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KEMENTERIAN KESIHATAN  
MALAYSIA



PROTECTHEALTH

**PeKa**  
B40

# MANUAL FOR MINISTRY OF HEALTH HOSPITAL







PROTECTHEALTH  
ProtectHealth Corporation Sdn. Bhd.

## PeKa B40 Manual for Ministry of Health Hospital

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## TABLE OF CONTENTS

<b>GENERAL INFORMATION</b> .....	3
<b>1.1 PURPOSE AND AUDIENCE</b> .....	3
<b>1.2 BACKGROUND</b> .....	3
<b>1.3 THE BENEFITS MANAGEMENT SYSTEM</b> .....	3
<b>1.4 PERSON IN CHARGE (PIC)</b> .....	4
<b>1.5 COMMUNICATION</b> .....	4
<b>HEALTH AID BENEFIT</b> .....	5
<b>2.1 ABOUT THE BENEFIT</b> .....	5
<b>2.2 TERMS AND CONDITIONS FOR APPLICATION</b> .....	5
<b>2.3 TYPES OF HEALTH AID CATEGORIES</b> .....	6
<b>2.4 DETAILED LIST OF HA BY CATEGORIES - SURGICAL CATEGORIES</b> .....	6
<b>2.5 DETAILED LIST OF HA BY CATEGORIES - NON-SURGICAL CATEGORIES</b> .....	9
<b>2.6 APPLICATION PROCESS</b> .....	10
<b>2.7 REJECTION OF APPLICATION</b> .....	14
<b>2.8 CO-PAYMENT PROCESS</b> .....	14
<b>2.9 REVIEW OF APPLICATION</b> .....	15
<b>2.10 APPROVAL OF APPLICATION</b> .....	15
<b>2.11 OVERALL TAT FOR HA APPROVAL</b> .....	16
<b>2.12 DELIVERY TIME AND VERIFICATION</b> .....	17
<b>2.13 PAYMENT OF HEALTH AID</b> .....	17
<b>2.14 HA WORKFLOW: PRE-HA APPROVAL FLOW</b> .....	19
<b>2.15 HA WORKFLOW: POST- HA APPROVAL FLOW</b> .....	20
<b>COMPLETING CANCER TREATMENT INCENTIVE (CCTI)</b> .....	21
<b>3.1 ABOUT THE BENEFIT</b> .....	21
<b>3.2 ELIGIBILITY</b> .....	21
<b>3.3 AUTHORISED USERS FOR CCTI</b> .....	22
<b>3.4 CCTI APPLICATION &amp; FIRST PAYMENT OF THE INCENTIVE</b> .....	23
<b>3.5 TRANSPORT INCENTIVE AND FOLLOW UP MODULE</b> .....	24
<b>3.6 SECOND PAYMENT OF THE INCENTIVE</b> .....	24
<b>3.7 CCTI WORKFLOW</b> .....	25

<b>TRANSPORT INCENTIVE .....</b>	<b>26</b>
<b>4.1 ABOUT THE BENEFIT.....</b>	<b>26</b>
<b>4.2 APPLICATION OF TRANSPORT INCENTIVE .....</b>	<b>28</b>
<b>4.3 PAYMENT.....</b>	<b>28</b>
<b>4.4 TRANSPORT INCENTIVE WORKFLOW DIAGRAM .....</b>	<b>30</b>
<b>HEALTH ASSESSMENT.....</b>	<b>31</b>
<b>5.1 CRITERIA FOR HEALTH ASSESSMENT IN MOH HOSPITAL .....</b>	<b>31</b>
<b>5.2 HEALTH ASSESSMENT COMPONENTS.....</b>	<b>31</b>
<b>5.3 HEALTH ASSESSMENT PROCESS.....</b>	<b>31</b>
<b>5.4 HOSPITAL RECORD.....</b>	<b>33</b>
<b>5.5 BENEFICIARY CONSENT .....</b>	<b>33</b>
<b>5.6 UPDATING BENEFICIARY’S INFORMATION .....</b>	<b>33</b>
<b>5.7 HEALTH ASSESSMENT FORMAT .....</b>	<b>34</b>
<b>5.8 PROVISIONAL DIAGNOSIS .....</b>	<b>35</b>
<b>5.9 LABORATORY INVESTIGATIONS .....</b>	<b>35</b>
<b>5.10 CONSULTATION AND REFERRAL.....</b>	<b>35</b>
<b>5.11 ENTERING HEALTH ASSESSMENT DETAILS INTO BMS.....</b>	<b>35</b>
<b>5.12 HEALTH ASSESSMENT WORKFLOW.....</b>	<b>36</b>
<b>UPDATING REFERRAL CASES .....</b>	<b>37</b>
<b>6.1 INTRODUCTION .....</b>	<b>37</b>
<b>6.2 UPDATING REFERRAL WORKFLOW .....</b>	<b>37</b>
<b>APPENDIX .....</b>	<b>39</b>

## GENERAL INFORMATION

### 1.1 PURPOSE AND AUDIENCE

This PeKa B40 Manual for Ministry of Health (MOH) Hospital (“Manual”) is intended to provide a clear description of the requirements, processes, and working arrangement between the MOH Hospital staff (MOH staff) and ProtectHealth Corporation Sdn Bhd (ProtectHealth) for the “*Peduli Kesehatan untuk Kumpulan B40*” (PeKa B40) scheme.

This Manual provides explanation about the PeKa B40 Benefits in the setting of a Hospital. The Manual is subjected to revision from time to time, at which MOH staff will be informed. This Manual is to be used as guidance for MOH Staff. Nothing in this Manual should be interpreted in a way that would be inconsistent with compliance to existing laws and regulations or professional duties

### 1.2 BACKGROUND

PeKa B40 is an initiative by the Government through the Ministry of Health (MOH) aimed at improving the wellbeing of the low-income group, focusing especially on reducing the burden of non-communicable diseases (NCDs). It is being implemented in phases, beginning with a nationwide pilot project that includes approximately 800,000 eligible persons in its first phase, and it shall be fully run by ProtectHealth.

Through PeKa B40, beneficiaries will receive four health-related benefits. These benefits are:

- Benefit 1: Health Screening
  - Benefit 2: Health Aid
  - Benefit 3: Completing Cancer Treatment Incentive
  - Benefit 4: Transport Incentive
- } Benefit 2,3 and 4 are only available if treated in MOH Hospital

PeKa B40 beneficiaries must complete Health Screening (i.e. Benefit 1) as the prerequisite prior to receiving Health Aid, Completing Cancer Treatment Incentive (CCTI) and/or Transport Incentive. Health Screening can be done at PeKa B40 General Practitioner (GP) Clinics or Klinik Kesihatan. In the event that the beneficiary is hospitalised in MOH Hospital, and the need for Benefit 2 and 3 is urgent, Health Assessment in MOH Hospital can be done in hospital as an alternative to complete Benefit 1 (**Section 5 on Health Assessment**)

### 1.3 THE BENEFITS MANAGEMENT SYSTEM

All transactions and activities relating to the PeKa B40 scheme must be recorded and conducted through the Benefits Management System (BMS). BMS is a web-based system or web portal that can be accessed through any computer or laptop

with internet access. It is also mobile responsive, although not fully mobile-friendly. The user manual for the use of the BMS is made available in the web portal.



**BMS Website:** <https://bms.pekab40.com.my/site/login>

## 1.4 PERSON IN CHARGE (PIC)

### 1.4.1 PIC Appointment

All departments of MOH Hospital involved in PeKa B40 Scheme will appoint a PeKa B40 Person in Charge (PIC). PICs will be trained and act as the liaison officer between MOH Hospital and ProtectHealth for PeKa B40. Therefore, MOH staffs must identify their respective PIC and refer to the PIC if there are any related matters. This is to ease communication between health facilities and ProtectHealth.

### 1.4.2 Roles and Responsibilities of PIC

- a) PIC will be registered as 'Primary Account Holders' in BMS for their respective departments.
- b) Determine the user access for the staffs in their department and register them as 'Authorised Users' for BMS according to their tasks.
- c) Ensure all required information are entered in BMS and all documents required are submitted.
- d) Maintain and update the 'Authorised Users' as required:
  - Register new users,
  - Deactivate/delete inactive users.
- e) Maintain records pertaining to PeKa B40 scheme.
- f) Ensure all hard copy forms (if needed by respective departments) are readily available.
- g) Become the liaison person for PeKa B40 related matters.

## 1.5 COMMUNICATION

Any enquiries, complaint or any form of feedback can be directed to ProtectHealth as below;

<b>Toll-Free number</b>	1-800-180-755
<b>Contact center</b>	+603-8687 2588
<b>Fax</b>	+603 8687 2599
<b>Email</b>	<a href="mailto:info@pekab40.com.my">info@pekab40.com.my</a>

Please note that the Toll-Free Number is developed specifically for MOH facilities and should not be shared to beneficiaries or GPs.

# HEALTH AID BENEFIT

## 2.1 ABOUT THE BENEFIT

### 2.1.1 Introduction

Treatment charges at MOH Hospitals are heavily subsidised by the Government except for certain items or medical devices of which the cost is borne by patients. Therefore, this benefit aims to cover cost incurred for these items to ease the financial burden specifically for the B40 population.

### 2.1.2 Definition of Health Aid

Health Aid (HA) refers to medical devices or items that are required for treatment, improvement of quality of life or functionality and for rehabilitative purpose.

### 2.1.3 PeKa B40 HA Benefit

This benefit offers health item which is currently not subsidised in MOH hospitals.

**It has a lifetime limit of RM 20,000 per beneficiary (head of household and spouse). HA under PeKa B40 scheme will cover ten (10) HA categories as stated in Section 2.4 and 2.5**

## 2.2 TERMS AND CONDITIONS FOR APPLICATION

### 2.2.1 Prerequisite for HA

- a) Open to all PeKa B40 beneficiaries
- b) The application must be made at the Ministry of Health (MOH) Hospital ONLY
- c) The HA item requested is in the listed HA categories as stated in Section 2.4 and 2.5
- d) The lifetime limit for HA is still available
- e) Beneficiaries must complete the Health Screening under PeKa B40 scheme

### 2.2.2 Exclusions

- a) Not a PeKa B40 beneficiaries
- b) HA item needed in urgent cases (within 24-48 H)
- c) Exhausted the RM 20,000 limit

### 2.2.3 Price Range

Each HA items covered under this benefit have a price range specified by ProtectHealth. Ideally, the HA applied must not exceed the upper limit of the price range. However, for HA application that is beyond the price range, additional process options come into effect. This will be further explained in **Section 2.6.5 (c)**.

## 2.3 TYPES OF HEALTH AID CATEGORIES

### 2.3.1 Definition:

- a) **Surgical HA** are HAs requiring surgical procedures
- b) **Non-Surgical HA** are HAs not requiring any surgical procedure

2.3.2 There are ten (10) categories of HA covered under this benefit. The categories are further divided into two groups; Surgical HA and Non-Surgical HA. These can further be categorised into:

Surgical Items Categories	Non-Surgical Items Categories
a) Cardiac Stent	a) Hearing aid
b) Pacemaker	b) Breathing machines & oxygen concentrator
c) Joint Arthroplasty Items	c) Nutritional support
d) Spinal surgery prosthesis & implant	d) Wheelchair
e) Limb prosthesis & orthosis	
f) Intraocular lens	

**Table 1: Categories of HA for Surgical and Non-Surgical HA**

## 2.4 DETAILED LIST OF HA BY CATEGORIES - SURGICAL CATEGORIES

### 2.4.1 Cardiac Stent

- a) Drug-Eluting Balloon
- b) Drug Eluting Stent
- c) Bioabsorbable Scaffolds
- d) Aortic Stent Graft for Aortic Aneurysm
- e) Inoue Balloon for Mitral Commissurotomy (for PTMC)

### 2.4.2 Pacemaker

- a) Single Chamber Pacemaker VVIR
- b) Dual Chamber Pacemaker
- c) Implantable Cardioverter Defibrillator (ICD)
  - Single Chamber ICD
  - Dual Chamber ICD
- d) Biventricular, Cardiac Resynchronization (CRTP)
- e) Biventricular, Cardiac Resynchronization with ICD (CRTD)

### 2.4.3 Joint Arthroplasty Items

- a) Primary total hip arthroplasty
- b) Primary total hip arthroplasty hybrid
- c) Primary total hip arthroplasty young (<56 years old)
- d) Revision total hip arthroplasty
- e) Complex primary total hip replacement
- f) Primary total knee replacement
- g) Complex primary total knee replacement:
  - Hinged knee
  - Complex primary tibia/femur augment with stem & bone graft
- h) Revision total knee replacement (rotating hinged knee with stems & bone graft)
- i) Total shoulder replacement
- j) Hemi-shoulder
- k) Reverse shoulder
- l) Total elbow replacement
- m) Total ankle replacement
- n) Wrist arthroplasty
- o) Small joint surface replacing arthroplasty
- p) Small joint silastic / silicone arthroplasty

### 2.4.4 Spinal Surgery Prosthesis and Implants

- a) Scoliosis instrumentation
- b) Anterior cervical fusion system (single level)
- c) Posterior cervical plate (lateral plate)
- d) Posterior cervical and lateral mass screw/pedicle screw with occipital plate
- e) Triple wires/cables
- f) Spinal cages (titanium cage)
- g) Expandable cage
- h) Spinal Fusion
  - Posterior Lumbar Interbody Fusion (PLIF) cage
  - Transforaminal Lumbar Interbody Fusion (TLIF) cage
  - Anterior Lumbar Interbody Fusion (ALIF) cage
- i) Anterior spinal implants
- j) Anterior spinal implants with titanium cage
- k) Pedicle Screws
  - Four (4) pedicle screws with one (1) cross link
  - Eight (8) pedicle screws one (1) cross link
- l) Revision of spinal surgery
- m) Spinal tumour reconstruction prosthesis
- n) Interspinous Spacer

## 2.4.5 Limb Prosthesis and Orthosis

### Orthopaedic related

- a) Proximal / Distal femur endoprosthesis
- b) Proximal tibia endoprosthesis
- c) Total femur prosthesis
- d) Proximal / Distal humerus endoprosthesis
- e) Total humerus / elbow / scapula endoprosthesis
- f) Oncology bipolar hemiarthroplasty
- g) Intercalary endoprosthesis
- h) Allo-prosthesis composite reconstruction
- i) Allograft bone (all types)
- j) Bone substitute (Hydroxyapatite) 10g
- k) Saddle prosthesis
- l) Long knee arthrodesis nail
- m) Radial head hemiprosthesis

### Rehabilitative related

- n) Upper Limb Prosthesis
  - Transhumeral
  - Transradial
- o) Hip disarticulation prosthesis
- p) Transfemoral prosthesis (Above knee)
- q) Knee disarticulation prosthesis
- r) Transtibial prosthesis (Below knee)
- s) Syme's foot prosthesis
- t) True knee prosthesis
- u) Knee prosthesis/ Knee orthosis
- v) Partial foot amputation prosthesis
- w) Foot/ ankle foot/ ankle foot orthosis (hinged)
- x) Knee ankle foot orthosis
  - Solid ankle
  - Articulated ankle joint
- y) Thoracolumbosacral orthosis (TLSO)
  - Ready-made
  - Custom made

## 2.4.6 Intraocular Lens

## 2.5 DETAILED LIST OF HA BY CATEGORIES - NON-SURGICAL CATEGORIES

### 2.5.1 Hearing Aid

- a) Behind the ear for the adult (less than 60 years old) with the type of hearing loss as below:
  - Conductive
  - Sensorineural
  - Mixed
- b) Behind the ear or in the ear (ITE) for elderly (60 years old and above) with the type of hearing loss as below:
  - Conductive
  - Sensorineural
  - Mixed
- c) Bone Conduction Hearing Aid for any age with the type of hearing loss as below:
  - Conductive
  - Mixed
- d) Bone Anchored Hearing Aid (BAHA) for the adult with the type of hearing loss as below:
  - Bilateral conductive
  - Bilateral mixed

### 2.5.2 Breathing machines & oxygen concentrator

- a) BiPAP (Bilevel positive airway pressure)
- b) CPAP (Continuous positive airway pressure)
- c) Oxygen Concentrator not including portable models
- d) Oxygen tank

### 2.5.3 Nutritional support

Manufacturer	Nutritional Support Brand Name
<b>Abbot</b>	Ensure Powder (Chocolate/ Vanilla)
	Ensure Gold Powder
	Glucerna Triple Care Powder
	Nepro High Protein (Hp)
	Prosure (Vanilla/Orange)
<b>Valens</b>	Valens Calco High Calorie
	Modular Whey Protein (Myotein)
	Valens Carborie
<b>Wyeth</b>	Enercal Plus

Manufacturer	Nutritional Support Brand Name
Nestle	Nutren Fibre
	Nutren Optimum (Vanilla)
	Nutren Diabetik
	Peptamen (Vanilla)
	Isosource 1.5 Cal
	Nutren Diabetes (Liquid)
	Resource Peach Flavour
	Peptamen (Vanilla)
Kotra Pharma	Appeton Wellness (Recovery)
Nutricia	Basic F
British Biological, India	Optimax Lite
	Supplement D

**Table 2: Nutritional Support**

#### 2.5.4 Wheelchair

- a) Manual standard fixed arm & footrest – Standard wheelchair
- b) Manual lightweight with detachable arm & footrest – DAF wheelchair lightweight
- c) Manual heavy duty with detachable arm & footrest – Heavy duty wheelchair
- d) Manual reclining with detachable arm & elevated footrest – DAF recliner wheelchair
- e) Standard motorized wheelchair
- f) Customized seating system wheelchair
- g) Tilt in space wheelchair
- h) Manual wheelchair & adaptive system
- i) Tilt-in recline with wheelchair with custom made seating & position – Tilt in space with seating system
- j) Custom made seating & positioning system
- k) Foam cushion

## 2.6 APPLICATION PROCESS

**2.6.1** The HA application process is similar to the current *Tabung Bantuan Perubatan* (TBP) application at MOH Hospital. PeKa B40 HA application will also use the Form C of TBP but will not require Medical Social Worker (MSW) to do Socioeconomic Assessment. This further explained in **Section 2.6.4**.

