGH)
1	Insurance card /e-card Kartu asuransi /kartu elektronik	<input type="checkbox"/>	<input type="checkbox"/>
2	Passport Paspor	<input type="checkbox"/>	<input type="checkbox"/>
3	Entry stamp Stempel masuk	<input type="checkbox"/>	<input type="checkbox"/>
4	Statement Letter (PMN format) Surat pernyataan format PMN	<input type="checkbox"/>	<input type="checkbox"/>
5	Pre-Authorisation Form Formulir Pra-Otorisasi	<input type="checkbox"/>	<input type="checkbox"/>
6	Examination Report Hasil pemeriksaan penunjang medis	<input type="checkbox"/>	<input type="checkbox"/>
7	Invoice & final bill Faktur & tagihan akhir	<input type="checkbox"/>	<input type="checkbox"/>
8	Suporting medical document (if any) Dokumen pendukung medis (jika ada)	<input type="checkbox"/>	<input type="checkbox"/>
9	Care Cost Form Formulir Biaya Perawatan	<input type="checkbox"/>	<input type="checkbox"/>
10	Discharge summary Ringkasan kepulangan	<input type="checkbox"/>	<input type="checkbox"/>

Document no. 1 – 4, 6 & 10 sent by customer to [pmnline@prudential.co.id](mailto:pmnline@prudential.co.id)  
 Dokumen no. 1 – 4, 6 & 10 dikirim oleh Nasabah ke [pmnline@prudential.co.id](mailto:pmnline@prudential.co.id)

Document no. 5, 7, 8 & 9 sent by SGH to [pmnline@prudential.co.id](mailto:pmnline@prudential.co.id)  
 Dokumen no. 5, 7, 8 & 9, dikirim oleh SGH ke [pmnline@prudential.co.id](mailto:pmnline@prudential.co.id)

Other document needed by PMN (if any):  
 Dokumen lainnya yang PMN perlukan (jika ada)

\_\_\_\_\_  
 \_\_\_\_\_

Stated in : \_\_\_\_\_  
 Dinyatakan di

Date :   -   -      
 Tanggal (date-month-year) (tanggal-bulan-tahun)

Sent by:  
 Dikirim oleh

Sent by:  
 Dikirim oleh

( \_\_\_\_\_ )  
 Customer  
 Nasabah

( \_\_\_\_\_ )  
 Financial Counselling Officer  
 Petugas Financial Counselling

## STATEMENT

I, the undersigned

Name :	Address :
Date of Birth :	Phone/Cell. No. :
e-KTP/ NIK No. :	
Relationship with the Patient :	

I, the undersigned, am the patient or the patient's representative/guardian ("I/my/me"). That I have registered the Patient with data as follows:

Name of Patient :	Claim No. :
Date of Birth :	Date of Admission :
Gender :	Name of Health Facility :
e-KTP No. :	
Policy No. :	Medical Record No. :
	Class : <input type="checkbox"/> According to the Eligible Plan
	<input type="checkbox"/> Not According to the Eligible Plan
	Reason :

Hereby state and confirm that PT PRUDENTIAL LIFE ASSURANCE (hereinafter referred to as "Prudential Indonesia") will issue the Letter of Guarantee in relation to the treatment in the name of the patient above. In connection with the above, I/the patient as described above state as follows :

1. That I guarantee that the Policy Number and Name of Patient stated in the Prudential Indonesia card are true as the Insured/insured member of Prudential Indonesia and I guarantee that the patient to be hospitalized is the same person named in such card.
2. That I agree that if the statement set out in point 1 above turns to be untrue, the Letter of Guarantee being issued by Prudential Indonesia to the hospital will be automatically void and I/the represented person am/is willing to pay all costs to the Hospital.
3. That I and/or the representative/guardian agree /agrees to be responsible for any costs difference or all costs if:
  - a. It exceeds the limit of health benefit set out in the policy directly, and agree to be responsible to make full payment if there is any outstanding costs difference in the future (after discharge from the Hospital) due to revision of costs or calculation.
  - b. This treatment does not meet the requirements pursuant to the patient's policy and the payment is made directly to the Hospital before being discharged from the Hospital, regardless that Prudential Indonesia has issued the guarantee at the time the patient is to be treated.
4. That I hereby give a power of attorney to the Specialist, General Physician, Paramedic (midwife/nurse), Hospital Staff with whom (I/the represented person) being examined or treated to give full statement regarding the condition/illness/medical history/ treatment/medical information, verbally or in writing to Prudential Indonesia including the employees or any other person designated by Prudential Indonesia in relation to the submission of Life/health insurance claim in the name set out above. In connection with the above, I am hereby responsible for the disclosure of medical information or data and hold harmless the Specialists, General Physicians, Paramedics (midwives/nurses), Hospital Staff /Insurers or other parties from all legal consequences arising therefrom or potentially arising from any party whatsoever. This power of attorney will not terminate if there is no revocation from me, or any reasons as set out in articles 1813, 1814, and 1816 of the Indonesian Civil Code and a copy of this power of attorney has the same legal and binding effect as the original thereof.
5. I give permission to Prudential Indonesia to give or receive information regarding my/the represented person's Policy data to pursue any necessary additional information from other Insurer and/or other agencies.

