MINISTRY OF HEALTH
SINGAPORE

MEDICAL CLAIMS AUTHORISATION FORM (SINGLE INSTITUTION)

Central Provident Fund Board Singapore

A - Particulars of Patient		
Name:	Date of Birth: (DD-MM-YYYY)	☐ Singapore Citizen (SC) ☐ Permanent Resident (PR) ☐ Foreigner
NRIC / CPF Account No:	FIN / Passport No: (for foreigners only)	

B - Particulars of the Additional MediSave Payer			
Name:	Date of Birth: (DD-MM-YYYY)	NRIC / CPF Account No:	☐ Singapore Citizen (SC) ☐ Permanent Resident (PR)
I am the Additional MediSave Payer, and the Patient is my: ☐ Spouse ☐ Child ☐ Parent ☐ Grandparent (Patient must be SC/PR) ☐ Sibling (Patient must be SC/PR)			

C – Authorisation as Patient / Additional MediSave Payer

(For the **Patient**)
I authorise the Medical Institution to:

Y	N	
Y	N	Check my MediSave balance and withdraw from my MediSave
Y	N	Check my coverage and claim from MediShield Life and my Health Insurance Policy

(For the **Additional MediSave Payer**)
I authorise the Medical Institution to:

Y	N	
Y	N	Check my MediSave balance and withdraw from my MediSave

For all treatments received on admission / visit date:

(a) ☐For an **indefinite** period, until amendment or revocation of consent, starting from: Date (DD/MM/YYYY):

(b) ☐Within a specified period, from: Date (DD/MM/YYYY): to Date (DD/MM/YYYY):

Note: You may choose **either** (a) or (b). Selecting (a) means authorisation provided is indefinite.

For the Patient's treatment charges incurred at (Name of Medical Institution):

D - Authorisation on Behalf of Patient / Additional MediSave Payer
(Please complete this part only if you are signing on behalf of the Patient or the Additional MediSave Payer.)

Name:	Date of Birth: (DD-MM-YYYY)	NRIC/ FIN / Passport No:

I am signing this form on behalf of (please tick):

☐ **The Patient,** because he/she is under 21 years of age, and I am his/her ☐ parent / ☐ legal guardian.

☐ **The Patient** because he/she:
☐ lacks capacity or ☐ is deceased,
and I am his/her:
☐ donee / deputy.
☐ adult Spouse / Child / Parent, and I confirm that I have the authority to agree on behalf of the Patient.

☐ **The Additional MediSave Payer**, because he/she is under 21 years of age, and I am his/her ☐ parent / ☐ legal guardian.

Doctor's Certification
I certify that the Patient lacks capacity and is unable to sign this form.

Name of Doctor:	Doctor's MCR:	Clinic / Hospital Stamp:
Doctor's Signature:	Date of Signature (DD-MM-YYYY):	

By signing or affixing my thumbprint, (a) I declare that the information I have provided is accurate; (b) I acknowledge that I have read, understood the definition and agree to the terms and conditions, which is accessible via https://go.gov.sg/mcaftncs	Signature / Thumbprint of Patient / Person signing on behalf of Patient	Signature / Thumbprint of Additional MediSave Payer / Person signing on behalf of the Additional MediSave Payer	Signature of Witness and Date of Signature (DD-MM-YYYY):
	Date of Signature (DD-MM-YYYY):	Date of Signature (DD-MM-YYYY):	Name of Witness:
	Interpreted by (Name & NRIC):	Interpreted by (Name & NRIC):	NRIC / Official Stamp: