



**OUT PATIENT - INPATIENT CLAIM FORM (To be filled out by Attending Physician)**  
**FORMULIR KLAIM RAWAT JALAN - RAWAT INAP (Diisi oleh Dokter yang merawat )**

**B**

|  |  |            |         |            |           |               |              |               |              |            |   |         |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
|--|--|------------|---------|------------|-----------|---------------|--------------|---------------|--------------|------------|---|---------|-------------|---------|-------------|--------------|--|------------|--|------------|--|--------------|--|------------|--|------------|--|---------|--|
| Nama pasien<br>(Patient's name)<br><br>Tanggal lahir / usia<br>(Date of birth / age)   | <div style="text-align: right;"> <input type="checkbox"/> Laki - laki (Male)      <input type="checkbox"/> Wanita (Female)         </div><br><table style="width: 100%; border: none;"> <tr> <td style="border: none; text-align: center;">[ ] [ ]</td> <td style="border: none; text-align: center;">/</td> <td style="border: none; text-align: center;">[ ] [ ]</td> <td style="border: none; text-align: center;">/</td> <td style="border: none; text-align: center;">[ ] [ ]</td> <td style="border: none; text-align: center;">[ ] [ ]</td> <td style="border: none; text-align: center;">tahun (years)</td> </tr> <tr> <td style="border: none; text-align: center;">tanggal (dd)</td> <td style="border: none;"></td> <td style="border: none; text-align: center;">bulan (mm)</td> <td style="border: none;"></td> <td style="border: none; text-align: center;">tahun (yy)</td> <td style="border: none;"></td> <td style="border: none;"></td> </tr> </table>  | [ ] [ ]    | /       | [ ] [ ]    | /         | [ ] [ ]       | [ ] [ ]      | tahun (years) | tanggal (dd) |            | bulan (mm)  |         | tahun (yy)  |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| [ ] [ ]  | /  | [ ] [ ]    | /       | [ ] [ ]    | [ ] [ ]   | tahun (years) |              |               |              |            |   |         |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| tanggal (dd)   |  | bulan (mm) |         | tahun (yy) |           |               |              |               |              |            |   |         |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| Nomor rekam medis<br>(Medical record number)   |  |            |         |            |           |               |              |               |              |            |   |         |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| Tanggal perawatan / jumlah hari perawatan<br>(Date of hospitalization / lengths of hospitalization)  | <table style="width: 100%; border: none;"> <tr> <td style="border: none; text-align: center;">[ ] [ ]</td> <td style="border: none; text-align: center;">/</td> <td style="border: none; text-align: center;">[ ] [ ]</td> <td style="border: none; text-align: center;">/</td> <td style="border: none; text-align: center;">[ ] [ ]</td> <td style="border: none; text-align: center;">s.d. (to)</td> <td style="border: none; text-align: center;">[ ] [ ]</td> <td style="border: none; text-align: center;">/</td> <td style="border: none; text-align: center;">[ ] [ ]</td> <td style="border: none; text-align: center;">/</td> <td style="border: none; text-align: center;">[ ] [ ]</td> <td style="border: none; text-align: center;">=</td> <td style="border: none; text-align: center;">[ ] [ ]</td> <td style="border: none; text-align: center;">hari (days)</td> </tr> <tr> <td style="border: none; text-align: center;">tanggal (dd)</td> <td style="border: none;"></td> <td style="border: none; text-align: center;">bulan (mm)</td> <td style="border: none;"></td> <td style="border: none; text-align: center;">tahun (yy)</td> <td style="border: none;"></td> <td style="border: none; text-align: center;">tanggal (dd)</td> <td style="border: none;"></td> <td style="border: none; text-align: center;">bulan (mm)</td> <td style="border: none;"></td> <td style="border: none; text-align: center;">tahun (yy)</td> <td style="border: none;"></td> <td style="border: none; text-align: center;">[ ] [ ]</td> <td style="border: none;"></td> </tr> </table> | [ ] [ ]    | /       | [ ] [ ]    | /         | [ ] [ ]       | s.d. (to)    | [ ] [ ]       | /            | [ ] [ ]    | /   | [ ] [ ] | =           | [ ] [ ] | hari (days) | tanggal (dd) |  | bulan (mm) |  | tahun (yy) |  | tanggal (dd) |  | bulan (mm) |  | tahun (yy) |  | [ ] [ ] |  |