## 2.6.2 Requesting Department

**Application for health aid must be from the respective department where the beneficiary receives his/her treatment**

For example:

- Spinal Surgery Prosthesis and Implants: Application from the spinal surgeon
- Limb prosthesis and orthosis (rehabilitative related): Application from a rehabilitative specialist

## 2.6.3 Step 1: Treating Doctor Refer Case to MSW

### a) Treating doctor must:

- **Be a Medical Officer/ Specialist at MOH Hospital**
- **Fill in the Form C (Appendix 1) of TBP and MSW Referral Letter (*Borang Rujukan*)**
- **Provide phone number and email to MSW**
- **Obtain three quotations, from three different vendors for HA**
- **Provide supporting documents and fulfil requirements for HA application where necessary (Refer to Section 2.6.2 (c))**
- **Refer MSW for HA application**

### b) Disclaimer

- Doctor is responsible to choose the most suitable HA items and reliable vendor to avoid undesired complications.
- ProtectHealth is not liable to any loss, damage, injury, death, delay, or complications as a result from the treating doctor's choice of HA and vendors.

### c) Supporting Documents and Requirements for certain HA categories

- Certain HA item must fulfil the specific requirement as specified in **Table 3**.

HA Categories	Requirements
Nutritional support	Dietitian recommendation.
Breathing machine and Oxygen concentrator	<b>BiPAP</b> <ul style="list-style-type: none"><li>• Cases that require BiPAP from other disciplines besides pulmonology should be referred to a pulmonologist.</li></ul>

HA Categories	Requirements
<p><b>Breathing machine and Oxygen concentrator</b></p>	<p><b>CPAP</b></p> <p>This item can be applied by:</p> <ul style="list-style-type: none"> <li>• Pulmonologist.</li> <li>• ENT specialist with sub-specialty in sleep disorder.</li> <li>• ENT specialist can apply for obstructive sleep apnea (OSA) cases only with sleep study results as below:               <ul style="list-style-type: none"> <li>○ CPAP result trial.</li> <li>○ The patient can use CPAP comfortably and there is evidence of improvement in the patient's condition.</li> </ul> </li> </ul>
	<p><b>Oxygen Concentrator</b></p> <ul style="list-style-type: none"> <li>• Portable Oxygen Concentrator is not included.</li> <li>• The application must be supported with ABG result.</li> </ul>

**Table 3: Supporting Documents and Requirements**

**d) Guidelines for vendor selection**

For the purpose of ensuring the best HA supplied to the beneficiary, the treating doctor must choose the vendor according to the criteria below:

- Vendor must have Medical Device Authority license
- Prioritise local/nearby suppliers to provide equipment to beneficiaries, for easy facilitation of after-sales service (example: maintenance, repair, and warranty).
- Prioritise vendors who are easy to reach, provide good service, and attentive to any problems faced by patients and hospitals.
- Prioritise vendors with the necessary proficiency, knowledge, and technical expertise in managing patient needs.

**2.6.4 Step 2: Application of HA by Medical Social Worker (MSW)**

- a) MSW must first be registered as Authorised Users in BMS.
- b) Receive Form C from the treating doctor
- c) Enter NRIC of the applicant in BMS to check eligibility for HA. Applicant will be eligible if :
  - i. they are Peka B40 beneficiaries
  - ii. the lifetime limit balance is still available
  - iii. the item requested in the listed HA items
  - iv. they have done PeKa B40 Health Screening
- d) Complete the online HA application

- e) Upload or fax required documents to ProtectHealth. The required documents include:
  - i. Form C (*Borang C*) as in **Appendix 1**
  - ii. Three quotations
  - iii. Relevant supporting documents as in **Table 3**

**There is no requirement for MSW to do socio-economic evaluation**

### 2.6.5 Issues Related to HA Application

#### a) No Health Screening Done

- i. If beneficiaries have not done PeKa B40 Health Screening, MSW can still proceed with the application. However, there will be a notification informing that HA application will only be processed and approved after beneficiaries' Health Screening data is entered into the system
- ii. MSW must inform the treating doctor to remind beneficiaries to go for Health Screening at PeKa B40 registered General Practitioner
- iii. However, if a beneficiary is currently admitted and unable to be discharged until they receive the HA, doctors in Hospital can do Health Assessment. Please refer to **Section 5 on Health Assessment**.

**If no Health Screening done, there will be a notification informing that HA application will only be processed and approved after beneficiaries' Health Screening data is entered into the system**

#### b) Balance inadequate

- i. After MSW submit application, if the balance is inadequate, beneficiary can co-pay.
- ii. Application will be reviewed by ProtectHealth and Co-Payment Letter (**Appendix 3**) can be downloaded from the BMS. It will also be emailed to the treating doctor, MSW and beneficiary
- iii. Treating doctor is responsible to inform and ask the beneficiary whether he/she agrees to co-pay.
- iv. The beneficiary has to agree to co-pay and the agreement has to be submitted to ProtectHealth (**Appendix 3**). Refer to **Section 2.8** on Co-Payment for the detailed process.

#### c) HA Quotation Exceeds the Price Range

- i. If the HA quotation exceeds the price range, ProtectHealth will email the treating doctor informing and notify them to negotiate the HA price.
- ii. Treating doctor must give feedback on the negotiated price within fifteen (15) working days from the date of notification.

- iii. The negotiation is considered as unsuccessful if:
  - negotiated price still exceeds the price range
  - no feedback from the treating doctor after fifteen (15) days
- iv. In the event of unsuccessful negotiation, the beneficiaries can co-pay. Refer to **Section 2.8** on Co-Payment process.

**If HA price exceeds price range, treating doctor needs to negotiate the price with the vendor. Feedback on the negotiated price should be submitted within fifteen (15) working days**

## 2.7 REJECTION OF APPLICATION

If the application is rejected due to any of the reasons below, a Rejection Letter to indicate unsuccessful application (as in **Appendix 2**) can be downloaded from the BMS to be given to the beneficiary, if there is a need.

- a) **Inadequate balance, and beneficiaries unable to co-pay.**
- b) **HA price is outside the price range, and beneficiaries unable to co-pay**
- c) **HA is not in the ten (10) listed HA categories**

## 2.8 CO-PAYMENT PROCESS

2.8.1 There are two (2) types of co-payment process:

- a) **Co-payment due to inadequate HA balance**
- b) **Co-payment due to price exceeding price range**

2.8.2 For Co-Payment process, ProtectHealth will issue a Co-Payment Letter (**Appendix 3**) which can be downloaded from the BMS. It will also be emailed to the treating doctor, MSW and beneficiary.

2.8.3 Treating doctor is responsible to inform and ask the beneficiary whether he/she agrees to co-pay. The beneficiary is given thirty (30) days to decide and sign the Co-Payment letter indicating their decision to co-pay.

2.8.4 MSW will email the signed Co-Payment letter to ProtectHealth or upload it in the BMS.

2.8.5 ProtectHealth will review the letter. If the beneficiary agrees for Co-Payment, the vendor will communicate directly with the beneficiary or next of kin for the co-payment.

2.8.6 However, if the beneficiaries were unable or do not agree to co-pay, ProtectHealth will issue a Rejection Letter. (Refer to **Section 2.7**)

## 2.9 REVIEW OF APPLICATION

### 2.9.1 Claim Review by ProtectHealth

All application request will be reviewed by ProtectHealth. ProtectHealth will ensure the HA requested fulfilled all the prerequisite requirement.

- a) Claim Department will review based on:
  - HA requested is from the relevant department.
  - All supporting documents provided
  - Accurate information provided in quotations
- b) Finance Department will give clearance based on the availability of PeKa B40 fund.

### 2.9.2 Turn-Around-Time for Review and Approval

**The Turn-Around-Time (TAT) for HA quotation selection and approval is within five (5) working days. However, for HA application that require negotiation, co-payment and/or other issues, this process may take a longer time for approval.**

## 2.10 APPROVAL OF APPLICATION

### 2.10.1 Successful Vendor

Successful Vendor is the vendor providing the quotation selected by ProtectHealth. Successful vendor will be notified by email. They are required to register/update their company profile in the BMS within three (3) working days. In the event vendors failed to register within the three (3) days, vendors will be notified by ProtectHealth. The unsuccessful vendor will also receive an email to notify that their quotation is rejected.

**Vendors are required to register/update their company profile in the BMS within three (3) working days following approval of HA**

### 2.10.2 Registration of Successful Vendor

Successful vendor must register or update information with ProtectHealth through the BMS. The information required for registration of vendors are as follows:

- a) Company Name
- b) Address
- c) email
- d) Phone number
- e) SSM registration number
- f) Medical Device Registration Certificate/Notification of Low Risk Medical Device
- g) Establishment Licence under Medical Device Act 2012 (Act 737) or Appointment Letter as Tenderer Agent (*Surat Pelantikan Sebagai Ejen Penender*)

- h) Health items supplied
- i) Bank Account Number
- j) Swift code

### 2.10.3 Letter of Award (LOA)

After successful registration, vendors can download the LOA (**Appendix 4**) from the BMS. Vendors should upload the signed LOA within three (3) working days. The copy of the signed LOA will be available in BMS for download and to be given to Hospital Director, Head of Department (HOD), treating doctor and beneficiaries. Beneficiaries will also receive SMS/whatsapp notification from ProtectHealth to inform that the HA application had been approved.

### 2.10.4 Validity of LOA

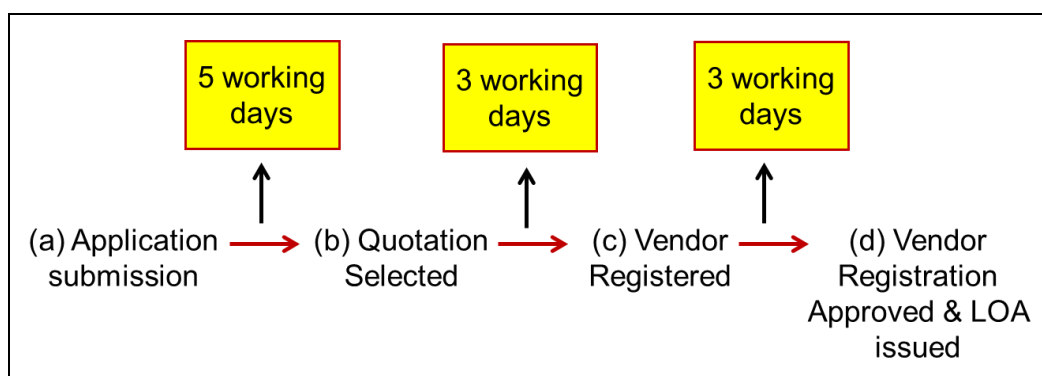
**Validity period for approved HA is:**

- **Surgical HA - one (1) year from the date of LOA issued**
- **Non-Surgical Items - six (6) months from the date of LOA issued**

If HA is not used within the validity period, the beneficiary needs to reapply.

## 2.11 OVERALL TAT FOR HA APPROVAL

2.11.1 In summary the overall TAT for HA approval is as illustrated in the **Figure 1**



**Figure 1: Summary of HA Approval TAT**

- a) Application submission** – is the date when MSW submit the application. In the event when Health Screening is not done, MSW may still submit application. However, the HA application will only be processed after Health Screening/Assessment information is entered in the BMS
- b) Quotation Selected** - ProtectHealth will take maximum of five (5) working days to process the application and select quotation
- c) Vendor Registration** – Once a quotation is selected, the successful vendor is given three (3) working days to register / update their information in the BMS

- d) **Vendor Registration Approved and LOA Issued** – After registration, ProtectHealth will approve Vendor registration and LOA will be issued within three (3) working days

## 2.12 DELIVERY TIME AND VERIFICATION

Health aid must be delivered on its specified time and verification is required in order to allow payment to the vendors.

### 2.12.1 Delivery time

- a) **Surgical HA: Vendors should deliver the HA before surgical operation/procedure**
- b) **Non-Surgical HA: Vendors should deliver the HA after submission of signed LOA.**

### 2.12.2 Verification of Delivery and Utilisation

In ensuring the HA is being delivered and utilised appropriately, the vendor must obtain verification from the treating doctors/MSW/relevant MOH Hospital staff. The verification process is a prerequisite for payment approval for vendors. The process of verifications for Surgical and Non-Surgical HA are as the following:

- a) **Surgical HA** - Vendor should obtain the signature and official stamp from the treating doctor for the consignment note (refer to **Section 2.12.3** below) after surgery done
- b) **Non-Surgical HA** - Vendor should obtain the signature and official stamp from MSW/relevant MOH Hospital staff for the consignment note (refer to **Section 2.12.3** below)

### 2.12.3 Consignment Notes

The consignment notes (**Appendix 5**) can be downloaded from the BMS. Vendor must upload the signed consignment note into the BMS within 1 month from the date of surgery/delivery of HA item.

## 2.13 PAYMENT OF HEALTH AID

**Conditions for payment: Vendor upload complete consignment note and invoice into the BMS system**

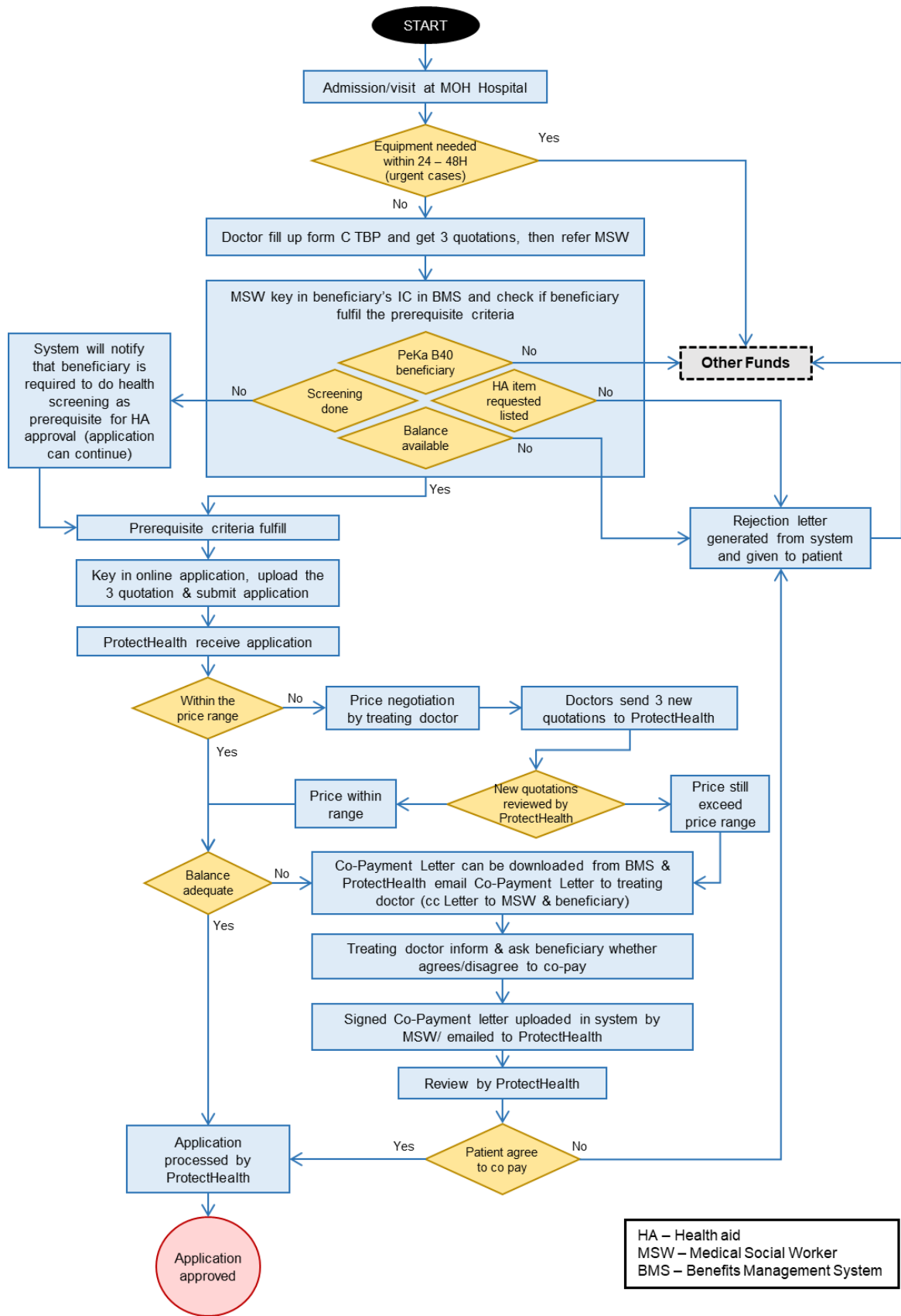
### 2.13.1 Payment to Vendors

Payment to the vendors by ProtectHealth will be done according to the payment schedule as in **Table 4** below:

