

**Important notes for Medisave Application Forms:**

**Please ensure that you have completed the following COMPULSORY items in the Medisave Application Forms and/or taken the necessary actions before visiting our polyclinics.**

1. Please complete **all** fields in Part I: Particulars of Patient
2. Please complete **all** fields in Part II: Particulars of Medisave Account Holder
3. Please tick one of the box to indicate the period over which the Medisave Account Holder wishes to authorise NHG Polyclinics to deduct their Medisave Account in Part III: Purpose of Withdrawal
4. Part IV & V: Authorisation & Declaration By Medisave Account Holder & Patient
  - Signature of Medisave Account Holder and Patient
  - Name and NRIC number of witness\*, followed by witness's signature
  - It is **compulsory** to submit a photocopy of the Medisave Account Holder's NRIC to our staff during the process of your application. We will not be able to process your application if this document is not given to our staff at the clinic.
  - Please ensure that all the necessary fields are completed and/or countersigned by the Medisave Account Holder. We seek your understanding that any incomplete form or any alteration without being countersigned by the Medisave Account Holder will **NOT** be processed.

*\*Witness has to be a third person, not the patient nor the Medisave Account Holder and must be a Singaporean 21 years old and above, and of sound mind*



MEDISAVE AUTHORISATION FORM FOR OUTPATIENT TREATMENTS

(This form may take about 3 minutes to complete.)

IT IS AN OFFENCE TO MAKE ANY FALSE STATEMENT OR TO PRODUCE ANY DOCUMENT WHICH IS FALSE FOR ANY PURPOSES CONNECTED WITH THE CENTRAL PROVIDENT FUND ACT ("CPF ACT")

PART I: PARTICULARS OF PATIENT

Name, NRIC/Birth Cert. No. \*S/T, Insured under MediShield? \*Y / N, Passport No. (for foreigners only), Wish to claim from MediShield? \*Y / N

Please complete PART I & II.

PART II: PARTICULARS OF MEDISAVE ACCOUNT HOLDER

Name, NRIC/CPF No. \*S/T

PART III: PURPOSE OF WITHDRAWAL

For charges incurred at (Name of Medical Institution) by the above patient for Dialysis#/ Chemotherapy/ Radiotherapy/ Scans & diagnostic/ Others: (please specify) \*

for the calendar year of (CCYY), for a period of 3 / 6 / 12 months \* from (DDMMCCYY) to (DDMMCCYY), on (DDMMCCYY), for an unlimited period unless revoked by notice in writing in accordance with Part IV (d) below

Please select the period that the Medisave Account Holder wishes to authorize NHG Polyclinics to deduct from their Medisave Account.

PART IV: AUTHORISATION & DECLARATION BY MEDISAVE ACCOUNT HOLDER

- (a) Patient is my \*self / spouse / child / parent / grandparent who is a Singapore citizen or permanent resident.
(b) I hereby authorise the Central Provident Fund Board ("the Board") to :
(i) deduct from my Medisave Account the amount specified by the medical institution for payment of the charges incurred, as provided under the Central Provident Fund (Medisave Account Withdrawals) Regulations and any amendment or re-enactment thereof (the "Medisave Account Deduction") ; and
(ii) disclose to the medical institution such information as the Board may consider appropriate for the purpose of the Medisave Account Deduction, and/or for the making of a claim from MediShield as provided under the Central Provident Fund (MediShield Scheme) Regulations and any amendment or re-enactment thereof (the "MediShield Claim").
(iii) disclose to the Ministry of Health (the "MOH") such information as the MOH may require for the purpose of any approval or authorisation of the withdrawal of such amount in my Medisave Account as may be approved or determined in accordance with the Central Provident Fund (Medisave Account Withdrawals) Regulations.
(c) I hereby undertake to pay immediately to the Board for the credit of my Medisave Account any money which I or the patient may subsequently receive from my or the patient's employer, insurer or any other person as reimbursement of all or part of the Medisave Account Deduction.
(d) This authorisation shall continue to be in force for the period indicated in Part III unless I have expressly revoked it by notice in writing delivered to the Board directly or through the medical institution.

