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FAQs on Disclosure of Patient Medical Records to Insurers

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Requirements relating to patient consent and documentation

1. Why are healthcare providers required to ensure that patients have provided consent for the disclosure of their medical records to insurers?

- Healthcare providers have a duty under the Healthcare Services Act (HCSA), specifically Regulation 38 of the Healthcare Services (General) Regulations, to safeguard the confidentiality of patient health information.
- When a patient consents to the disclosure of their health information to an insurer for the specified purpose(s), healthcare providers should provide relevant patient health information to insurers and ensure that the patient consent is properly documented in the patient's medical records.

2. Is separate patient consent required for each request to disclose medical records to insurers?

- Healthcare providers (including hospitals, polyclinics, general practitioner clinics and specialist clinics) and insurers should ensure that patient consent is obtained.
- Patient consent **can be obtained through various means**, including relevant insurers' policy application, policy contract, claim form, patient consent form, preauthorisation request or the Medical Claims Authorisation Form (MCAF). The scope of consent depends on what the policyholder has agreed to in the specific form, which may cover underwriting and/or claims assessment.
- As a matter of best practice, insurers should:
    - Obtain fresh consent for the disclosure of patient health information for each request, except where it relates to a prior request (e.g. to seek further release of health information relating to an earlier request; to clarify previously submitted medical reports) and serves the same purpose.; and
    - Clearly state in their requests that the necessary patient consent has been obtained, and that it covers the purpose for which the information is being requested.
- To illustrate:
    - For insurance underwriting, if the policyholder consented in their policy application form for the insurer to obtain health information for underwriting or processing the application, then such consent would suffice to provide information relevant to the underwriting.
    - Alternatively, the MCAF or claims form may be used as it obtains patient consent for relevant items related to a claim made under that policy, such as allowing the insurer to obtain patient health information for claims processing, administration, assessment, auditing and adjudication of claims-related disputes.
    - As a matter of best practice, where an insurer has obtained patient consent to request health information for underwriting at the point of policy application, but subsequently seeks to obtain health information to assess a stroke claim, <u>fresh consent should be sought for claims assessment (e.g. via the claims form)</u>. For clarity, where an insurer has already obtained patient consent to request health information to assess a stroke claim and subsequently seeks clarification on the information provided or requests for additional documentation relating to the stroke

claim, fresh consent need not be sought as it relates to the original request and serves the same purpose.

Requirements relating to scope of disclosure

3. What is considered relevant information that insurers may request from healthcare professionals?

- Generally, insurers request patient health information from healthcare professionals for the purposes of assessing a patient's claim or whether to issue a pre-authorisation / Letter of Guarantee.
    - Insurers should set out their request clearly and with sufficient details, including:
        i. The purpose and context of the request e.g. for claims assessment
        ii. Details of the relevant claim being conducted e.g. for a stroke episode
        iii. Patient consent has been obtained
    - Healthcare professionals should then provide relevant patient health information e.g. medical history relating to stroke or its risk factors to insurers to facilitate assessment.
- Healthcare professionals should prepare separate medical reports, memos, or clinical/ discharge summaries for insurers, drawing from their own medical records (electronic or otherwise).
- There is no need to provide the raw medical records to the insurers, except in specific circumstances where it may be needed, e.g. radiological or laboratory test records relevant and appropriate to the information provided (laboratory test records not relevant to the request by the insurer should be redacted) – see Question 4 for more details.

S/N	Purposes which patient health information may be requested	Scope of relevant information that may be requested
1.	Assessment of insurance claim	• Only patient health information relevant to the claim may be disclosed, provided the patient has consented. • As a matter of best practice, insurers may develop a reference guide setting out the type of information considered relevant to a claim assessment, e.g. relevant information for top ten most frequently submitted claims.
2.	Underwriting or investigation (e.g. into early/ suspicious claims)	• A broader scope of patient health information may be requested (e.g. comprehensive medical history) as the assessment evaluates the overall health status of the individual, rather than being specific to a particular claimed condition. • When making such a request, insurers should make clear (i) the purpose and context of the request e.g. underwriting assessment, and (ii) the patient has consented.

a) Examples of relevant information in the context of insurance claims

- When a patient makes a claim for stroke:
    - As a matter of best practice, insurers should set out their request clearly. Vague requests (e.g. “please list all visits to this clinic and the diagnosis”), or request for information unrelated to the stroke claim assessment (e.g. bowel surgery, or irrelevant minor illnesses) should not be made.
    - Upon receipt of the insurers’ request, healthcare professionals should provide the requested information as relevant to the purpose. Relevant patient health information includes related medical history and risk factors for stroke (e.g. diabetes, transient ischaemic attack, atrial fibrillation, and hyperlipidaemia, hypertension), dates of related diagnoses, dates of relevant visits, appearance of relevant symptoms (e.g. facial asymmetry, weakness, numbness), and prescribed medications, as these are related to the claim assessment.

- When a patient makes a claim for cataract surgery:
    - Vague requests (e.g. “please list all visits to this clinic and the diagnosis”), or request for information unrelated to the cataract surgery claim assessment (e.g. treatment history of chlamydia (a sexually transmitted infection)) should not be made.
    - Upon receipt of the insurers’ request, healthcare professionals should provide the requested information if relevant to the purpose. Relevant patient health information includes the diagnosis date of the eye condition, date of visits relating to the diagnosis, relevant risk factors, management and treatment of the eye condition, and appearance of relevant symptoms (e.g. deterioration or loss of visual function etc), as these are related to the claim assessment.

b) Examples of relevant information in the context of underwriting or investigation into early/ suspicious claims

- When an individual applies for insurance coverage, he is required to make a declaration of any health conditions on the basis of “utmost good faith”.
- If the individual declares, or is suspected of having medical conditions (e.g. hypertension, diabetes, psychiatric conditions), the insurer will assess the severity of the health condition, assess the risk classification and overall insurability of the individual, in accordance with its commercial and actuarial considerations. The insurer may thus request broader and more comprehensive health information (not confined to a specific medical condition) including consultation notes, diagnoses, investigation results, treatment history, compliance with medication, and related co-morbidities.
- In these cases, insurers should clearly state that the request is for underwriting/ investigation purposes, and that the applicant has provided consent for such disclosure through relevant forms. The healthcare provider in turn should provide such information in full.

4. Can healthcare professionals provide insurers with raw medical records e.g. notes from electronic medical records (EMRs) and radiology and blood test reports?

- Raw medical records are defined as the unprocessed, original clinical documentation, which typically include:
  - Notes from the EMRs or handwritten clinical notes
  - Surgical notes and operative reports
  - Laboratory and radiology test reports (including imaging studies)
  - Diagnostic images e.g. CT, MRI, X-ray images
  - Histopathology report
  - Patient charts or files
- As a general rule, healthcare professionals should prepare separate medical reports, memos, or clinical/ discharge summaries for insurers. Certain raw medical records such as laboratory test reports and radiology images and reports may also be provided, with non-relevant details redacted as necessary, to corroborate the clinical findings and treatment recommendations in the medical report.

- <u>To illustrate:</u>
  - Laboratory test reports may include multiple tests results such as blood counts, glucose levels, kidney function tests, tumour markers etc. If the purpose is to verify a diabetes-related claim, relevant findings (e.g. Oral glucose tolerance tests, HbA1c, lipid panel, kidney function) should be provided to the insurer. Irrelevant parameters in the laboratory report that are assessed as irrelevant to diabetes management (e.g. blood group) should be redacted.

  - When a spine surgery claim is submitted, the insurer may request underlying images and surgical notes to verify the indication of the procedure, and placement of various implants, as part of claim assessment. Healthcare professionals should provide (i) the pre-surgery investigations (e.g. ultrasound, X-ray, MRI, CT scan images and reports) to show the presence and extent of disease; (ii) intra-operative notes and images that document the surgical findings and outcomes, in addition to information on the patient's clinical signs and symptoms; and (iii) post-surgery imaging or other investigations that show post-surgical outcome, placement of implants etc. Details irrelevant to the claim such as incidental findings of kidney cysts in the MRI report should redacted. Healthcare professionals should only provide the full radiologist report if it is relevant to the claims assessment.

  - When a cardiology claim is submitted, the insurer may request the full echocardiogram images and report to assess the severity of the cardiac condition. Such reports may contain images, structured measurements and interpretations (e.g. ejection fraction, chamber dimensions, wall thickness, valve function, regional wall motion abnormalities) that may be necessary to assess severity of the condition for the claims assessment.

- In addition, insurers may request for further raw records in exceptional circumstances, such as where:
    - Insurers need to ascertain adherence to terms specified in their panel contracts with healthcare providers (e.g. to check if a claim is in line with the panel contract terms);
    - Insurers need to carry out audits to safeguard against fraud, waste and abuse; and
    - Perform underwriting or risk assessments that require review of the overall health status of the individual.

- As a matter of best practice:
    - Healthcare professionals should seek clarification from the insurer rather than declining outright or limiting the disclosure, if there is uncertainty regarding the scope of information required.
    - Insurers should set out their request clearly and with sufficient details.

5. What should healthcare providers/professionals do when insurers request information that appears irrelevant to the patient's claim or underwriting assessment, or when insurers' requests are unclear?