<b>Date Invoice sent by vendors to ProtectHealth</b>	<b>Date of payment to vendors by ProtectHealth</b>
1 <sup>st</sup> to 12 <sup>th</sup> of the month	15 <sup>th</sup> of the month
13 <sup>th</sup> to 27 <sup>th</sup> of the month	30 <sup>th</sup> of the month
28 <sup>th</sup> to 30 <sup>th</sup> /31 <sup>st</sup> of the month	15 <sup>th</sup> of the following month

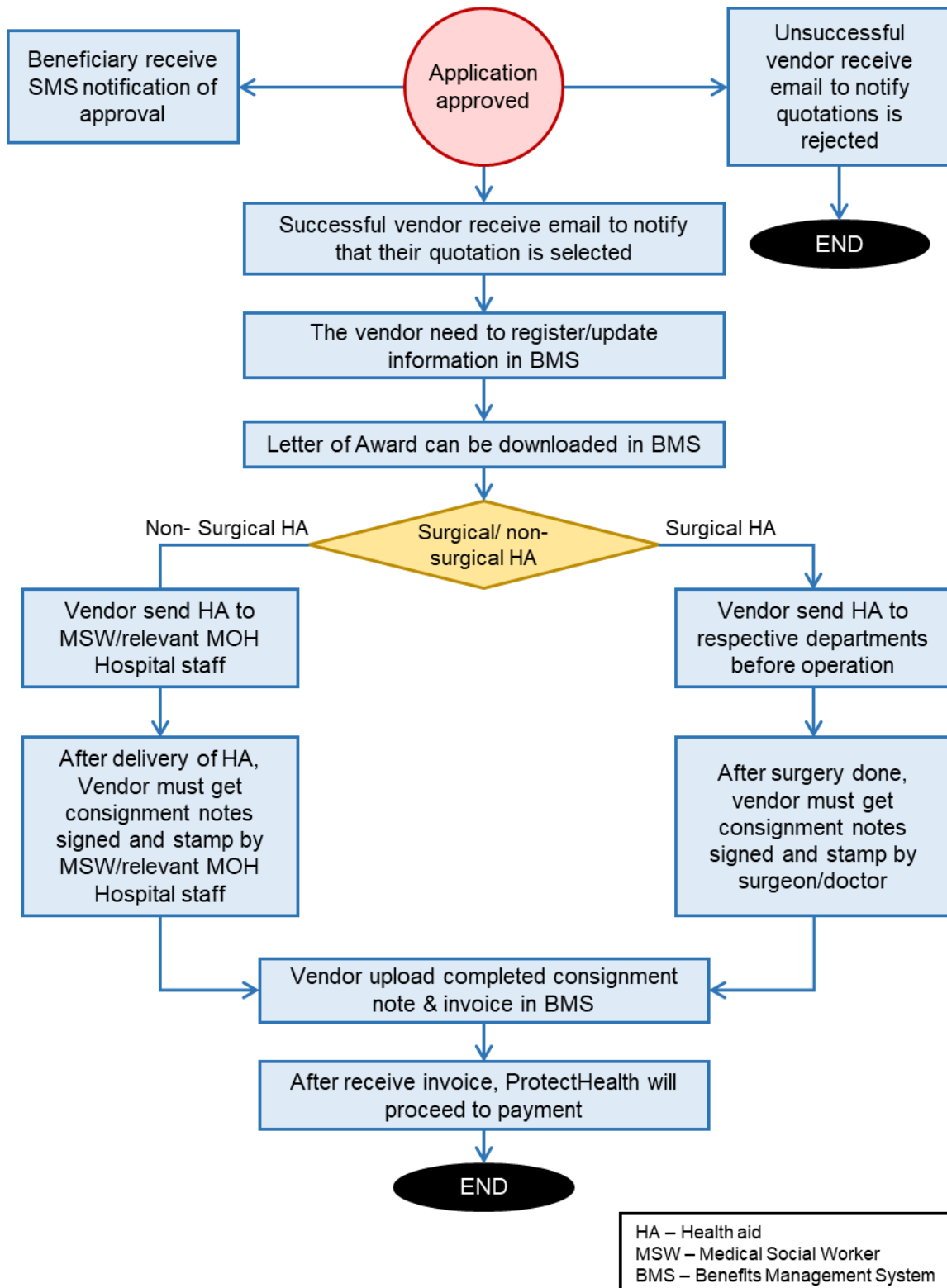
**Table 4: Payment schedule**

**2.14 HA WORKFLOW: PRE-HA APPROVAL FLOW**



**Figure 2: HA Workflow Process: Pre-HA Approval Flow**

**2.15 HA WORKFLOW: POST- HA APPROVAL FLOW**



**Figure 3: HA Workflow Process: Post-HA Approval Flow**

## COMPLETING CANCER TREATMENT INCENTIVE (CCTI)

### 3.1 ABOUT THE BENEFIT

#### 3.1.1 Introduction

Data from the National Health Cancer Registry shows an alarming increase on the incidence of cancer with 60% detected at a late stage. Many patients do not complete their cancer treatment; thus this complicates the management and increases the need for more expensive but less effective treatment. The main purpose for introducing the CCTI benefit is to encourage beneficiaries diagnosed with cancer to comply and complete their treatment.

#### 3.1.2 The Benefit

**CCTI recipients will receive a total of RM 1000 for completing their cancer treatment. The incentive is given in 2 stages and will be credited directly into the beneficiary's registered bank account:**

- a) First payment (RM 300) - upon successful application.**
- b) Second payment (RM 700) - upon completing cancer treatment, and verified by the treating doctor**

### 3.2 ELIGIBILITY

#### 3.2.1 Prerequisite:

- a) Open to all PeKa B40 beneficiaries**
- b) Application must be made by a treating doctor at Ministry of Health (MOH) Hospital**
- c) Beneficiaries must complete the Health Screening under PeKa B40 scheme for CCTI application to be approved.**

#### 3.2.2 Eligibility

- a) The beneficiary has been diagnosed with any type of cancer as confirmed by histopathological examination (HPE), radiological, and/or blood investigations which includes:**
  - Newly diagnosed cancer**
  - Previously diagnosed cancer and still on treatment.**
- b) In the rare case where the beneficiary has more than one (1) type of primary cancers, he/she will be eligible for CCTI for each of the cancer diagnosed and treated\***

\*For example, if the beneficiary has primary cancer of breast cancer and primary cancer of thyroid, he/she is eligible to apply CCTI for each of the primary cancer and receive a total of RM2000.

### 3.2.2 Exclusion

#### a) Cancer treatment completed

A beneficiary who was previously diagnosed with cancer and has completed treatment (?active? and curative) is not eligible for this benefit.

#### b) Recurrence and metastases

A beneficiary who is diagnosed with recurrent or metastatic cancer, whom CCTI has been given upon his/her primary diagnosis, is not eligible for a second application

#### c) Provisional Diagnosis

A beneficiary with a provisional diagnosis awaiting HPE, radiological, and/or blood investigations is not eligible for CCTI

### 3.3 AUTHORISED USERS FOR CCTI

As stated in **Section 1.4**, PIC must register their department staffs as “Authorised Users”. However, for CCTI, there are three levels of Authorised Users as outlined below.

#### a) Person In Charge (PIC)

- Each of the relevant Hospital Departments will have one PIC who will be registered and serve as the ‘Primary Account Holder’ in the BMS for his/her respective department. PIC of a clinical department must be a medical doctor or specialist.
- They will be able to:
  - Create and deactivate other account users
  - Control who may have access to the system and register them as ‘Authorised Users’ (“Team Leads” or “Normal Users”) for the BMS.
  - Verify that the beneficiary has completed cancer treatment

#### b) Team Leads

- Team Leads are the treating doctors for the particular department.
- They will be able to:
  - Update medical information of the beneficiary in the BMS
  - Verify that the beneficiary has completed cancer treatment

#### c) Normal Users

- Normal Users should be MOH staff whose main role is to update the beneficiary’s upcoming appointment date.
- They may be nurses, administrative staff or any personnel as deemed fit by the department.
- They will not be able to verify that the beneficiary has completed cancer treatment

## 3.4 CCTI APPLICATION & FIRST PAYMENT OF THE INCENTIVE

### 3.4.1 Steps for Application of CCTI

In CCTI, the treating doctor is defined as the medical officer, the specialist or the surgeon at MOH Hospitals, who evaluate signs and symptoms, diagnose cancer, carry out relevant examinations, tests and medical procedures, advise on cancer treatment options, monitor the progress of treatment and if necessary, refer the beneficiary onwards to other medical disciplines or health professional for further opinion.

CCTI application should be submitted by the treating doctor for eligible PeKa B40 beneficiaries. Below are the steps required for the CCTI application:

- a) Prior to application, the treating doctor must be registered as the “Team Lead” to the BMS by their department’s PIC.
- b) Once logged in to the system, the doctor will be able to check whether the beneficiary has fulfilled the prerequisites.
- c) In cases where Health Screening was not done, the doctor has to advise the beneficiary to do screening first at GPs, or the treating doctor him/herself to undertake inpatient Health Assessment at the hospital, depending on the beneficiary’s condition. Please refer to **Section 5** on Health Assessment
- d) The treating doctor must ensure that all of the required beneficiary’s information as listed below are filled in before submitting the application.
  - MRN
  - Date of diagnosis
  - Diagnosis
  - Stage of cancer
  - Type of treatment given
  - Next appointment date

Please refer **Appendix 6** for the application form

### 3.4.2 Mode of Payment and Turnaround Time

After CCTI application has been submitted, ProtectHealth will review and approve. The first payment of incentive (i.e. RM300) will be made within 3 working days from the date of successful application. If the beneficiary has not completed Health Screening, there will be a notification informing that CCTI application will only be processed and approved after beneficiaries' Health Screening data is entered into the system.

Subsequently, the first payment will only be released within three (3) working days after approval. Payments will be directly credited to the beneficiary’s registered bank account.


### 3.5 TRANSPORT INCENTIVE AND FOLLOW UP MODULE

Beneficiaries who receive CCTI will also automatically receive Transport Incentive with the condition that the beneficiary's next appointment date is keyed into the system during every follow-up visit. Please refer **Section 4** for further details on Transport Incentive.

### 3.6 SECOND PAYMENT OF THE INCENTIVE

#### 3.6.1 Steps to Verify Completed Cancer Treatment to Allow Second Payment

For the second payment of CCTI (i.e. RM700) to be released, only treating doctor has to verify in the BMS, as the steps below.

- 
- a) **Notification will be emailed to the last treating doctor to remind the doctor to verify in the BMS that**
    - **9 months of treatment duration has been completed by the beneficiary, starting from the date of application; AND**
    - **at least 2 visits have been made for treatment, inclusive of the first visit at when the application was done.**
  - a) **The treating doctor must log into the BMS and verify in the system that this beneficiary has indeed fulfilled the criteria above.**

#### 3.6.2 Exclusion from the Second Payment

a) **Defaulted treatment**

The beneficiary will not be paid the second payment if they fail to fulfil the criteria above, as confirmed by the treating doctor.

b) **Death**

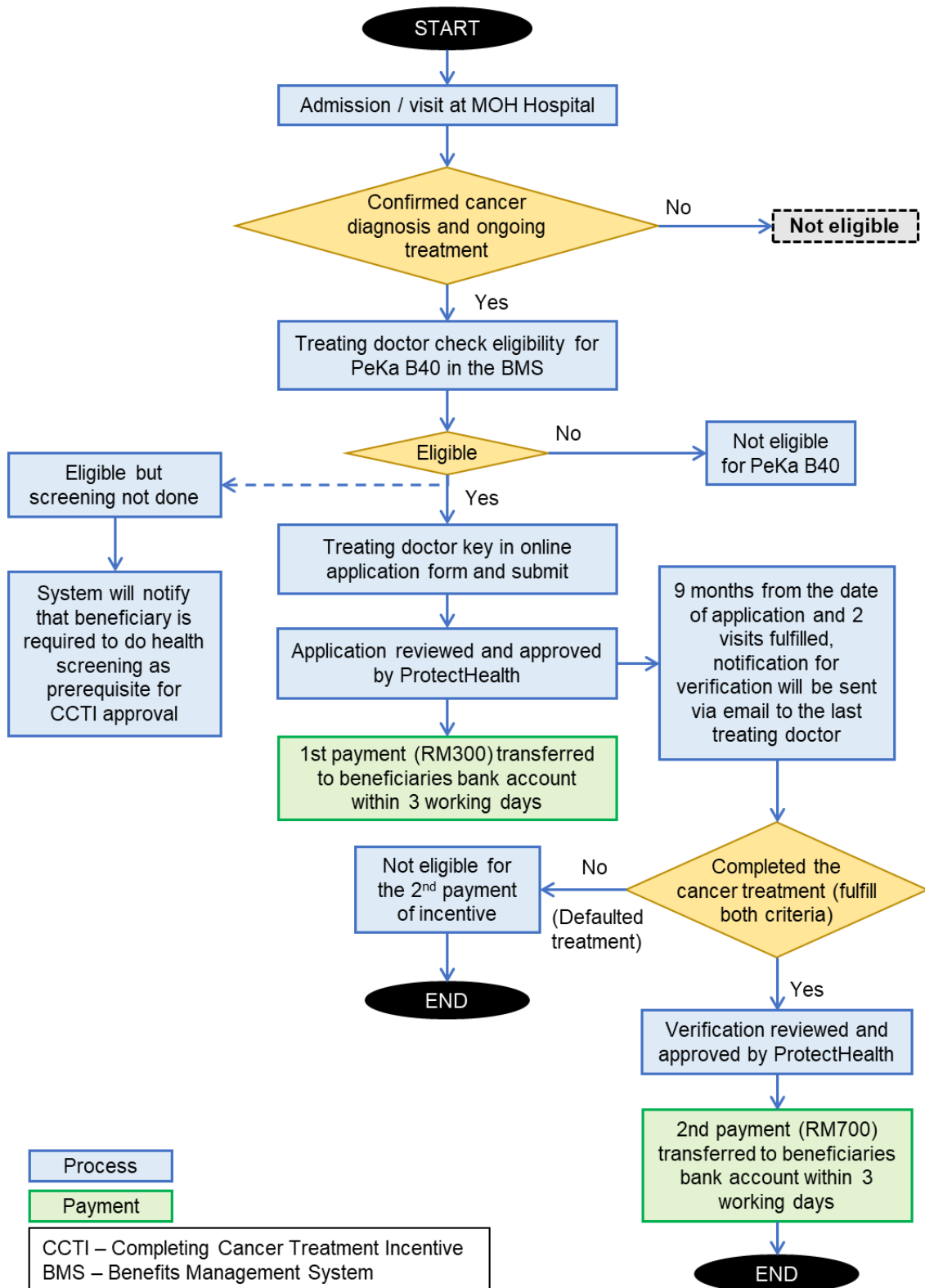
Upon death, the second payment will not be made as only the beneficiary is allowed to receive the second payment.