Please sign & complete details

Signature of Medisave Account Holder / Date, Name & NRIC No. of Witness®, Signature of Witness® / Date

PART V: AUTHORISATION & DECLARATION BY PATIENT FOR WITHDRAWAL/CLAIM OF MEDISAVE/MEDISHIELD

- a I hereby authorise the doctor-in-charge / (Name of Medical Institution), to disclose to the Board and the MOH such information relating to my/patient's medical condition as may be necessary for the Medisave Account Deduction, and/or for the MediShield Claim, and/or for Medisave/MediShield and other healthcare policy purposes.
(b) I hereby authorise the Board to disclose to the medical institution such information as the Board may consider appropriate for the Medisave Account Deduction and/or for the MediShield Claim.

Please sign & complete details

Signature of patient / parent or lawful guardian of the patient / Donee\*\*/ Deputy\*\*\*/ Date, Name & NRIC of Witness@, Signature of Witness@ / Date (@ The witness cannot be the patient and shall be 21 years of age and above and does not lack capacity\*)

PART VI: MEDICAL DOCTOR'S CERTIFICATION (Only for dialysis or scans/diagnostics for cancer/neoplasm related treatments)

- I certify that the above patient is currently under my care for his/her dialysis; or
I certify that the scan(s)/ diagnostic received by the above patient is for his/her cancer/neoplasm related treatments.

Name & Signature of Doctor/Date, SMC Registration No., Stamp of Hospital/Clinic

\* Delete where not applicable

- # Prior approval must be obtained from the Board for a patient who is not the Medisave Account Holder or his child aged 18 years and below.
\*\* "Donee" means a person under a lasting power of attorney registered under the MCA 08 with power in relation to the patient for the purposes of the CPF Act.
\*\*\* "Deputy" means a person appointed or deemed to be appointed for the patient by the court under the MCA 08 with power in relation to the patient for the purposes of the CPF Act.
\* "lack capacity" has the same meaning as section 4 of the Mental Capacity Act 2008 (Act 22 of 2008) ("MCA 08")
^ Part VI need not be completed if the medical doctor's certification is attached.

Please note

Please ensure that all the necessary fields are completed and/or counter-signed by the Medisave Account Holder. We seek your understanding that any incomplete form or any alteration without being countersigned by the Medisave Account Holder will NOT be processed.



Central Provident Fund Board



**MEDISAVE AUTHORISATION FORM FOR CHRONIC DISEASES**

(This form may take about 3 minutes to complete.)

CPF/MAF/CHRONIC/JAN2012

IT IS AN OFFENCE TO MAKE ANY FALSE STATEMENT OR TO PRODUCE ANY DOCUMENT WHICH IS FALSE FOR ANY PURPOSES CONNECTED WITH THE CENTRAL PROVIDENT FUND ACT (S17(1)(a))

Please complete PART I & II

**PART I: PARTICULARS OF PATIENT**

Name \_\_\_\_\_ NRIC/Birth Cert. No. \*S/T \_\_\_\_\_

Passport No. (for foreigners only) \_\_\_\_\_

**PART II: PARTICULARS OF MEDISAVE ACCOUNT HOLDER**

Name \_\_\_\_\_ NRIC/CPF No. \*S/T \_\_\_\_\_

**PART III: PURPOSE OF WITHDRAWAL**

Please select the period that the Medisave Account Holder wishes to authorize NHG Polyclinics to deduct from their Medisave Account

For charges incurred at \_\_\_\_\_ (Name of Medical Institution) by the above patient for

treatment of chronic diseases for the calendar year of \_\_\_\_\_ (CCYY)

treatment of chronic diseases for a period of 3 / 6 / 12 months\* from \_\_\_\_\_ to \_\_\_\_\_ (DDMMCCYY)

treatment of chronic diseases on \_\_\_\_\_ (DDMMCCYY)

for an unlimited period unless revoked by notice in writing in accordance with Part IV (d) below

**PART IV: AUTHORISATION & DECLARATION BY MEDISAVE ACCOUNT HOLDER**

(a) Patient is my \*self / spouse / child / parent / grandparent who is a Singapore citizen or permanent resident.