- It is in the patient's interest for insurers to obtain the relevant information to process claims or underwriting in a timely manner.
    - If the request appears irrelevant or vague, **healthcare providers/professionals should clarify with the insurer why the information is required rather than decline the request outright.** There may be reasons that are not immediately apparent. Declining without proper clarification may lead to unfavourable outcomes for the patient such as delayed claims processing or a denied application or claim.
    - After clarification, healthcare providers/ professionals may provide the requested information relevant to the purpose. In doing so, healthcare providers/ professionals should provide information factually and neutrally.
- **Insurers should be clear and upfront about the purpose and context of their request at the outset as a matter of best practice.** This would help facilitate the process and minimise miscommunication.
- Healthcare providers/ professionals should not inadvertently support any under-declaration of pre-existing medical conditions, as this would disadvantage the patient when uncovered and is also unfair to others who declare their conditions truthfully.
- If healthcare providers/ professionals continue to receive inappropriate pressure from insurers to access irrelevant patient medical records, they may report the case to MOH at HCSA_Enquiries@moh.gov.sg. MOH will also review cases where healthcare providers/ professionals inappropriately decline valid requests for patient health information.

Requirements relating to NEHR access

6. Can healthcare providers/professionals access the National Electronic Health Record system (NEHR) to prepare medical reports for insurance purposes?

- No, healthcare professionals are strictly prohibited from accessing NEHR for any insurance-related purposes and unauthorised access of NEHR is a serious offence under the Health Information Act (HIA). NEHR access is primarily for patient care purposes.
    - Insurers do not and should not have access to NEHR and are not allowed to ask or require healthcare professionals to access NEHR on their behalf, including requests such as "Please include all her past medical histories including all date of her relevant visits, types of complaints, treatment given and the diagnoses *according to her NEHR*.".
    - Healthcare professionals must decline insurer requests for patients' NEHR information and may inform insurers that accessing NEHR for insurance purposes is prohibited.
- When a patient consents to the disclosure of their health information to an insurer for the specified purpose(s), healthcare providers/ professionals should provide relevant patient health information to insurers. When preparing such documentation for insurance purposes, healthcare providers/ professionals should rely on their institution's medical records system, such as EMRs and physical notes, and/or information from patient interactions.
    - Healthcare providers/ professionals should not simply decline to respond to requests for a patient's relevant medical history on the basis that access to NEHR is prohibited.
- If healthcare providers/ professionals continue to receive inappropriate pressure from insurers to access NEHR, they may report the case to MOH at HCSA_Enquiries@moh.gov.sg. MOH will also review cases where healthcare providers professionals inappropriately decline valid requests for patient health information.

Others

7. Are healthcare providers required to ascertain and monitor how insurers handle patient health information provided by the providers?

- In general, healthcare providers are not expected to monitor how insurers handle patient health information. For example, in providing a medical report to a patient for onward submission to an insurer, it will be for the patient to take the relevant steps to ensure the confidentiality of his/her health information is preserved.
- However, where healthcare providers provide patient medical reports to insurers, Circular 02/2026 Guidance on Disclosure of Patient Medical Records to Insurers guides that licensees should continue to take reasonable steps to ensure that insurers handle patient health information with confidentiality. For instance, where there is a panel contract between the insurer and the healthcare provider, healthcare providers could work with insurers to provide for appropriate data protection and/or confidentiality clauses in panel contracts.

8. Can the medical reports and memos for insurance purposes be issued directly by doctors, or must they be processed through requests to the medical records office (MRO)? Can patients request these documents directly?

- Healthcare institutions may establish their own internal processes for preparing documentation for insurance purposes, whether directly through patient interactions with their doctors or processed through patient requests to the MRO.
- Both insurers and patients may request medical documentation for insurance purposes. Healthcare providers should respond to requests for medical documentation per their internal processes, in compliance with the applicable regulatory requirements.

9. How should healthcare providers handle insurers' requests to inspect and audit patient medical records under panel contracts?

- Healthcare providers have a duty to safeguard the confidentiality of patient medical records in compliance with their legal and professional obligations e.g. under the HCSA, the HIA, and the relevant Ethical Code and Ethical Guidelines (ECEG).
- When the "right to audit and inspect" clauses in panel contracts are triggered under exceptional circumstances (e.g. ascertain adherence to terms specified in the panel contract with healthcare providers), such clauses must respect and do not compromise healthcare providers' ability to comply with their legal and professional obligations. Free and unfettered access to all patient medical records in healthcare providers' systems including EMRs should not be permitted.
- If healthcare providers/ professionals continue to receive inappropriate pressure from insurers to access irrelevant patient medical records, they may report the case to MOH at HCSA_Enquiries@moh.gov.sg. MOH will also review cases where healthcare providers/ professionals inappropriately decline valid requests for patient health information.