#### 3.6.3 Turnaround Time and Mode of Payment



**The second payment of CCTI (i.e. RM700) should be made within three (3) working days from the date of verification by the treating doctor**

### 3.7 CCTI WORKFLOW



**Figure 4: CCTI Workflow Diagram**

# TRANSPORT INCENTIVE

## 4.1 ABOUT THE BENEFIT

### 4.1.1 Introduction

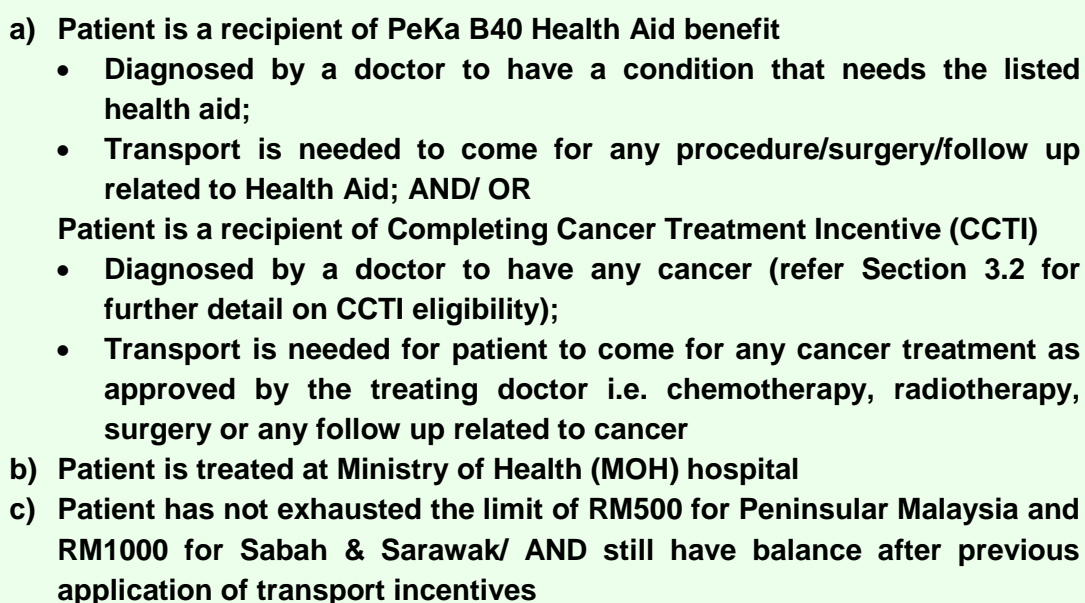
One of the reasons for delay or non-compliant to treatment and follow up is due to transportation issues especially for those living in Sabah, Sarawak and the rural areas of Peninsular Malaysia.

Transportation issues are even more challenging for individuals in the B40 or low-income group population. Delay and non-compliance to treatment and follow ups will worsen the patients' condition and eventually incur a higher treatment cost to the government.

The main reason for introducing the Transport Incentive in PeKa B40 Scheme is to provide some financial risk protection by providing aid for patients' transportation to enable them to access healthcare. By aiding their transport to the hospital, their financial burden can be lessened and their compliance to treatment can be encouraged. The aim for transport incentive is to get patient to come for follow-up/treatment.

### 4.1.2 Eligibility Criteria

To be eligible for Transport Incentive, patients must fulfill these criteria:

- 
- a) **Patient is a recipient of PeKa B40 Health Aid benefit**
    - Diagnosed by a doctor to have a condition that needs the listed health aid;
    - Transport is needed to come for any procedure/surgery/follow up related to Health Aid; AND/ OR
  - Patient is a recipient of Completing Cancer Treatment Incentive (CCTI)**
    - Diagnosed by a doctor to have any cancer (refer Section 3.2 for further detail on CCTI eligibility);
    - Transport is needed for patient to come for any cancer treatment as approved by the treating doctor i.e. chemotherapy, radiotherapy, surgery or any follow up related to cancer
  - b) **Patient is treated at Ministry of Health (MOH) hospital**
  - c) **Patient has not exhausted the limit of RM500 for Peninsular Malaysia and RM1000 for Sabah & Sarawak/ AND still have balance after previous application of transport incentives**

#### 4.1.3 Exclusion Criteria

Patients are not eligible for transport incentives in the following circumstances:

- a) Patients attend follow up in hospitals **BUT NOT** related to health aid/ cancer treatment
- b) Patients come to hospital for emergency treatment
- c) Patients use transport provided by the MOH hospital/clinics
- d) Patients transferred between public hospitals for upgrade/ downgrade of treatment using public hospital's ambulance
- e) Patients attend follow up in primary care
- f) Patients discharged themselves at their own risk (AOR)/ against medical advice
- g) Transport cost for other family members or care takers
- h) Patient receive treatment related to health aid/ cancer treatment in private hospitals/ Ministry of Defence hospitals/ university hospitals/ abroad.

#### 4.1.4 Rate of Payment

The rate or payment for the transport incentive is **RM 0.80 per kilometer**. The distance and amount for each payment will be auto-calculated by the BMS based on the **distance between beneficiary registered home address to the Hospital where application is made**.

#### 4.1.5 Per diagnosis

**Limit for RM500 for Peninsular and RM1000 for Sabah, Sarawak and Labuan is for each diagnosis of health aid AND/ OR cancer**

Example: If Encik Ali has prostate cancer and is receiving cancer treatment, he is eligible for transport incentive (up to RM500 for Semenanjung) for his cancer follow up. Encik Ali then involve in an accident and require health aid. Then, he is also eligible for another transport incentive (up to RM500) for his health aid follow up.

#### 4.1.6 Responsible Staff for Transport Incentive

- a) PIC should appoint at least one (1) staff at their department to be responsible for applying the Transport Incentive (Responsible Staff).
- b) Any request for Transport Incentive should be directed to the Responsible Staff for Transport Incentive at each department
- c) The responsible staff should be registered as Authorised User in order to be able to access the online application module for Transport Incentive

## 4.2 APPLICATION OF TRANSPORT INCENTIVE

### 4.2.1 Step 1: Ensure Eligibility and Balance Availability for Transport Incentive

- a) Once the responsible staff enter the beneficiary's NRIC in the BMS, the availability of transport incentive balance will be displayed

**For CCTI recipients, beneficiaries do not need to request for transport incentive as this will be automatically applied once the staff/ doctor enter the next appointment date for cancer treatment in the BMS**

### 4.2.2 Step 2: Online Application

- a) The application must be done during the **current follow up**
- b) For health aid recipients, if the balance is available, the staff can apply for the transport incentive. The required information are:
  - Next follow up date
  - Department where beneficiary's receiving treatment
- c) Submit the application

## 4.3 PAYMENT

### 4.3.1 Payment Method

After the information required is entered into the BMS and submitted, the request will be processed by BMS. Payment will be done via bank transfer to beneficiaries' registered bank account.

### 4.3.2 Maximum Limit Per-Application

**The transport incentive for the journey from patients' home to the hospital, and then from hospital back to patient's home (to and fro journey) is considered as one (1) application. The maximum limit for one (1) application is as stated below:**

- a) Peninsular: RM 200 per-application
- b) Sabah: RM 400 per-application

### 4.3.3 Review and Approval by ProtectHealth

All request will be reviewed by ProtectHealth and TAT for approval is within three (3) working days from the date of application.

#### 4.3.4 Payment of Transport Incentive

##### a) First Transport Incentive

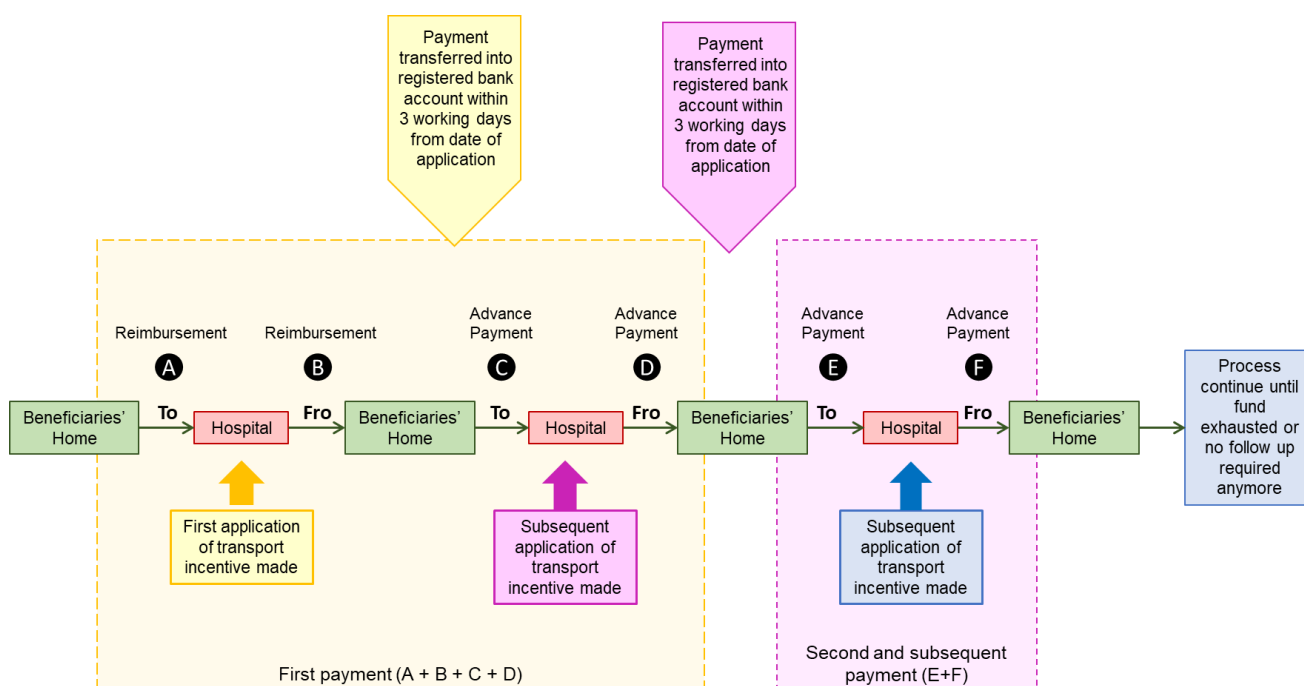
For the first application of transport incentive, beneficiaries will receive the total amount for:

- Reimbursement of transport incentive for the journey to and fro on the day of appointment where the first application made, and
- Transport incentive of the to and fro journey for the next appointment visit

##### b) Subsequent Transport Incentive (Advance Payment)

For the subsequent transport incentive applied, beneficiaries will receive advance payment of Transport Incentive for travelling to and fro for the next appointment visit.

The summary of first and subsequent Transport Incentive payments is illustrated as in **Figure 5** below.



**Figure 5: Summary of First and Subsequent Transport Incentive Payments**

#### 4.3.5 Transport Incentive Inadequate

If the balance for transport incentive is available, but inadequate, the beneficiary will receive only the balance available. For example, if the calculated rate for the incentive is RM 150, but the balance is RM100, patient will only receive RM100.

#### 4.4 TRANSPORT INCENTIVE WORKFLOW DIAGRAM

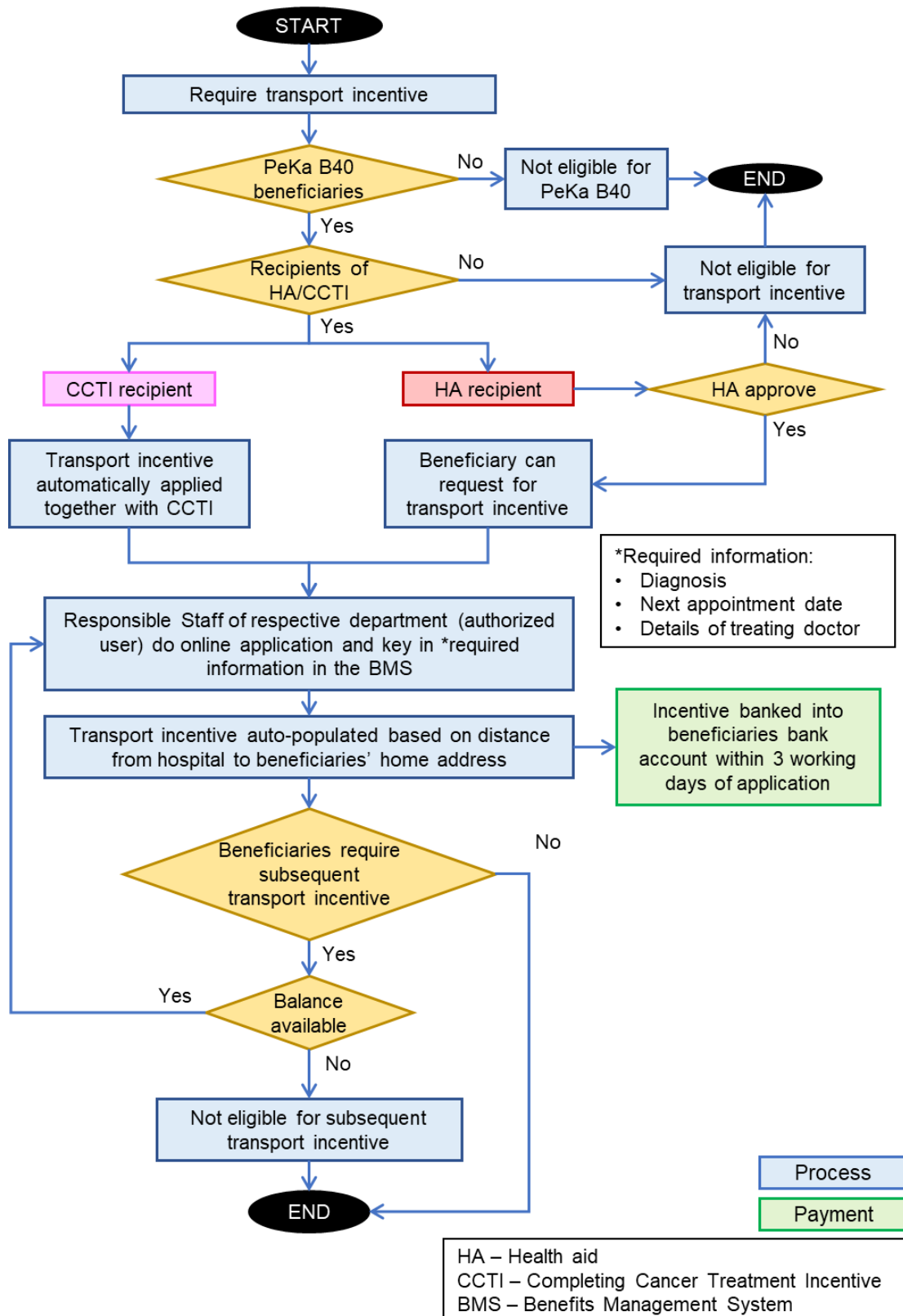


Figure 6: Transport Incentive Workflow Diagram

## HEALTH ASSESSMENT

### 5.1 CRITERIA FOR HEALTH ASSESSMENT IN MOH HOSPITAL

Health Screening is a prerequisite for beneficiaries to access the other 3 benefits under PeKa B40 Scheme. There are cases where beneficiaries are admitted in MOH Hospital and they require Health Aid (HA) and/or the Completing Cancer Treatment Incentive (CCTI) benefit, but they have not undergone screening yet. Under such circumstances, Health Assessment at MOH Hospital can be done as an alternative. However, all following criteria must be met in order to allow PeKa B40 Health Assessment at MOH Hospital:

- a) Beneficiaries are eligible for PeKa B40 Scheme
- b) Have not undergone Health Screening at GP/KK
- c) Require HA or CCTI benefit while admitted at MOH Hospital
- d) Unable to be discharged from hospital

### 5.2 HEALTH ASSESSMENT COMPONENTS

- a) Medical history taking (Refer **Section 5.7.1**)
  - Past medical history
  - Family history
  - Social history
  - Screening symptoms and risk factors for NCDs
  - Screening symptoms for mental health (Refer **Section 5.7.2**)
- b) Physical examination (Refer **Section 5.7.3**)
  - Weight and height
  - Blood pressure and pulse rate
  - General and systemic examination
  - Clinical breast examination (CBE)
  - Digital rectal examination (DRE) if indicated
- c) Taking blood and urine specimens for the following laboratory investigations (Refer **Section 5.9**)
  - Full blood count (FBC)
  - Renal profile with estimated glomerular filtration rate (eGFR)
  - Glycosylated haemoglobin A1c (HbA1c)
  - Random lipid profile
  - Urine biochemistry
- d) Consultation on Health Assessment result
- e) Referral (when indicated)

### 5.3 HEALTH ASSESSMENT PROCESS

- 5.3.1 Application for HA and/or CCTI can be done concurrently with Health Assessment. However, the application for HA and/or CCTI will only be processed and approved after the results of Health Assessment including laboratory results are entered into BMS.


### 5.3.2 Steps for Health Assessment

#### a) Health Assessment for Health Aid (HA) Approval

- Treating doctor who has identified beneficiary requiring HA will refer the case to MSW
- MSW key in beneficiary's NRIC in BMS and check if beneficiary fulfil the prerequisite criteria as in **Section 2.2.1**
- If beneficiaries have not done PeKa B40 Health Screening, MSW can still proceed with the application
- There will be a notification informing that HA application will only be processed and approved after beneficiaries' Health Screening/Assessment data is entered into the system
- Till then, the status of HA application will be 'pending for review'
- MSW must inform the treating doctor to complete the Health Assessment for the HA application to be processed
- Before doing the Health Assessment, the treating doctor must request beneficiary to sign **Declaration and Consent Form for Personal Data (Appendix 7)**
- Once the treating doctor has completed the Health Assessment as stated in **Section 5.2**, the treating doctor/PIC in the respective department must enter the information into the BMS.
- Treating doctor/PIC also need to update beneficiary's information in the BMS and upload required documents to complete the Health Assessment process.
- The HA application will then be reviewed by ProtectHealth. TAT for processing of HA approval is as stated in **Section 2.10**

#### b) Health Assessment for CCTI Approval

- Treating doctor who has identified beneficiary requiring CCTI will check beneficiary's eligibility in the BMS
- If beneficiary is eligible for PeKa B40, treating doctor will proceed to CCTI online application as in **Section 3.4.1**
- There will be a notification informing that CCTI application will only be processed and approved after beneficiary's Health Screening/Assessment data is entered into the system
- Till then, the status of CCTI application will be 'pending for review'
- Before doing the Health assessment, the treating doctor request beneficiary to sign **Declaration and Consent Form for Personal Data (Appendix 7)**
- The treating doctor must complete all Health Assessment components as stated in **Section 5.2**
- Once the treating doctor has completed the Health Assessment, the treating doctor/PIC of the respective department must enter the information into the BMS.
- Treating doctor/PIC also need update beneficiary's information in the BMS and upload required documents to complete the Health Assessment process.
- The CCTI application will then be review by ProtectHealth. The TAT for processing of CCTI approval is as stated in **Section 3.4.2**



**Treating doctor must complete Health Assessment and enter the information into the system in order for HA/CCTI application to be processed for approval**

#### 5.4 HOSPITAL RECORD


MOH Hospital shall maintain the record of every PeKa B40 beneficiary that has done Health Assessment at hospital. The hospital's record of the PeKa B40 beneficiary should include (but is not limited to) the following:

- a) Beneficiary name and NRIC
- b) Date of Health Assessment
- c) Declaration and Consent Form for Personal Data (**Appendix 7**)
- d) Clinical history, physical examination, lab results, and referral letters
- e) Any other relevant documents related to the PeKa B40 beneficiary

ProtectHealth reserves the right to review the hospital records of the PeKa B40 beneficiaries for medical audit including site review purposes.