(b) I hereby authorise the Central Provident Fund Board ("the Board") to :

(i) deduct from my Medisave Account the amount specified by the medical institution for payment of the charges incurred, as provided under the Central Provident Fund (Medisave Account Withdrawals) Regulations and any amendment or re-enactment thereof (the "Medisave Account Deduction"); and

(ii) disclose to the medical institution such information as the Board may consider appropriate for the purpose of the Medisave Account Deduction.

(iii) disclose to the Ministry of Health (the "MOH") such information as the MOH may require for the purpose of any approval or authorisation of the withdrawal of such amount in my Medisave Account as may be approved or determined in accordance with the Central Provident Fund (Medisave Account Withdrawals) Regulations.

(c) I hereby undertake to pay immediately to the Board for the credit of my Medisave Account any money which I or the patient may subsequently receive from my or the patient's employer, insurer or any other person as reimbursement of all or part of the Medisave Account Deduction.

(d) This authorisation shall continue to be in force for the period indicated in Part III unless I have expressly revoked it by notice in writing delivered to the Board directly or through the medical institution.

Please sign & complete details

Signature of Medisave Account Holder / Date \_\_\_\_\_ Name & NRIC No. of Witness@ \_\_\_\_\_ Signature of Witness@ / Date \_\_\_\_\_

**PART V: AUTHORISATION & DECLARATION BY PATIENT FOR WITHDRAWAL OF MEDISAVE**

(a) I hereby authorise the doctor-in-charge / \_\_\_\_\_ (Name of Medical Institution) to disclose to

(i) the Board such information relating to my/patient's\* medical condition as may be necessary for the Medisave Account Deduction

(ii) the MOH such information relating to my/patient's\* medical condition as may be necessary for the purpose of (A) assessing and auditing the doctor's/medical institution's compliance with the MOH's stipulated clinical standards\*, and (B) national healthcare finance planning\*.

(b) I hereby authorise the Board to disclose to the medical institution such information as the Board may consider appropriate for the Medisave Account Deduction.

Please sign & complete details

Signature of patient / parent or lawful guardian of the patient/ Donee\*\*/ Deputy\*\*\*/ Date \_\_\_\_\_ Name & NRIC of Witness@ \_\_\_\_\_ Signature of Witness@ / Date \_\_\_\_\_

@The witness cannot be the patient and shall be 21 years of age and above and does not lack capacity\*.)

**PART VI: MEDICAL DOCTOR'S CERTIFICATION \***

Please note

I certify that the above patient is suffering from a chronic disease approved for Medisave withdrawals, and that deduction is for management related to this condition.

Name & Signature of Doctor \_\_\_\_\_ SMC Registration No. \_\_\_\_\_ Stamp of Clinic \_\_\_\_\_

\* Delete where not applicable

# Clinical standards are stipulated as conditions to the approval granted to the doctor/medical institution under the Central Provident Fund (Medisave Account Withdrawals) Regulations to participate in the Chronic Disease Programme.

% MOH assesses aggregated clinical data in order to make improvements to the Medisave, MediShield and Medifund Schemes.

\*\* "Donee" means a person under a lasting power of attorney registered under the MCA 08 with power in relation to the patient for the purposes of the CPF Act.

\*\*\* "Deputy" means a person appointed or deemed to be appointed for the patient by the court under the MCA 08 with power in relation to the patient for the purposes of the CPF Act

\* "lack capacity" has the same meaning as section 4 of the Mental Capacity Act 2008 (Act 22 of 2008) ("MCA 08")

^ Part VI need not be completed if the medical doctor's certification is attached.

Please ensure that all the necessary fields are completed and/or countersigned by the Medisave Account Holder. We seek your understanding that any incomplete form or any alteration without being countersigned by the Medisave Account Holder will **NOT** be processed.