In witness whereof, this Statement is made truthfully, consciously and without any duress from any party whatsoever.

The undersigned

Date:

Signed by Hospital Officer and

Hospital Stamp

Name :

Name :

Department :



PRE-AUTHORISATION FORM TO BE COMPLETED BY ATTENDING DOCTOR

(Indicate "NA" if not applicable.)

(Fill dates in format "DDMMYYYY") \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Patient :		NRIC / FIN No	
Policy Number :			
<b>A. Details of Hospitalization</b>			
Name of Principal Doctor and Clinic		Name of Hospital / Surgery Centre	
Preferred Ward Type		Date of Admission	Est. Length of Stay (No. of days)
<u>Private</u> <input type="checkbox"/> Day Surgery <input type="checkbox"/> 2 Bed <input type="checkbox"/> Standard Single Bed <input type="checkbox"/> 4 Bed <input type="checkbox"/> Others:		Is the condition typically managed on an outpatient basis? If Yes, please provide reason for <u>this</u>  <b>Hospitalization.</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, reasons are:	
<u>Public/Restructured</u> <input type="checkbox"/> Day Surgery (subsidised) <input type="checkbox"/> Class B1/B1+ <input type="checkbox"/> Day Surgery (non-subsidised) <input type="checkbox"/> Class B2/B2+ <input type="checkbox"/> Class A <input type="checkbox"/> Class C			
Date of first consultation of symptoms	Date of diagnosis/ provisional diagnosis	Diagnosis / Provisional diagnosis in ICD 10 AM with description	
Date of onset of symptoms / Duration of symptoms		Description of symptoms	
Did the patient come to see you with a referral letter? <input type="checkbox"/> No <input type="checkbox"/> Yes (If a referral letter is available, please attach a copy to speed up the pre-authorisation process.)		Based on the information available to you, does the patient have any of the following major co-morbidities? (Note: Only co-morbidities that have impact on the patient's treatment, impact on the duration of hospitalization, or which are medically related to the patient's condition, need to be indicated.)	
Based on the information available to you, is the event for which pre-authorisation is being requested:  <input type="checkbox"/> For a routine check-up/screening <input type="checkbox"/> Related to a clinical trial/study		Comorbidities	Date of diagnosis, if available
		<input type="checkbox"/> Cancer	
		<input type="checkbox"/> Stroke, Heart Failure, Cardiovascular Disease	
		<input type="checkbox"/> Diabetes	

<input type="checkbox"/> Related to self-inflicted injuries/attempted suicide <input type="checkbox"/> Related to alcohol/drug abuse <input type="checkbox"/> Related to a congenital anomaly/genetic disorder <input type="checkbox"/> Related to a mental/psychiatric disorder <input type="checkbox"/> Related to an elective cosmetic procedure <input type="checkbox"/> Related to a dental procedure <input type="checkbox"/> Related to an STD or HIV/AIDS <input type="checkbox"/> Related to pregnancy/ childbirth/infertility /caesarian section /miscarriage or any complications arising there from <input type="checkbox"/> Related to cosmetic reason/ dental care/ refractive error correction	<input type="checkbox"/> Hyperlipidaemia	
	<input type="checkbox"/> Hypertension	
<b>Date of onset of symptoms / Duration of symptoms</b>	<input type="checkbox"/> Kidney Failure	
	<input type="checkbox"/> Other Significant Comorbidities that impact the patient's care (Please state):	
a. If hospitalization was due to injury, please describe circumstance and cause of injury		NOT APPLICABLE
b. Please indicate date/time of accident : (dd/mm/yyyy) _____/_____/_____ (hrs)_____ am <input type="checkbox"/> pm <input type="checkbox"/>		