#### 5.5 BENEFICIARY CONSENT

Beneficiaries are required to read and understand the **Declaration and Consent Form for Personal Data (Appendix 7)** which can be downloaded from the BMS. The treating doctor must get the beneficiary's signature for the consent before undergoing Health Assessment.



**A scanned copy of the signed Declaration and Consent Form must be uploaded into the system as part of claims requirements**

The original copy of the signed Declaration and Consent Form must be kept at the hospital for 6 years.

#### 5.6 UPDATING BENEFICIARY'S INFORMATION

##### 5.6.1 Below are the required information to be updated:

- a) Beneficiary name
- b) Citizenship
- c) Date of birth
- d) Age
- e) Sex
- f) Ethnicity
- g) Home address
- h) Marital status
- i) Occupation
- j) Religion
- k) Education level

- l) Email address
- m) Beneficiary's phone number
- n) Preferred Methods of instant messaging application for beneficiary

#### 5.6.2 Updating beneficiary's information is required for the purpose of: -

- a) Ensuring that beneficiaries are contactable
- b) Risk profiling
- c) Optimizing the provision of other benefits, such as Transport Incentive (Benefit 4) which involves calculation of standard rates from beneficiaries' home to MOH hospitals

Please refer to **Appendix 8: Update Beneficiary Information Form**

### 5.7 HEALTH ASSESSMENT FORMAT

#### 5.7.1 Structured Medical History Taking

The structure of the history taking process focuses on NCDs and risk assessment. To ease data capture of the history taking process, the format of the health screening questionnaire is prepared in a checklist manner to reduce free text entry as much as possible. However, there are some areas of history where the doctor needs to document in detail, for example, when there are abnormalities or positive medical findings. Please refer to appendices 3 and 4 for further information on the Health Screening module:

- a) **Appendix 9: Health Screening Form**
- b) **Appendix 10: Physical Activity Guide**

#### 5.7.2 Screening Symptoms for Mental Health

Patient Health Questionnaire-9 (PHQ-9) and Generalised Anxiety Disorder-7 (GAD-7) Questionnaire are used to screen for possible mental health concerns. The questionnaires are self-administered using a four-point Likert scale of frequency or severity based on the beneficiary's experiences over the last two weeks. If a beneficiary is having difficulty in understanding or answering the questions, the doctor is expected to provide assistance and to explain the questions. The doctor must enter the responses into the BMS and the system will auto-populate the final score. Please refer to the **Screening Symptoms for Mental Health** questionnaire as in **Appendix 11**.

**Beneficiaries who score 10 or above in either Questionnaire should be referred**

#### 5.7.3 Physical Examination

The physical examination requirements are mostly prepared in a checklist format, unless in the case of abnormalities, in which the doctor is required to explain in detail the findings in the comments section. The treating doctor must counsel and obtain

consent from the beneficiary before performing CBE and DRE. Please refer to the Physical Examination section of the Health Screening form as in **Appendix 9**.

## 5.8 PROVISIONAL DIAGNOSIS

Taking into consideration the findings from the history and physical examination, the doctor may propose a provisional diagnosis for the beneficiary.

## 5.9 LABORATORY INVESTIGATIONS

The doctor will take an adequate volume of blood and urine from the beneficiaries for the following investigations (**Laboratory parameters as attached in Appendix 12**);

- a) Full blood count (FBC)
- b) Glycosylated hemoglobin A1C (HbA1C)
- c) Random lipid profile
- d) Renal profile (RP) with estimated glomerular filtration rate (eGFR)
- e) Urine Biochemistry

For Health Assessment, the doctor will use existing hospital pathology services in MOH Hospital and existing hospital laboratory request form.

**Laboratory results must be reviewed, and a scanned copy of the laboratory results must be uploaded in the system**

## 5.10 CONSULTATION AND REFERRAL

Following health assessment, consultation will be given to beneficiary and referral will be made if indicated.

## 5.11 ENTERING HEALTH ASSESSMENT DETAILS INTO BMS

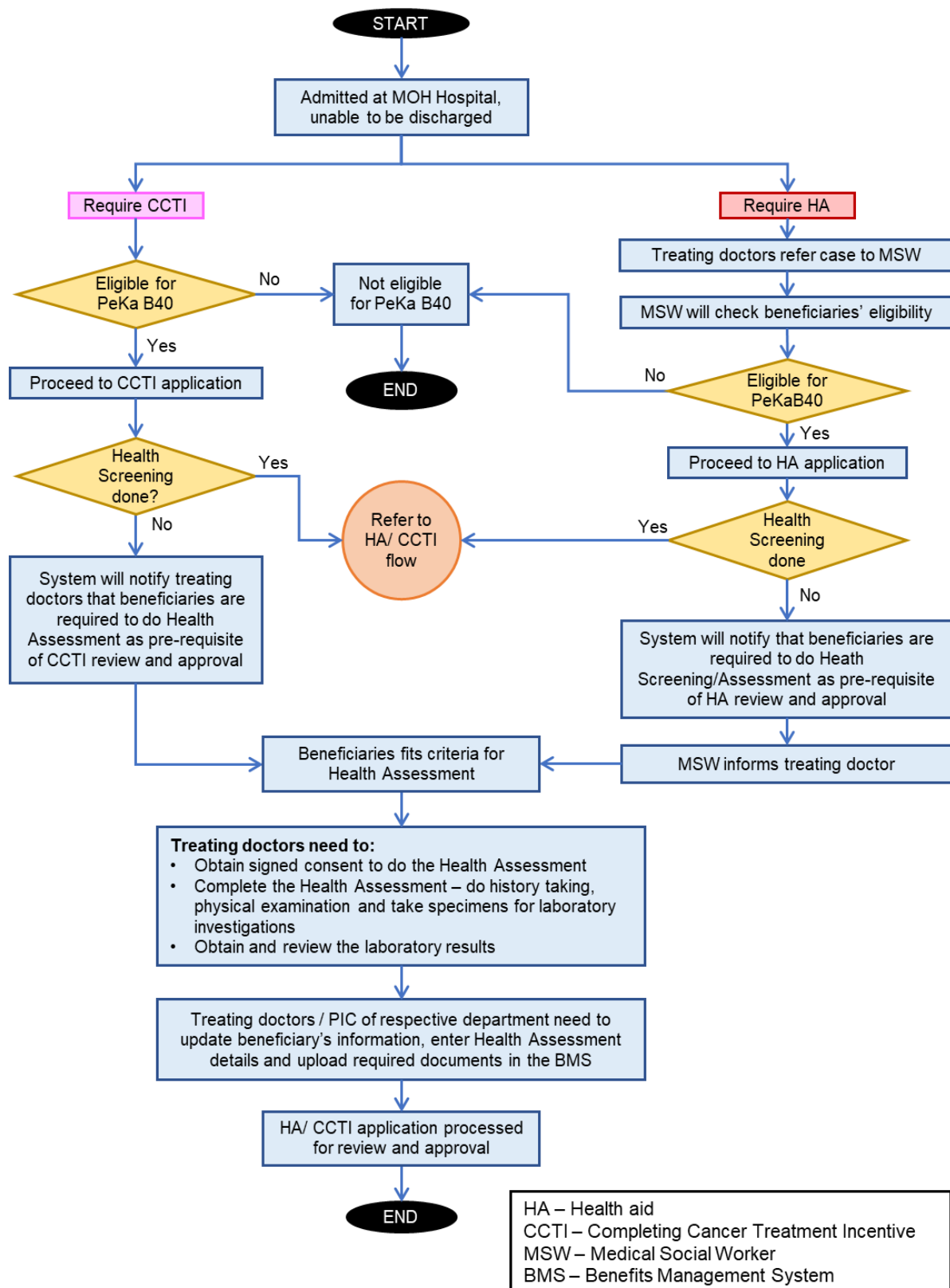
**PIC is responsible to make sure the screening information is entered into BMS after all the Health Assessment components are completed within 10 days from date of the Health Assessment.**

### 5.11.1 Documents to be Uploaded in BMS for Health Assessment Completion

- a) Declaration and Consent Form for Personal Data
- b) Laboratory results

5.11.2 Once the Health Assessment details are entered and documents uploaded, the Screening Summary can be generated from BMS. This Screening Summary can be printed to be given to beneficiary.

## 5.12 HEALTH ASSESSMENT WORKFLOW



**Figure 7: Health Assessment Workflow**

## UPDATING REFERRAL CASES

### 6.1 INTRODUCTION

The pathway for PeKa B40 Health Screening is through registered PeKa B40 General Practitioner (GP) or Klinik Kesihatan (KK). Following Health Screening, GP/KK may refer cases (if indicated) to MOH Hospital. PeKa B40 beneficiaries referred from PeKa B40 Health Screening are identified by PeKa B40 Referral Letter as shown in **Appendix 13**.

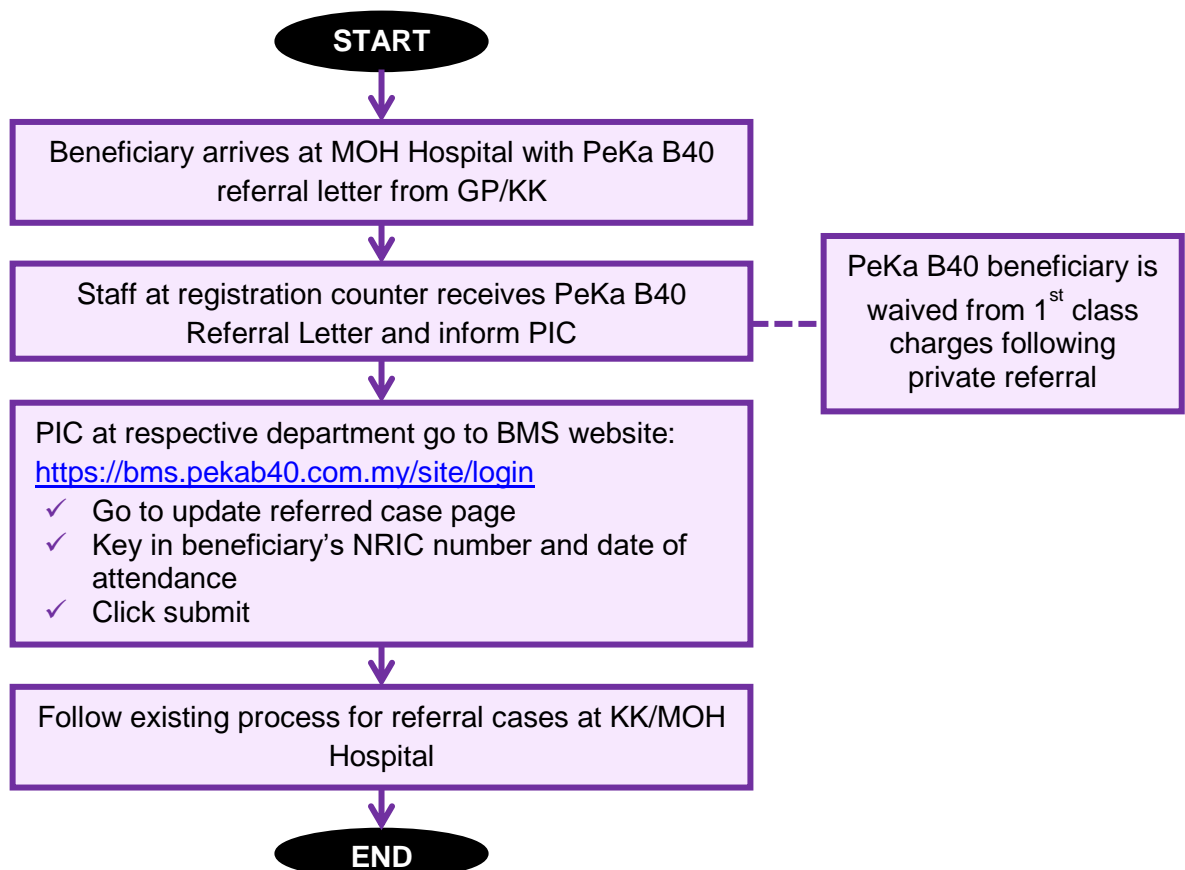
**PeKa B40 referrals must be monitored to enable MOH to take appropriate measures in relation to the increased workload and capturing beneficiaries who default referral**

PeKa B40 beneficiaries is waived from first class charges following private referral. The Official Letter for Approval of the 1<sup>st</sup> Class Waiver Charges is as attached in **Appendix 14**.

### 6.2 UPDATING REFERRAL WORKFLOW

**Updating of referral cases should be done at least on a weekly basis by the staff at the department receiving the referral.**

The workflow for updating referral cases is illustrated in the **Figure 8**.



**Figure 8: Updating Referral Workflow**

## APPENDIX

### List of Appendices

- Appendix 1 : Form C (*Borang C*)
- Appendix 2 : Rejection Letter
- Appendix 3 : Co-Payment Letter
- Appendix 4 : Letter of Award
- Appendix 5 : Consignment Note
- Appendix 6 : Completing Cancer Treatment Incentive (CCTI) and Transport Incentive for Cancer Patients Application Form
- Appendix 7 : Declaration and Consent Form for Personal Data
  - Malay Version
  - English Version
  - Chinese Version
  - Tamil Version
- Appendix 8 : Update Information Form
- Appendix 9 : Health Screening Form
  - First Visit Screening Form
  - Second Visit Screening Form
- Appendix 10 : Physical Activity Guide
- Appendix 11 : Mental Health Symptoms Screening Questionnaire
  - Malay Version
  - English Version
  - Chinese Version
  - Tamil Version
- Appendix 12 : Laboratory Investigation Parameters
- Appendix 13 : Referral Letter
- Appendix 14 : Official Letter for Approval of 1<sup>st</sup> Class Charges Waiver

## APPENDIX 1

LAPORAN PEGAWAI PERUBATAN/PAKAR  
PERMOHONAN TABUNG BANTUAN PERUBATAN

NAMA PESAKIT :

NO. K/P :

NO. RUJUKAN HOSPITAL:

JABATAN KEPAKARAN:

Jenis Penyakit (Diagnosis) : \_\_\_\_\_

Latar belakang penyakit dan rawatan : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Peralatan / Ubat yang diperlukan:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Jangkamasa rawatan dengan menggunakan peralatan/ ubat yang diperlukan:

\_\_\_\_\_ (minggu/bulan/ sepanjang hayat). Sebab  
peralatan/ubat itu diperlukan : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Aggaran kos bagi rawatan /ubat / alatan perubatan\* \_\_\_\_\_.

(\* Bersama-sama ini disertakan sebutharga dari syarikat pembekal)

Kekerapan penilaian semula (review) ialah \_\_\_\_\_ (minggu/ bulan/  
tahun).

Prognosis :

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Lain-lain maklumat yang berkaitan :

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---

Sekiranya terdapat pertanyaan, Unit ini boleh dihubungi di talian \_\_\_\_\_

Perakuan Pegawai /Pakar Perubatan

Pengesahan Ketua Jabatan

.....

.....

(Tandatangan)

(Tandatangan)

Nama :

Nama Ketua Jabatan:

Cop Rasmi :

Cop Rasmi :

Tarikh :

Tarikh:

\* Sila potong yang tidak berkenaan

\*\* Sila sertakan lampiran, jika ruang tidak mencukupi

# APPENDIX 2



PROTECTHEALTH

ProtectHealth Corporation Sdn Bhd

F01 & F02, 1st Floor, Block 2300

Century Square, Jalan Usahawan,

63000 Cyberjaya, Selangor

No Tel : 03-8687 2500

No Faks : 03-8687 2599

## SURAT PENOLAKAN

Rujukan :

Tarikh :

## SULIT

Tuan/ Puan,

### Surat Penolakan Bantuan Alat Perubatan bagi Peduli Kesihatan (PeKa) B40

Nama:

Kad Pengenalan:

---

Dengan hormatnya perkara di atas adalah dirujuk.