| [ ] [ ]  | /  | [ ] [ ]    | /       | [ ] [ ]    | s.d. (to) | [ ] [ ]       | /            | [ ] [ ]       | /            | [ ] [ ]    | =   | [ ] [ ] | hari (days) |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| tanggal (dd)   |  | bulan (mm) |         | tahun (yy) |           | tanggal (dd)  |              | bulan (mm)    |              | tahun (yy) |   | [ ] [ ] |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| Riwayat penyakit dahulu<br>(Previous medical history)<br><br>Sejak kapan pertama kali pasien terdiagnosa<br>(On which date the patient first diagnosed)  | <table style="width: 100%; border: none;"> <tr> <td style="border: none; text-align: center;">[ ] [ ]</td> <td style="border: none; text-align: center;">/</td> <td style="border: none; text-align: center;">[ ] [ ]</td> <td style="border: none; text-align: center;">/</td> <td style="border: none; text-align: center;">[ ] [ ]</td> </tr> <tr> <td style="border: none; text-align: center;">tanggal (dd)</td> <td style="border: none;"></td> <td style="border: none; text-align: center;">bulan (mm)</td> <td style="border: none;"></td> <td style="border: none; text-align: center;">tahun (yy)</td> </tr> </table>   | [ ] [ ]    | /       | [ ] [ ]    | /         | [ ] [ ]       | tanggal (dd) |               | bulan (mm)   |            | tahun (yy)  |         |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| [ ] [ ]  | /  | [ ] [ ]    | /       | [ ] [ ]    |           |               |              |               |              |            |   |         |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| tanggal (dd)   |  | bulan (mm) |         | tahun (yy) |           |               |              |               |              |            |   |         |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| Riwayat penyakit sekarang<br>(Recent medical history)<br><br>Sejak kapan pertama kali pasien terdiagnosa<br>(On which date the patient first diagnosed)  | <table style="width: 100%; border: none;"> <tr> <td style="border: none; text-align: center;">[ ] [ ]</td> <td style="border: none; text-align: center;">/</td> <td style="border: none; text-align: center;">[ ] [ ]</td> <td style="border: none; text-align: center;">/</td> <td style="border: none; text-align: center;">[ ] [ ]</td> </tr> <tr> <td style="border: none; text-align: center;">tanggal (dd)</td> <td style="border: none;"></td> <td style="border: none; text-align: center;">bulan (mm)</td> <td style="border: none;"></td> <td style="border: none; text-align: center;">tahun (yy)</td> </tr> </table>   | [ ] [ ]    | /       | [ ] [ ]    | /         | [ ] [ ]       | tanggal (dd) |               | bulan (mm)   |            | tahun (yy)  |         |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| [ ] [ ]  | /  | [ ] [ ]    | /       | [ ] [ ]    |           |               |              |               |              |            |   |         |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| tanggal (dd)   |  | bulan (mm) |         | tahun (yy) |           |               |              |               |              |            |   |         |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| Diagnosa, atau dugaan diagnosa<br>(Diagnosa or pre diagnose)   |  |            |         |            |           |               |              |               |              |            |   |         |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| Diagnosa berhubungan dengan<br>(The diagnose related to)   | Kecelakaan (Accident) : <input type="checkbox"/> Ya (Yes) <input type="checkbox"/> Tidak (No)<br>Obat terlarang (Drug abuse) : <input type="checkbox"/> Ya (Yes) <input type="checkbox"/> Tidak (No)<br>HIV (AIDS) : <input type="checkbox"/> Ya (Yes) <input type="checkbox"/> Tidak (No)   |            |         |            |           |               |              |               |              |            |   |         |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| Terapi Tindakan<br>(Therapy or treatment)  |  |            |         |            |           |               |              |               |              |            |   |         |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| Penyebab / penyakit yang mendasari<br>(Cause / underlying disease)   |  |            |         |            |           |               |              |               |              |            |   |         |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| Penyebab / penyakit yang mendasari diderita sejak<br>(The date of the caused / underlying diseases occurred)   | <table style="width: 100%; border: none;"> <tr> <td style="border: none; text-align: center;">[ ] [ ]</td> <td style="border: none; text-align: center;">/</td> <td style="border: none; text-align: center;">[ ] [ ]</td> <td style="border: none; text-align: center;">/</td> <td style="border: none; text-align: center;">[ ] [ ]</td> </tr> <tr> <td style="border: none; text-align: center;">tanggal (dd)</td> <td style="border: none;"></td> <td style="border: none; text-align: center;">bulan (mm)</td> <td style="border: none;"></td> <td style="border: none; text-align: center;">tahun (yy)</td> </tr> </table>   | [ ] [ ]    | /       | [ ] [ ]    | /         | [ ] [ ]       | tanggal (dd) |               | bulan (mm)   |            | tahun (yy)  |         |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| [ ] [ ]  | /  | [ ] [ ]    | /       | [ ] [ ]    |           |               |              |               |              |            |   |         |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| tanggal (dd)   |  | bulan (mm) |         | tahun (yy) |           |               |              |               |              |            |   |         |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| Nama dan alamat Dokter yang merujuk<br>(Name and address of referral Doctor)   |  |            |         |            |           |               |              |               |              |            |   |         |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| Apakah pasien pernah konsultasi / dirawat sebelumnya ?<br>(Has the patient ever been consulted / hospitalized before) ?<br>a. Tanggal (Date)<br><br>b. Diagnosa (Diagnose)<br><br>c. Nama Dokter (Doctor's name)<br><br>d. Nama Rumah Sakit (Hospital's name)  | <table style="width: 100%; border: none;"> <tr> <td style="border: none; text-align: center;">[ ] [ ]</td> <td style="border: none; text-align: center;">/</td> <td style="border: none; text-align: center;">[ ] [ ]</td> <td style="border: none; text-align: center;">/</td> <td style="border: none; text-align: center;">[ ] [ ]</td> </tr> <tr> <td style="border: none; text-align: center;">tanggal (dd)</td> <td style="border: none;"></td> <td style="border: none; text-align: center;">bulan (mm)</td> <td style="border: none;"></td> <td style="border: none; text-align: center;">tahun (yy)</td> </tr> </table>   | [ ] [ ]    | /       | [ ] [ ]    | /         | [ ] [ ]       | tanggal (dd) |               | bulan (mm)   |            | tahun (yy)  |         |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| [ ] [ ]  | /  | [ ] [ ]    | /       | [ ] [ ]    |           |               |              |               |              |            |   |         |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| tanggal (dd)   |  | bulan (mm) |         | tahun (yy) |           |               |              |               |              |            |   |         |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| Jenis serta hasil pemeriksaan fisik, lab, rontgen, USG, CT scan, Patologi Anatomi, dll<br>(Physical exam result, lab, X ray, USG, CT scan, Pathology Anatomy, etc)   |  |            |         |            |           |               |              |               |              |            |   |         |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| Saya, sebagai Dokter yang menangani pasien tersebut di atas menyatakan telah membaca dan menjawab pertanyaan-pertanyaan tersebut di atas dengan lengkap dan benar.<br>(As the Doctor handling the care of the above-mentioned patient, I hereby state that I have read and answered the questions in this form clearly and completely).<br>Nama Dokter : _____<br>(Doctor's name)<br>Nama Rumah Sakit : _____<br>(Hospital's name)<br>Alamat Rumah Sakit : _____<br>(Hospital's address)<br>Tempat dan tanggal : _____<br>(Place and date)   |  |            |         |            |           |               |              |               |              |            |   |         |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| <table style="width: 100%; border: none;"> <tr> <td style="border: none; text-align: center;">[ ] [ ]</td> <td style="border: none; text-align: center;">/</td> <td style="border: none; text-align: center;">[ ] [ ]</td> <td style="border: none; text-align: center;">/</td> <td style="border: none; text-align: center;">[ ] [ ]</td> </tr> <tr> <td style="border: none; text-align: center;">tanggal (dd)</td> <td style="border: none;"></td> <td style="border: none; text-align: center;">bulan (mm)</td> <td style="border: none;"></td> <td style="border: none; text-align: center;">tahun (yy)</td> </tr> </table> | [ ] [ ]  | /          | [ ] [ ] | /          | [ ] [ ]   | tanggal (dd)  |              | bulan (mm)    |              | tahun (yy) | <div style="display: flex; justify-content: space-between;"> <div style="width: 45%; text-align: center;">           _____<br/>           Tandatangan dan nama Dokter         </div> <div style="width: 45%; text-align: center;">           _____<br/>           Stempel Rumah Sakit         </div> </div> |         |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| [ ] [ ]  | /  | [ ] [ ]    | /       | [ ] [ ]    |           |               |              |               |              |            |   |         |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |
| tanggal (dd)   |  | bulan (mm) |         | tahun (yy) |           |               |              |               |              |            |   |         |             |         |             |              |  |            |  |            |  |              |  |            |  |            |  |         |  |