B. Best Estimated Costs	S\$																		
<b>1. Total Professional Fees</b> <table border="1" style="width: 100%;"> <tr> <td colspan="2">TOSP Code and Description: Breakdown as:</td> </tr> <tr> <td>Surgeon fees</td> <td style="text-align: right;">S\$</td> </tr> <tr> <td>Anaesthetist fees</td> <td style="text-align: right;">S\$</td> </tr> </table> <table border="1" style="width: 100%;"> <tr> <td colspan="2">TOSP Code and Description:</td> </tr> <tr> <td>Surgeon fees</td> <td style="text-align: right;">S\$</td> </tr> <tr> <td>Anaesthetist fees</td> <td style="text-align: right;">S\$</td> </tr> </table> <table border="1" style="width: 100%;"> <tr> <td colspan="2">TOSP Code and Description:</td> </tr> <tr> <td>Surgeon fees</td> <td style="text-align: right;">S\$</td> </tr> <tr> <td>Anaesthetist fees</td> <td style="text-align: right;">S\$</td> </tr> </table>	TOSP Code and Description: Breakdown as:		Surgeon fees	S\$	Anaesthetist fees	S\$	TOSP Code and Description:		Surgeon fees	S\$	Anaesthetist fees	S\$	TOSP Code and Description:		Surgeon fees	S\$	Anaesthetist fees	S\$	.....
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Anaesthetist fees	S\$																		
TOSP Code and Description:																			
Surgeon fees	S\$																		
Anaesthetist fees	S\$																		
<b>2. Total Attendance Fees</b>	.....																		
<b>3. Total of Other Fees (E.g. Secondary treating doctors' fees, surgical implants, medical consumables, and other charges.)</b> Breakdown as: a. S\$ b. S\$ c. S\$	.....																		

d.	S\$	
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<b>4. Total Hospital Charges</b>		.....
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<b>5. Total Bill Size = 1 + 2 + 3 + 4</b>		.....
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**C. Principal Doctor's Declaration & Signature**

1. I represent and warrant that:

- (a) I have personally examined and treated the Insured (i.e. patient) in respect of the medical condition described above and that the information stated above represent my genuine and honest opinion of his/her condition and my recommended treatment; and
- (b) the answers given above are true, accurate and complete to the best of my knowledge and belief and that no information has been withheld.

Official Stamp of Hospital / Clinic

Name of Doctor: \_\_\_\_\_

Doctor's Signature and Date: \_\_\_\_\_

# Prosedur Pendaftaran Cashless di Singapore General Hospital (SGH)

## Informasi Penting!

### T&C Pre-Admission

1. Nasabah dapat melengkapi dokumen diperlukan untuk penjaminan seperti yang terlampir diatas atau di [bit.ly/PRUMedicalNetwork](https://bit.ly/PRUMedicalNetwork)
2. Dokumen lain yang diperlukan: **E-card, Passport, Entry Stamp, Hasil penunjang rawat jalan (jika ada)**
3. Seluruh Dokumen untuk keperluan penjaminan dapat dikirim **oleh Nasabah** ke PMN melalui email ke : [pmnline@prudential.co.id](mailto:pmnline@prudential.co.id) dengan mencantumkan nomor polis dan nama tertanggung/peserta di subject email.
4. Dokumen cek list dapat di print dan diberikan ke bagian Financial counselling di RS.
5. Nasabah melakukan pembayaran Pribadi untuk **rawat jalan / Pre-admission**.

### T&C Rawat Inap

1. Seluruh hasil penunjang selama perawatan dapat **dikirimkan oleh Nasabah** ke PMN, [pmnline@prudential.co.id](mailto:pmnline@prudential.co.id) dengan mencantumkan nomor polis dan nama tertanggung/peserta di subject email.
2. Discharged Summary dapat **dikirimkan oleh Nasabah** ke PMN, [pmnline@prudential.co.id](mailto:pmnline@prudential.co.id) dengan mencantumkan nomor polis dan nama tertanggung/peserta di subject email.