2. Dukacita dimaklumkan bahawa permohonan anda bagi bantuan alat perubatan **XXX** berjumlah RM **XXX** di bawah Peduli Kesihatan (PeKa) B40 telah ditolak.

3. Penolakan ini adalah disebabkan oleh:

- |                          |  |
|--------------------------|--|
| <input type="checkbox"/> | Peralatan yang dipohon tidak termasuk di dalam senarai         |
| <input type="checkbox"/> | Had seumur hidup Bantuan Alat Perubatan telah habis digunakan  |
| <input type="checkbox"/> | Tidak bersetuju untuk pembayaran bersama ( <i>co-payment</i> ) |
| <input type="checkbox"/> | Lain-lain. Nyatakan.....                                       |

Sekian, terima kasih.

**“LEBIH PEKA LEBIH CAKNA”**

Ketua Pegawai Eksekutif

ProtectHealth Corporation Sdn. Bhd. (Company No. 1212734-T)

(Surat ini adalah cetakan komputer dan tidak memerlukan tandatangan)



PROTECTHEALTH

ProtectHealth Corporation Sdn Bhd

F01 & F02, 1st Floor, Block 2300

Century Square, Jalan Usahawan,

63000 Cyberjaya, Selangor

No Tel : 03-8687 2500

No Faks : 03-8687 2599

## **SURAT TAWARAN PEMBAYARAN BERSAMA (CO-PAYMENT)**

Rujukan :

Tarikh :

**SULIT**

Tuan/ Puan,

**Surat Setuju Terima Tawaran Pembayaran Bersama Bantuan Alat Perubatan bagi Peduli Kesihatan Untuk Kumpulan B40 (PeKa B40)**

**Nama:**

**Kad Pengenalan:**

---

Dengan hormatnya perkara di atas adalah dirujuk.

2. Adalah dimaklumkan bahawa permohonan Tuan/Puan bagi Bantuan Alat Perubatan di bawah PeKa B40 iaitu XXX yang berjumlah RMXXX tidak dapat diproses selanjutnya kerana baki Bantuan Alat Perubatan tidak mencukupi/ melebihi julat harga.

3. Walau bagaimanapun sekiranya pihak Tuan/Puan dapat menyumbangkan pembayaran berjumlah RMXXX permohonan ini akan diproses.

Sekian, terima kasih.

**“LEBIH PEKA LEBIH CAKNA”**

Ketua Pegawai Eksekutif

ProtectHealth Corporation Sdn. Bhd. (Company No. 1212734-T)

(Surat ini adalah cetakan komputer dan tidak memerlukan tandatangan)



PROTECTHEALTH

ProtectHealth Corporation Sdn Bhd

F01 & F02, 1st Floor, Block 2300

Century Square, Jalan Usahawan,

63000 Cyberjaya, Selangor

No Tel : 03-8687 2500

No Faks : 03-8687 2599

## SURAT SETUJU TERIMA TAWARAN PEMBAYARAN BERSAMA (CO-PAYMENT)

Rujukan :

Tarikh :

### SULIT

ProtectHealth Corporation Sdn Bhd,  
Century Square, F01 & F02, 1st Floor, Block 2300,  
Jalan Usahawan, 63000 Cyberjaya, Selangor.

### Surat Tawaran Pembayaran Bersama (Co-Payment) Bantuan Alat Perubatan bagi Peduli Kesihatan untuk Kumpulan B40 (PeKa B40)

Nama:

Kad Pengenalan:

---

Merujuk kepada surat Tuan dengan nombor rujukan..... bertarikh .... dengan hormatnya perkara di atas adalah dirujuk.

2. Adalah dimaklumkan setelah meneliti tawaran di atas, saya dengan ini **BERSETUJU/ TIDAK BERSETUJU** membayar sebanyak RM..... untuk tawaran alat bantuan perubatan ..... yang berjumlah RM.....

3. Saya ambil maklum bahawa pembayaran perlu dijelaskan sebelum pihak pembekal membekalkan alat perubatan berkenaan.

Sekian Terima Kasih,

---

Tandatangan Pesakit/ Waris Pesakit

Nama:

No Kad Pengenalan:

---

Tandatangan Saksi

Nama:

No Kad Pengenalan:



PROTECTHEALTH

ProtectHealth Corporation Sdn Bhd

F01 & F02, 1st Floor, Block 2300

Century Square, Jalan Usahawan,

63000 Cyberjaya, Selangor

No Tel : 03-8687 2500

No Faks : 03-8687 2599

## LETTER OF AWARD

Ref No:

Date:

## CONFIDENTIAL

Vendor's Name

(Address \_\_\_\_\_)

(Attention: XXX )

Dear Sir/ Madam,

## **LETTER OF AWARD FOR SUPPLYING HEALTH AID UNDER SKIM PEDULI KESIHATAN BAGI KUMPULAN B40 (PeKa B40) (HEREINAFTER REFERRED TO AS "LETTER")**

**Beneficiary Name:**

**NRIC No:**

---

Reference is made to the above.

2. ProtectHealth Corporation Sdn Bhd ("ProtectHealth") is pleased to inform you that the above beneficiary's application for the **XXX** (health aid) under the PeKa B40 has been approved for **RM XXXX**. Please note that there will be a copayment from beneficiary for an amount of **RM XXX**

3. The validity period of this Letter shall be within **6 months / 1 year** from the date hereof (hereinafter referred to as "the Term"). Upon the expiring of the said Term, this Letter shall be lapsed and/or annulled.

4. Kindly liaise with the attending doctor and beneficiary for verification process. You are advised to submit consignment note and invoice **within one (1) month** from the date of surgery or delivery of the health item. ProtectHealth shall not be liable for the failure of your documentation submission to ProtectHealth, upon the expiry of the stipulated dateline.

5. You shall undertake to indemnify, defend and hold harmless ProtectHealth from and against any claim in respect of loss, damage, liabilities, fines, penalties, forfeitures, suits and the costs and expenses incidental thereto, arising from damage to life or bodily injury or real or tangible personal property or violation of governmental laws, regulations or orders, caused in whole or in part, by your organization's misrepresentation or breach of any warranty, term or provision of the Letter of Award; or any negligent or wilful act or omission on your

organization's part, its employees and/or agents while engaged in the performance of the Services.

6. Your cooperation and assistance are highly appreciated.

Thank you.

**“LEBIH PEKA LEBIH CAKNA”**

**DATUK HJ AB LATIFF HJ ABU BAKAR**

Chief Executive Officer

ProtectHealth Corporation Sdn. Bhd.

c.c:

Hospital director

Hospital XXX

Jalan XXX

Postcode

State

(att: Social Worker's name)

Head of XXX department

Hospital XXX

Jalan XXX

Postcode

State

(att: Dr ABC)

Patient's name and address



**PROTECTHEALTH**

**ProtectHealth Corporation Sdn Bhd**

F01 & F02, 1st Floor, Block 2300

Century Square, Jalan Usahawan,

63000 Cyberjaya, Selangor

No Tel : 03-8687 2500

No Faks : 03-8687 2599

Date: XX April 2019

### **ACKNOWLEDGEMENT RECEIPT OF THE LETTER OF AWARD BY THE COMPANY**

It is hereby confirmed that the undersigned below acknowledge receipt of this Letter dated XX March 2019 (Ref No: \_\_\_\_\_). Thus, hereby agrees with the terms and conditions contained in this Letter unconditionally where a copy of this Letter has been retained, and it is further reconfirmed that no terms, conditions or additional stipulations other than those contained in the quotation document and this Letter have been imposed.

.....  
Signature by the Company

Full Name :

I/C Number :

Address :

Date :

Company's seal or stamp

# APPENDIX 5



PROTECTHEALTH

**ProtectHealth Corporation Sdn Bhd**  
F01 & F02, 1st Floor, Block 2300  
Century Square, Jalan Usahawan,  
63000 Cyberjaya, Selangor  
No Tel : 03-8687 2500  
No Faks : 03-8687 2599

## CONSIGNMENT NOTE

### Letter of Confirmation of Health Aid To Beneficiaries Under the PeKa B40 Scheme

1. I certify that treatment / health aid to the patients below have been executed based on the approval letter from the Protecthealth Corporation Sdn Bhd \_\_\_\_\_

No. reference (autogenerate) dated (autogenerate)

The health aid supplies details are as follows: -

- 1.1 Patient Name : (autogenerate)
- 1.2 NRIC number : (autogenerate)
- 1.3 Type of Treatment : (autogenerate)
- 1.4 Actual Health Aid Cost : RM (autogenerate)
- 1.5 Approved Health Aid Cost : RM (autogenerate)
- 1.6 Date Received Item : \_\_\_\_\_ (for Non-Surgical Item)
- 1.7 Date of Surgery : \_\_\_\_\_ (for Surgical Item)
- 1.8 Place of Treatment : (autogenerate)

2. Included original copy of invoice from Company \_\_\_\_\_

Invoice number \_\_\_\_\_ Dated \_\_\_\_\_

The claim charged RM ( \_\_\_\_\_ ) as the person who has supplied the health aid.

\*notes

Certified by

Verified by Head of Department

**Name**

**Name**

**Position**

**Position**

**IC no**

**IC no**

**Official stamp**

**Official stamp**

**MMC/Valid APC**

**MMC/Valid APC**

**Date**

**Date**

Note: can be certified by treating/referring  
Doctor or Medical Social Worker

\* confirmed if there is a difference in the  
amount of approval with the invoice / treatment  
made prior to approval or others

# APPENDIX 6

PEKAB40/CCTI/2019/01



**Peduli Kesihatan untuk Kumpulan B40**  
Completing Cancer Treatment Incentive



KEMENTERIAN KESIHATAN  
MALAYSIA



PROTECTHEALTH

**ProtectHealth Corporation Sdn Bhd**

(1212734-T)

F01 & F02, 1st Floor, Block 2300  
Century Square, Jalan Usahawan  
63000 CyberJaya, Selangor  
**T** +603 8687 2500  
**F** +603 8687 2599  
**E** info@protecthealth.com.my  
**www.protecthealth.com.my**

## Completing Cancer Treatment Incentive (CCTI) and Transport Incentive for Cancer Patients

**INSTRUCTION: Where checkboxes () are provided, check () one or more boxes. Where radio buttons () are provided, select () one option only.**

New IC number	<input type="text"/>
Full name	<input type="text"/>
Sex	<input type="radio"/> Female <input type="radio"/> Male
Date of visit/application	<input type="text"/>
Medical registration number (MRN)	<input type="text"/>

### Section A: Cancer Diagnosis

Any change in diagnosis? <i>Note: For new application, select "Not applicable"</i>	<input type="radio"/> Yes, reason for change <input type="text"/> <input type="radio"/> No <input type="radio"/> Not applicable			
Date of diagnosis	<input type="text"/>			
Diagnosis	Diagnosis	<input type="text"/>		
	ICD-10 code	<input type="text"/>		
Stages of cancer	TNM staging	<input type="text"/> T	<input type="text"/> N	<input type="text"/> M
	<input type="checkbox"/> Not applicable			
	Cancer stage	<input type="radio"/> Stage I <input type="radio"/> Stage II	<input type="radio"/> Stage III <input type="radio"/> Stage IV	<input type="radio"/> Unknown

### Section B: Treatment Plan

Any change in treatment plan? <i>Note: For new application, select "Not applicable"</i>	<input type="radio"/> Yes, reason for change <input type="text"/> <input type="radio"/> No <input type="radio"/> Not applicable		
Type of treatment	Start date	Administered in current visit	
<input type="checkbox"/> Surgery	<input type="text"/>	<input type="checkbox"/>	
<input type="checkbox"/> Chemotherapy	<input type="text"/>	<input type="checkbox"/>	
<input type="checkbox"/> Radiotherapy	<input type="text"/>	<input type="checkbox"/>	
<input type="checkbox"/> Hormonal drug therapy	<input type="text"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other, please specify <input type="text"/>	<input type="text"/>	<input type="checkbox"/>	
Next appointment date	<input type="text"/>		
Treating doctor	Full name	<input type="text"/>	
	MMC registration number	<input type="text"/>	
	Designation	<input type="radio"/> Specialist <input type="radio"/> Medical Officer	
	Hospital	<input type="text"/>	Department

## **APPENDIX 7: Declaration and Consent Form for Personal Data**

- **Malay version**
- **English version**
- **Chinese version**
- **Tamil version**

## PERSETUJUAN DAN DEKLARASI BAGI TUJUAN DATA PERIBADI

### 1. KLAUSA PERSETUJUAN

Dengan menandatangani dan mengemukakan borang ini, saya akui bahawa saya telah membaca, memahami, dan bersetuju dengan terma-terma Dasar Privasi ProtectHealth Corporation Sdn Bhd ("ProtectHealth"). Saya dengan sukarela mengizinkan dan memberi kuasa kepada ProtectHealth bagi mengumpul, mentadbir, mengurus, dan memproses semua data peribadi saya termasuk data peribadi sensitif (dikenali sebagai "Data Peribadi") untuk digunakan hanya untuk tujuan yang berkaitan dengan Skim Peduli Kesehatan untuk Kumpulan B40 (secara kolektif dikenali sebagai "**PeKa B40**") termasuk yang berikut:-

- Saringan Kesehatan;
- Bantuan Alat Perubatan;
- Insentif Melengkapkan Rawatan Kanser;
- Insentif Tambang Pengangkutan;
- Audit Perubatan dan Kualiti;
- Profil Kesehatan;
- Analisis data; dan
- Pemantauan dan Penilaian;

secara kolektif dikenali sebagai "**Tujuan**".

1.1. Saya juga **membenarkan** ProtectHealth untuk: -

- a. mengumpul, mentadbir, mengurus, dan memproses Data Peribadi saya (termasuk data peribadi sensitif) yang diperolehi secara langsung atau tidak langsung daripada pihak ketiga, pengamal perubatan berdaftar, klinik-klinik, hospital-hospital, makmal-makmal, lain-lain fasiliti kesehatan yang relevan, dan/atau Kementerian Kesehatan Malaysia;
- b. berkongsi data peribadi saya dengan Kementerian Kesehatan Malaysia, jika perlu.

1.2. Bagi mengelakkan keraguan, Data Peribadi merangkumi semua data yang ditakrifkan di dalam Akta Perlindungan Data Peribadi 2010 ("APDP").

### 2. DEKLARASI

- 2.1. Saya mengakui dan mengesahkan bahawa saya telah membaca, memahami dan bersetuju untuk tertakluk dengan terma-terma Dasar Privasi ProtectHealth.
- 2.2. Saya mengesahkan dan mengisytiharkan bahawa data dan maklumat peribadi saya yang saya berikan kepada ProtectHealth adalah benar dan betul berdasarkan pengetahuan saya.
- 2.3. Saya akan maklumkan kepada ProtectHealth dengan serta-merta mengenai apa-apa perubahan kepada data peribadi saya.

Tandatangan

Nama :

No Kad Pengenalan :

Tarikh :

## CONSENT AND DECLARATION FOR PERSONAL DATA

### 1. CONSENT CLAUSE

By signing and submitting this form, I am declaring that I have read, understand, and agree to the terms of the Privacy Policy of ProtectHealth Corporation Sdn Bhd (“ProtectHealth”). I voluntarily consent and authorise ProtectHealth to collect, administer, manage, and process all my personal data including sensitive personal data, (collectively known as “Personal Data”) to be used only for the purposes related to *Skim Peduli Kesehatan untuk Kumpulan B40* (known as “**PeKa B40**”), including the following: -

- Health Screening;
- Health Equipment Aid;
- Completing Cancer Treatment Incentive;
- Transport Incentive;
- Medical Audit and Quality;
- Health Profiling;
- Data Analytics; and
- Monitoring and Evaluation;

collectively known as “**the Purposes**”.

1.1. I also **consent** for ProtectHealth to: -

- a. collect, administer, manage, and process my Personal Data (including sensitive personal data) obtained directly or indirectly from third parties, registered medical practitioners, clinics, hospitals, laboratories, other relevant healthcare facilities and/or the Ministry of Health Malaysia;
- b. disclose my personal data to the Ministry of Health Malaysia, if necessary.

1.2. For avoidance of doubt, Personal Data includes all data defined within the Personal Data Protection Act 2010 (“PDPA”).

### 2. DECLARATION

2.1. I acknowledge and confirm that I have read and understand the Privacy Policy of ProtectHealth.

2.2. I confirm and declare that my personal data and information disclosed to ProtectHealth are true and correct to the best of my knowledge.