1

Nasabah harus melakukan Pre-admission sebelum Tindakan / rawat inap, melalui konsultasi terlebih dahulu dengan dokter yang akan dituju / merawat.

2

Pastikan nomor HP yg terdaftar di Prudential masih aktif di negara tujuan agar dapat menerima notifikasi keputusan penjaminan.

3

Nasabah harus meminta nomer rekening RS untuk pembayaran excess / selisih claim (jika ada).

4

Kamar yang tersedia di Singapore General Hospital (SGH) adalah kelas kamar 1 dan 4 tempat tidur. Nasabah dianjurkan untuk memilih kelas kamar sesuai plan benefit asuransi yang dimiliki untuk menghindari selisih biaya (ekses) klaim akibat prorata.

# Alur Pendaftaran Cashless di Singapore General Hospital (SGH)

 = Point 1 s/d 3 Menggunakan biaya Pribadi

**1** Nasabah datang ke SGH untuk proses rawat jalan / Pre-admission.

**2** Nasabah konsultasi dengan dokter.

**3** Mendapatkan jadwal Tindakan / perawatan.

**4** Nasabah mengirimkan dokumen ke PMN via email: **dokumen ceklist, Ecard, Passport, Entry Stamp, Hasil penunjang rawat jalan (jika ada), Surat Pernyataan (SP).** Ke [pmnline@prudential.co.id](mailto:pmnline@prudential.co.id)

**5** Nasabah Memberikan form Pre-Autoritation Form (PAF) kosong ke Financial counselling dan untuk mendapatkan informasi estimasi biaya Tindakan / perawatan.

**6** Nasabah pulang dan menunggu konfirmasi keputusan penjaminan dari PMN.

**7** Nasabah menerima konfirmasi penjaminan dari PMN **melalui sms yang terdaftar di Prudential.**

**8** Nasabah kembali ke RS sesuai jadwal tindakan untuk melakukan registrasi rawat inap / one day care. **(dokumen hasil penunjang selama perawatan dikirimkan ke PMN)**

**9** Nasabah sudah diijinkan pulang oleh dokter dan **menerima Summary Discharged** dari Rumah Sakit. Nasabah **wajib** mengirimkan **summary discharge** ke [pmnline@prudential.co.id](mailto:pmnline@prudential.co.id)

**10** Nasabah akan menerima konfirmasi tentang selisih biaya perawatan (jika ada) **maksimal 14 hari sejak keluar dari RS.**



## FAQ - Cashless di Singapore General Hospital (SGH)

No.	Question	Answer
1	Menagapa memilih SGH untuk melakukan perawatan?	Karena proses penjaminan di SGH dilakukan langsung oleh PMN tanpa TPA dan SGH <b>berada di peringkat ke-9 pada kategori World's Best Hospitals 2023 – top 250 versi newsweek.com</b>
2	Apakah biaya rawat jalan bisa di claim ke Prudential?	Jika rawat jalan dilanjutkan dengan rawat inap, maka proses rawat jalan dapat diajukan secara reimbus. Dengan penggantian sesuai ketentuan polis
3	Bagaimana cara mengetahui pengajuan Tindakan sudah disetujui / tidak oleh PMN?	Akan ada informasi via SMS ke nomer yang terdaftar di Prudential
4	Mengapa Nasabah harus mengirimkan dokumen ke PMN bukan melalui RS?	Mengacu pada ketentuan Negara Singapore terkait Personal Data Protection Act. Bahwa data medis pasien tidak bisa dikirimkan ke pihak luar manapun selain pasien.
5	Nomer telpon Prudential yang dapat dihubungi selama berada di Singapore?	Silahkan menghubungi customer care PMN di nomor +62 1500085 tekan 1 (untuk bahasa) kemudian tekan 1 (untuk nasabah).
6	Apakah ada deposit untuk perawatan di SGH?	Tidak ada deposit, tetapi RS akan menagihkan selisih biaya diawal, jika terdapat selisih antara nilai jaminan awal (LOG) dengan biaya estimasi yang diajukan RS.
7	Apakah selisih biaya pada surat jaminan awal dapat di reimbursement?	Tidak, biaya selisih pada LOG tidak dapat diajukan reimbursement.
8	Jika Tindakan CITO apakah dapat dijamin oleh PMN?	Tindakan Cito bisa diajukan penjaminan oleh PMN akan tetapi Nasabah harus membayar deposit RS terlebih dahulu.