2.3. I undertake to inform ProtectHealth immediately on any changes of my personal data.

---

Signature

Name :

NRIC No :

Date :

## 個人資料收集同意書及聲明

### 1. 同意條款

通過簽署並提交此表格，我宣佈我理解並同意 ProtectHealth Corporation Sdn Bhd (“ProtectHealth”) 隱私政策的條款。我自願同意並授權 ProtectHealth 收集、管理和處理我的所有個人資料（包括敏感的個人資料，統稱為“個人資料”）。此授權僅限於與 Skim Peduli Kesehatan untuk Kumpulan B40（稱作“PeKa B40”）相關的目的，包括：

- 免費健康檢查；
- 醫療器材及配備援助；
- 完成癌症治療獎勵；
- 交通補貼；
- 醫療審計及質量；
- 健康狀況；
- 資料分析；及
- 監測與評估；

統稱為“目的”。

1.1. 我也**同意** ProtectHealth： -

- a. 收集，管理和處理從選定的協力廠商、參與此計劃的全科醫生、診所、醫院、實驗室、其他相關醫療機構及馬來西亞衛生部直接或間接獲得的個人資料（包括敏感個人資料）；
- b. 如有需要的話，向馬來西亞衛生部披露我的個人資料。

1.2. 為避免疑義，個人資料包括 2010 年“個人資料保護法”（“PDPA”）中定義的所有資料，包括我在本表格中向 ProtectHealth 提供的所有資料。

### 2. 聲明

- 2.1. 我承認並確認我已閱讀並理解 ProtectHealth 的隱私政策。
- 2.2. 我確認並聲明我向 ProtectHealth 提供的個人資料及資訊是真實和正確的。
- 2.3. 我承諾在我的個人資料有異動變更時，立即通知 ProtectHealth。

簽名

姓名 :

身份證號碼 :

日期 :            年    月    日

## தனிப்பட்ட தரவுக்கான இசைவு மற்றும் சாற்றுதல்

### 1. இசைவுக்கூறு

இந்தப் படிவத்தில் கையொப்பமிட்டு ஒப்படைப்பதின் மூலம், நான் ப்ரோதெக்ட் ஹெல்த் கார்ப்பரேஷன் செண்டிரியான் பெர்ஹாட் / ProtectHealth Corporation Sdn. Bhd. (ப்ரோதெக்ட் ஹெல்த் / ProtectHealth) - இன் தனியுரிமைக் கொள்கையின் விதிகளைப் புரிந்துகொண்டு ஒப்புக்கொள்கிறேன் எனச் சாற்றுக்கிறேன். என் அனைத்து தனிப்பட்ட தரவை (முகமையான தனிப்பட்ட தரவு உட்பட, மொத்தமாக தனிப்பட்ட தரவு என அறியப்படும்) B40 பிரிவுக்கான பெடுலி கெசிஹாட்டான் / Skim Peduli Kesehatan untuk Kumpulan B40 (பெகா B40 / PeKa B40) என அறியப்படும்) நலத்திட்டத்திற்குத் தொடர்பான நோக்கங்களுக்காக மட்டுமே சேகரிக்க, நிர்வகிக்க, மேலாண்மை மற்றும் செயலாக்கம் செய்யப் பயன்படுத்த தன்விருப்பத்துடன் இசைவையும் அதிகாரத்தையும் பின்வருவனவற்றுக்கு உட்பட ப்ரோதெக்ட் ஹெல்த்திற்கு வழங்குகிறேன்:

- சுகாதாரப் பரிசோதனை;
- சுகாதார உதவி; மருத்துவ சாதன உதவிகள்;
- புற்றுநோய் சிகிச்சை ஊக்கத்தொகை நிறைவடைதல்; புற்றுநோய் சிகிச்சை முழுமையடைவதற்கான ஊக்கத்தொகை;
- போக்குவரத்து ஊக்கத்தொகை;
- மருத்துவத் தணிக்கை (audit) மற்றும் தரம் (quality);
- சுகாதார விவரக் குறிப்புகள்;
- தரவு பகுப்பாய்வு, அறிக்கை மற்றும் வெளியீடு; மற்றும்
- கண்காணிப்பு மற்றும் மதிப்பீடு;

ஒட்டுமொத்தமாக, "நோக்கங்கள்" என்று அழைக்கப்படுகிறது.

1.1. நான் ப்ரோதெக்ட் ஹெல்த்துக்கு ("ProtectHealth") இசைவு அளித்த மற்றவை வருமாறு:-

- a. தேர்ந்தெடுக்கப்பட்ட மூன்றாம் தரப்பினர், பதிவு செய்யப்பட்ட பொது தனியார் மருத்துவர்கள், மருத்துவகங்கள், மருத்துவமனைகள், ஆய்வுக்கூடங்கள், பிற தொடர்புடைய சுகாதார வசதிகள் மற்றும் / அல்லது சுகாதார அமைச்சு ஆகியவற்றிலிருந்து நேரடியாகவோ அல்லது மறைமுகமாகவோ பெறப்பட்ட, தனிப்பட்ட தரவை (முகமையான தனிப்பட்ட தரவு உட்பட) சேகரித்தல், நிர்வகித்தல், மேலாண்மை மற்றும் செயலாக்குதல்;
- b. எனது தனிப்பட்ட தரவை சுகாதார அமைச்சுக்கு வெளியிட்டுத்தல்.

- 1.2. ஐயத்தைத் தவிர்ப்பதற்காக, இந்தப் படிவத்தில் ப்ரோதெக்ட் ஹெல்துக்கு ("ProtectHealth") நான் தெரிவித்த அனைத்துத் தரவுகளும், தனிப்பட்ட தரவுப் பாதுகாப்புச் சட்டம் 2010 ("PDPA") இல் வரையறுக்கப்பட்ட அனைத்துத் தரவையும் உள்ளடக்கியது.

## 2. சாற்றுதல்

- 2.1. ப்ரோதெக்ட் ஹெல்தின் ("ProtectHealth") தனியுரிமைக் கொள்கையை நான் படித்துப் புரிந்து கொள்கிறேன் என்பதை ஒப்புக்கொண்டு உறுதி செய்கிறேன்.
- 2.2. நான் ப்ரோதெக்ட் ஹெல்துக்கு ("ProtectHealth") வெளிப்படுத்திய எனது தனிப்பட்ட தரவுகள் மற்றும் தகவல்கள் என் அறிவுக்கு எட்டியவரை உண்மை மற்றும் சரியானது என்பதை உறுதியுடன் சாற்றுகிறேன்.
- 2.3. என் தனிப்பட்ட தரவில் ஏதேனும் மாற்றங்கள் இருப்பின், உடனடியாக ப்ரோதெக்ட் ஹெல்துக்கு ("ProtectHealth") தெரிவிக்கும் பொறுப்பை மேற்கொள்வேன்.

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கையொப்பம்

பெயர் :

அடையாள அட்டை எண் :

தேதி :

# APPENDIX 8

PEKAB40/HS/UI/2019/01



**Peduli Kesehatan untuk Kumpulan B40**  
Health Screening Form



KEMENTERIAN KESIHATAN  
MALAYSIA



PROTECTHEALTH

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## Update Beneficiary Information

### Section A: Demographic Information

Citizenship	<input type="radio"/> Citizen <input type="radio"/> Permanent resident <input type="radio"/> Non-resident		
New IC number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
Full name	<input type="text"/>		
Date of birth	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Sex	<input type="radio"/> Male <input type="radio"/> Female
Ethnic	<input type="radio"/> Malay <input type="radio"/> Chinese <input type="radio"/> Indian/Punjabi <input type="radio"/> Indigenous Sabah, please specify: _____ <input type="radio"/> Indigenous Sarawak, please specify: _____ <input type="radio"/> Orang Asli (Peninsular) <input type="radio"/> Other		
Religion	<input type="radio"/> Islam <input type="radio"/> Hindu <input type="radio"/> Other <input type="radio"/> Christian <input type="radio"/> Sikhism <input type="radio"/> No religion <input type="radio"/> Buddha <input type="radio"/> Taoism		
Marital status	<input type="radio"/> Never married <input type="radio"/> Widowed <input type="radio"/> Separated <input type="radio"/> Currently married <input type="radio"/> Divorced		
Highest level of education	<input type="radio"/> No formal schooling <input type="radio"/> Pre-primary education <input type="radio"/> Primary education (Standard 1–6/UPSR) <input type="radio"/> Lower secondary education (Remove class to Form 3/PMR/SRP/LCE/III Thanawi) <input type="radio"/> Upper secondary education (Form 4–5/SPM/MCE/SPMV/IV Thanawi) <input type="radio"/> Pre-university education (Form 6/Matriculation/STP/HSC/STPM/V Thanawi [STA/STAM]) <input type="radio"/> Certificate from college/polytechnic/university <input type="radio"/> Diploma from college/polytechnic/university <input type="radio"/> Bachelor's degree/postgraduate diploma <input type="radio"/> Master's degree <input type="radio"/> Doctoral degree		
Work status	<input type="radio"/> Government employee <input type="radio"/> Retired <input type="radio"/> Semi-government employee <input type="radio"/> Homemaker <input type="radio"/> Private company employee <input type="radio"/> Student <input type="radio"/> Self-employed <input type="radio"/> Unemployed (able to work) <input type="radio"/> Non-paid <input type="radio"/> Unemployed (unable to work)		

### Section B: Contact Information

Address 1	<input type="text"/>		
Address 2	<input type="text"/>		
Address 3	<input type="text"/>		
Postcode	<input type="text"/>	Town/city	<input type="text"/>
State	<input type="text"/>	District	<input type="text"/>
Landline number 1	<input type="text"/>	Landline number 2	<input type="text"/>
Mobile phone number 1	<input type="text"/>		
	<input type="checkbox"/> WhatsApp <input type="checkbox"/> Facebook Messenger		<input type="checkbox"/> WeChat <input type="checkbox"/> None of the above
Mobile phone number 2	<input type="text"/>		
	<input type="checkbox"/> WhatsApp <input type="checkbox"/> Facebook Messenger		<input type="checkbox"/> WeChat <input type="checkbox"/> None of the above
Email	<input type="text"/>		
Language choice for PeKa B40 messages	<input type="radio"/> Melayu <input type="radio"/> English <input type="radio"/> 中文 <input type="radio"/> தமிழ்		

## **APPENDIX 9: Health Screening Form**

- **First Visit Screening Form**
- **Second Visit Screening Form**



**Peduli Kesehatan untuk Kumpulan B40**  
Health Screening Form



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### History Taking and Physical Examination

**INSTRUCTION: Where checkboxes (☐) are provided, check (☑) one or more boxes. Where radio buttons (○) are provided, select (●) one option only.**

New IC number       -   -

Full name

Sex  Female  Male

Date of examination    -   -

### Section C: Medical History

Have you ever been told by a doctor or other health professional that you have any of the following conditions?	Disease duration	Currently being treated
<input type="checkbox"/> Diabetes mellitus	<input type="text"/> years <input type="text"/> months <input type="checkbox"/> Don't know/remember	<input type="radio"/> Yes <input type="radio"/> No
<input type="checkbox"/> Hypertension	<input type="text"/> years <input type="text"/> months <input type="checkbox"/> Don't know/remember	<input type="radio"/> Yes <input type="radio"/> No
<input type="checkbox"/> Hypercholesterolemia	<input type="text"/> years <input type="text"/> months <input type="checkbox"/> Don't know/remember	<input type="radio"/> Yes <input type="radio"/> No
<input type="checkbox"/> Coronary heart disease	<input type="text"/> years <input type="text"/> months <input type="checkbox"/> Don't know/remember	<input type="radio"/> Yes <input type="radio"/> No
<input type="checkbox"/> Stroke	<input type="text"/> years <input type="text"/> months <input type="checkbox"/> Don't know/remember	<input type="radio"/> Yes <input type="radio"/> No
<input type="checkbox"/> Chronic kidney disease	<input type="text"/> years <input type="text"/> months <input type="checkbox"/> Don't know/remember	<input type="radio"/> Yes <input type="radio"/> No
<input type="checkbox"/> Breast cancer	<input type="text"/> years <input type="text"/> months <input type="checkbox"/> Don't know/remember	<input type="radio"/> Yes <input type="radio"/> No
<input type="checkbox"/> Colorectal cancer	<input type="text"/> years <input type="text"/> months <input type="checkbox"/> Don't know/remember	<input type="radio"/> Yes <input type="radio"/> No
<input type="checkbox"/> Lung cancer	<input type="text"/> years <input type="text"/> months <input type="checkbox"/> Don't know/remember	<input type="radio"/> Yes <input type="radio"/> No
<input type="checkbox"/> Asthma	<input type="text"/> years <input type="text"/> months <input type="checkbox"/> Don't know/remember	<input type="radio"/> Yes <input type="radio"/> No
<input type="checkbox"/> Epilepsy or fits	<input type="text"/> years <input type="text"/> months <input type="checkbox"/> Don't know/remember	<input type="radio"/> Yes <input type="radio"/> No
<input type="checkbox"/> Mental illness	<input type="text"/> years <input type="text"/> months <input type="checkbox"/> Don't know/remember	<input type="radio"/> Yes <input type="radio"/> No
<input type="checkbox"/> Other, please specify <input type="text"/>	<input type="text"/> years <input type="text"/> months <input type="checkbox"/> Don't know/remember	<input type="radio"/> Yes <input type="radio"/> No
<input type="checkbox"/> None of the above		

### Section D: Family History

Do your **immediate family members (parents, children and siblings)** have any of the following conditions?

<input type="checkbox"/> Diabetes mellitus	<input type="checkbox"/> Breast cancer
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Colorectal cancer
<input type="checkbox"/> Hypercholesterolemia	<input type="checkbox"/> Lung cancer
<input type="checkbox"/> Coronary heart disease	<input type="checkbox"/> Mental illness
<input type="checkbox"/> Stroke	<input type="checkbox"/> Sudden death
<input type="checkbox"/> Chronic kidney disease	<input type="checkbox"/> Other, please specify: _____
<input type="checkbox"/> None of the above	

Section E: Behavioural Risk Factors		
<b>Tobacco Use</b>		
Do you currently smoke any tobacco products (such as cigarettes or vapes)?	<input type="radio"/> Yes, daily <input type="radio"/> Yes, less than daily <input type="radio"/> No, I have stopped smoking <input type="radio"/> No, I have never smoked tobacco	
<b>["Daily" smoker only]</b> On average, how many cigarettes or vapes do you smoke each day?	<input type="text"/> per day	
<b>["Less than daily" smoker only]</b> On average, how many cigarettes or vapes do you smoke each week?	<input type="text"/> per week	
<b>Alcohol Consumption</b>		
Have you ever consumed any alcohol (such as beer, wine, alcoholic herbal beverages, todhi, samsu, tuak, or stout)?	<input type="radio"/> Yes <input type="radio"/> No	
<b>[Drinker only]</b> During the past 12 months, how frequently have you had at least one standard alcoholic drink?	<input type="radio"/> Never <input type="radio"/> Once a month or less <input type="radio"/> 2-4 times a month <input type="radio"/> 2-3 times a week <input type="radio"/> 4 or more times a week	
<b>[Drinker only]</b> How often do you have six or more standard drinks in a single drinking occasion?	<input type="radio"/> Never <input type="radio"/> Less than once a month <input type="radio"/> Monthly <input type="radio"/> Weekly <input type="radio"/> Daily or almost daily	
<b>Physical Activity</b>		
Vigorous activity  <i>Examples:</i> <ul style="list-style-type: none"> <li>• carrying or lifting heavy loads</li> <li>• digging or construction work</li> <li>• aerobic exercise</li> <li>• fast cycling</li> <li>• playing football</li> </ul>	In a typical week, on how many days do you do vigorous-intensity activities at work and during leisure time for <b>AT LEAST 10 MINUTES CONTINUOUSLY?</b>  How much time do you spend doing vigorous-intensity activities on <b>one of those days?</b>	<input type="text"/> days per week  <input type="text"/> hours <input type="text"/> minutes per day  <input type="checkbox"/> No vigorous-intensity activities
Moderate activity  <i>Examples:</i> <ul style="list-style-type: none"> <li>• carrying light loads</li> <li>• brisk walking</li> <li>• cycling at normal speeds</li> <li>• swimming</li> <li>• playing volleyball</li> <li>• mopping the floor</li> </ul>	In a typical week, on how many days do you do moderate-intensity activities at work and during leisure time for <b>AT LEAST 10 MINUTES CONTINUOUSLY?</b>  How much time do you spend doing moderate-intensity activities on <b>one of those days?</b>	<input type="text"/> days per week  <input type="text"/> hours <input type="text"/> minutes per day  <input type="checkbox"/> No moderate-intensity activities
Walking	In a typical week, on how many days do you walk for <b>AT LEAST 10 MINUTES CONTINUOUSLY?</b>  How much time do you spend walking on <b>one of those days?</b>	<input type="text"/> days per week  <input type="text"/> hours <input type="text"/> minutes per day  <input type="checkbox"/> No walking
Sedentary Behaviour	On a typical day, how much time do you usually spend sitting or reclining at work, at home, travelling, or with friends, <b>BUT NOT INCLUDING</b> time spent sleeping?	<input type="text"/> hours <input type="text"/> minutes per day

Section F: Physical Examination				
Chaperone	New IC number		<input type="text"/> - <input type="text"/> - <input type="text"/>	
	Full name			
Height	<input type="text"/> cm	Blood pressure	<input type="text"/> / <input type="text"/> mmHg	
Weight	<input type="text"/> kg	Pulse rate	<input type="text"/> beats/min	
Body mass index (BMI)	<input type="text"/> kg/m <sup>2</sup>	Pulse rhythm	<input type="radio"/> Regular <input type="radio"/> Irregular	
	Normal	Abnormal	Remarks (Mandatory if "Abnormal")	
General appearance	<input type="radio"/>	<input type="radio"/>		
Head & neck (including eyes, ears, nose, and throat)	<input type="radio"/>	<input type="radio"/>		
Lungs	<input type="radio"/>	<input type="radio"/>		
Heart	<input type="radio"/>	<input type="radio"/>		
Abdomen	<input type="radio"/>	<input type="radio"/>		
Back & extremities	<input type="radio"/>	<input type="radio"/>		
Neurological	<input type="radio"/>	<input type="radio"/>		
Section G: Digital Rectal Examination				
Indications <i>Please proceed to perform digital rectal examination and refer beneficiary for further investigation based on clinical judgement</i>	<b>[For males ONLY]</b>		<b>[Both females and males]</b>	
	<input type="checkbox"/> Nocturia <input type="checkbox"/> Difficulty starting urination (hesitancy) <input type="checkbox"/> Weak flow or poor stream <input type="checkbox"/> Dribbling after urination <input type="checkbox"/> Haematuria <input type="checkbox"/> Blood in semen		<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Change in bowel habit <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Anorectal pain <input type="checkbox"/> Anorectal mass <input type="checkbox"/> None of the above	
	Normal	Abnormal	Remarks (Mandatory if "Abnormal")	
Digital rectal examination (DRE) <input type="checkbox"/> Beneficiary refused	<input type="radio"/>	<input type="radio"/>		

Section H: Basic Breast Cancer Screening Including Clinical Breast Examination (CBE) [For Females ONLY]						
Age at menarche		<input type="text"/> years old		Age at menopause <input type="text"/> years old <input type="checkbox"/> Not yet		
Parity		Number of children		Breastfeeding history <input type="checkbox"/> Yes <input type="checkbox"/> No		
		Yes <input type="checkbox"/> No <input type="checkbox"/>		Remarks (Mandatory if "Yes")		
Hormonal history (HRT/OCP/others)		<input type="checkbox"/> <input type="checkbox"/>				
Genetic testing (BRCA1/BRCA2/others)		<input type="checkbox"/> <input type="checkbox"/>				
<input type="checkbox"/> Beneficiary refused CBE		Left		Right		
		Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>		
Breast pain/tenderness		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		
Lump in breast		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		
Nipple discharge		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		
Skin & nipple changes		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		
Nipple retraction/inversion		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		
Axillary nodes swelling		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		
Biopsy history & HPE		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		
Previous intervention (surgery/implant/radiotherapy/chemotherapy)		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		
Section I: Laboratory Investigation						
Reference number		<input type="text"/>				
Date specimen taken		<input type="text"/>			Time specimen taken <input type="text"/>	
Specimen type		<input type="checkbox"/> Fasting		<input type="checkbox"/> Non-fasting		
Testing laboratory		<input type="checkbox"/> BP Clinical Lab <input type="checkbox"/> Clinipath <input type="checkbox"/> Gribbles Pathology		<input type="checkbox"/> Pantai Premier <input type="checkbox"/> Pathlab <input type="checkbox"/> Quantum Diagnostics		
Section J: Initial Screening Outcome						
Provisional diagnosis						
<input type="checkbox"/> No apparent clinical disease						
Additional clinical notes (if any)						
Appointment for 2nd consultation		<input type="text"/>				
Examining doctor	Full name					
	MMC registration number		<input type="text"/>			
Section K: Final Review [After Laboratory Results Are Ready]						
Laboratory results		<input type="checkbox"/> Normal		<input type="checkbox"/> Abnormal		
Provisional diagnosis						
<input type="checkbox"/> No apparent clinical disease						
Additional clinical notes (if any)						
Reviewing doctor	Full name					
	MMC registration number		<input type="text"/>			



**Peduli Kesihatan untuk Kumpulan B40**  
Health Screening Form



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**Peduli Kesihatan B40 (PeKa B40) Scheme: Health Screening Second Consultation**

New IC number		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				
Full name						
Second consultation	Date	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				
	Type	<input type="radio"/> Clinic visit		<input type="radio"/> Teleconsultation		
Provisional diagnosis (only if update in diagnosis is required)						
Referral to Klinik Kesihatan	Referral proposition	<input type="radio"/> Referral to Klinik Kesihatan <input type="radio"/> Treatment at current facility <input type="radio"/> Referral not indicated				
	<b>Only if "Referral to Klinik Kesihatan" is selected</b>					
	Receiving facility	State			District	
		Klinik Kesihatan				
Referral to MOH hospital	Referral proposition	<input type="radio"/> Referral indicated <input type="radio"/> Referral not indicated				
	<b>Only if "Referral indicated" is selected.</b>					
	Receiving facility 1	State			Department	
		Hospital			Department	
	Receiving facility 2	State			Department	
		Hospital			Department	
Receiving facility 3	State			Department		
	Hospital			Department		
Doctor	Full name					
	MMC registration number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				

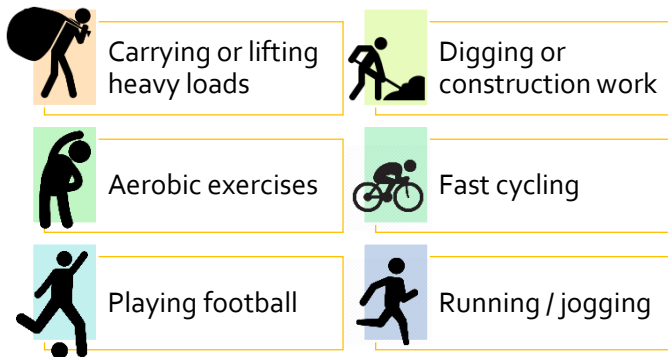


# PHYSICAL ACTIVITY GUIDE

## Vigorous Activity

Vigorous – intensity are activities that require hard physical effort cause large increases in breathing or heart rate

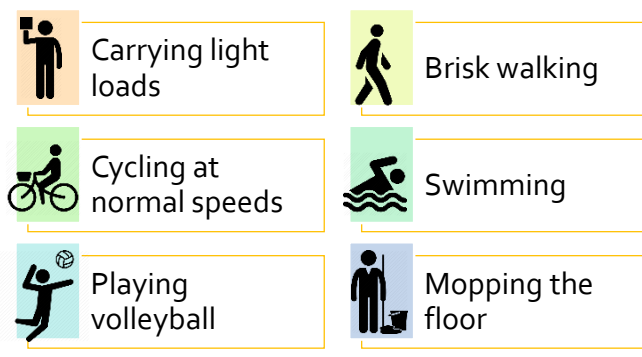
### Example of activity :



## Moderate Activity

Moderate-intensity activity are activities that require moderate physical effort and cause small increases in breathing or heart rate

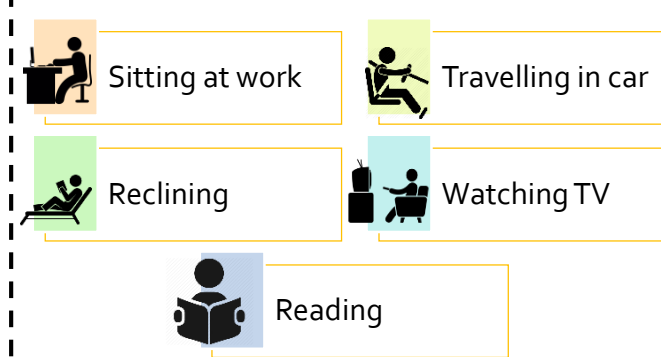
### Example of activity :



## Sedentary

Activities that require low physical effort but does not include time spent for sleeping

### Example of activity :



## **APPENDIX 11: Mental Health Symptoms Screening Questionnaire**

- **Malay version**
- **English version**
- **Chinese version**
- **Tamil version**



**Peduli Kesehatan untuk Kumpulan B40**  
Health Screening Form



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### Saringan Kesehatan Mental

Nombor KP baru

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	---	----------------------	----------------------	---	----------------------	----------------------	----------------------	----------------------

Nama lengkap

Tarikh

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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### Bahagian A: Soal Selidik Kesehatan Pesakit-9 (PHQ-9)

**ARAHAN:** Sila tanda "✓" untuk menyatakan jawapan anda

Dalam tempoh **2 minggu yang lepas**, berapa kerap kali anda terganggu oleh masalah berikut?

	Tidak pernah sama sekali	Beberapa hari	Lebih dari seminggu	Hampir setiap hari
1. Sedikit minat atau keseronokan dalam melakukan kerja-kerja				
2. Merasa murung, sedih, atau tiada harapan				
3. Masalah hendak tidur / semasa tidur, tidur terlalu banyak				
4. Merasa letih atau kurang bertenaga				
5. Kurang selera atau terlalu banyak makan				
6. Mempunyai perasaan buruk terhadap diri sendiri—ataupun merasa gagal terhadap diri sendiri ataupun menghampakan diri atau keluarga				
7. Masalah menumpukan perhatian terhadap perkara-perkara seperti membaca surat khabar atau menonton televisyen				
8. Bergerak atau bercakap dengan terlalu lambat sehingga disedari oleh orang lain. Atau pun bertentangan—terlalu resah atau gelisah sehingga anda bergerak lebih dari biasa				
9. Berfikiran bahawa lebih elok jika anda telah mati atau ingin mencederakan diri anda dalam sesuatu cara				

Sambung muka surat belakang →

**Bahagian B: Soal Selidik Gangguan Kebimbangan Umum-7 (GAD-7)**

Dalam tempoh **2 minggu yang lepas**, berapa kerap kali anda terganggu oleh masalah berikut?

	Tidak pernah sama sekali	Beberapa hari	Lebih dari seminggu	Hampir setiap hari
1. Berasa resah, gelisah atau tegang				
2. Tidak dapat menghentikan atau mengawal kebimbangan				
3. Terlalu bimbang mengenai pelbagai perkara yang berlainan				
4. Mempunyai masalah untuk tenang				
5. Terlalu resah sehingga susah untuk berdiam diri				
6. Mudah menjadi rimas dan menjengkelkan				
7. Berasa takut bahawa sesuatu yang buruk akan terjadi				



**Peduli Kesehatan untuk Kumpulan B40**  
Health Screening Form



**ProtectHealth Corporation Sdn Bhd**  
(1212734-T)  
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Century Square, Jalan Usahawan  
63000 CyberJaya, Selangor  
**T** +603 8687 2500  
**F** +603 8687 2599  
**E** info@protecthealth.com.my  
[www.protecthealth.com.my](http://www.protecthealth.com.my)

### Mental Health Screening

New IC number       -   -

Full name

Date    -    -

**INSTRUCTION: Use "✓" to indicate your answer.**

#### Section A: Patient Health Questionnaire-9 (PHQ-9)

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead or of hurting yourself in some way				

#### Section B: Generalised Anxiety Disorder-7 Questionnaire (GAD-7)

Over the **last 2 weeks**, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that it is hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid as if something awful might happen				



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Health Screening Form



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**www.protecthealth.com.my**

### 心理健康篩查

新身份證號碼

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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英文姓名

日期

年 月 日

提示：請勾選“✓”您的答案。

#### (一) 病人健康狀況問卷抑鬱量表 (PHQ-9)

在過去兩個星期，有多少時候您受到以下任何問題所困擾？

	完全沒有	幾天	一半以上的天數	幾乎每天
1. 做事時提不起勁或沒有樂趣				
2. 感到心情低落、沮喪或絕望				
3. 入睡困難、睡不安穩或睡眠過多				
4. 感覺疲倦或沒有活力				
5. 食慾不振或吃太多				
6. 覺得自己很糟—或覺得自己很失敗，或讓自己或家人失望				
7. 對事物專注有困難，例如閱讀報紙或看電視時				
8. 動作或說話速度緩慢到別人已經察覺，或正好相反—煩躁或坐立不安、動來動去的情況更勝於平常				
9. 有不如死掉或用某種方式傷害自己的念頭				

#### (二) 廣泛性焦慮量表 (GAD-7)

在過去兩個星期，有多少時候您受到以下任何問題所困擾？

	完全沒有	幾天	一半以上的天數	幾乎每天
1. 感到緊張、不安或煩躁				
2. 無法停止或控制憂慮				
3. 對各種事情過度擔憂				
4. 身心難以放鬆				
5. 焦躁不安，以至於很難安靜地坐下來				
6. 容易心煩或生氣				
7. 感到害怕，好像有可怕的事情要發生一樣				



**பதட்டம் மற்றும் கவளை (Anxiety Disorder) தொடர்பான கேள்வித்தாள் (GAD-7)**

**கடந்த 2 வாரங்களில், பின்வரும் பிரச்சனைகளால் நீங்கள் எத்தனை நாட்களுக்கு பாதிப்படைந்தீர்கள்?**

	இல்லை	ஒரு சில நாட்கள்	ஒரு வாரத்திற்கும் மேலாக	கிட்டத்தட்ட ஒவ்வொரு நாளும்
1. அமைதியின்மை, பதட்டம் அல்லது மன அழுத்தம் அடைதல்				
2. கவலைப்படுவதைத் தடுக்க அல்லது கட்டுப்படுத்த இயலாமை				
3. பல்வேறு விஷயங்களைப் பற்றி மிக அதிகமாக கவலைப்படுதல்				
4. ஓய்வு மற்றும் மன அமைதி நிலை அடைவதில் சிரமம்				
5. பதட்டம் காரணத்தினால் அமைதியின்றி அங்கும் இங்கும் அலைமோதுதல்				
6. எளிதில் கோபமடைதல் மற்றும் எரிச்சலடைதல்				
7. மோசமான நிகழ்வு நடக்கப்போகிறது என்ற அச்சம்/ பயம்				

## APPENDIX 12: Laboratory Investigation Parameters

Full Blood Count
Hemoglobin
RBC
MCV
HCT
MCH
MCHC
RDW-CV
WBC
Neutrophils
Lymphocytes
Monocytes
Eosinophils
Basophils
Platelets

Renal Profile
Sodium
Potassium
Urea
Creatinine
Estimated Glomerular Filtration Rate (E-Gfr)

HbA1c
-------

Random Lipid Profile
Total Cholesterol
Triglyceride
HDL Cholesterol
LDL Cholesterol
Total Cholesterol/HDL-Cholesterol

Urine Biochemistry
Appearance
Colour
Specific gravity
pH
Leucocytes
Nitrite
Protein
Glucose
Ketones
Urobilinogen
Bilirubin
Blood

# APPENDIX 13



**Peduli Kesehatan untuk Kumpulan B40**  
Referral Letter



KEMENTERIAN KESIHATAN  
MALAYSIA



PROTECTHEALTH

**ProtectHealth Corporation Sdn Bhd**

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**www.protecthealth.com.my**

Referral to:

Date/time:

Dear Colleague,

Thank you for seeing this patient.

## Referral Indications

Please kindly review this patient and do the needful.

The PeKa B40 Health Screening Summary is also attached for your further reference.

Thank you for your anticipated assistance.

\_\_\_\_\_  
Name :

MMC Number :

Doctor's Stamp :



KEMENTERIAN KESIHATAN MALAYSIA  
BAHAGIAN KEWANGAN  
Aras 6-7, Blok E7, Kompleks E  
Pusat Pentadbiran Kerajaan Persekutuan  
62590 PUTRAJAYA

Tel. : 03-8883 3269/3099/3362  
Faks : 03-8883 4389/4364/4395  
Web : <http://finance.moh.gov.my>

## APPENDIX 14

PEJABAT TIMBALAN PENGARAH KANAN  
(PERANCANGAN)  
DITERIMA

10 APR 2019

KEMENTERIAN KESIHATAN MALAYSIA  
BAHAGIAN PERANCANGAN



CERTIFIED TO ISO 9001:2015  
CERT. NO : QMS 02440

PEJABAT PENGARAH  
DITERIMA

9 APR 2019

KEMENTERIAN KESIHATAN MALAYSIA  
BAHAGIAN PERANCANGAN

Ruj : (78) KKM.400-8/1/89 Jld. 8  
Tarikh : 28 Mac 2019

Semua Pengarah Institusi  
Semua Pengarah Kesihatan Negeri  
Semua Pengarah Hospital  
Kementerian Kesihatan Malaysia

YBhg. Datuk / Dato' / Tuan / Puan,

### PENGECUALIAN CAJ KELAS PERTAMA KEPADA GOLONGAN B40 YANG DIRUJUK DARIPADA PENGAMAL PERUBATAN SWASTA KE FASILITI KEMENTERIAN KESIHATAN MALAYSIA DI BAWAH SKIM PEDULI KESIHATAN B40 (PEKA B40)

Dengan hormatnya saya merujuk kepada perkara di atas.

2. Untuk makluman YBhg. Datuk / Dato' / Tuan / Puan, pada 23 November 2018, Jemaah Menteri telah memutuskan supaya Kementerian Kesihatan Malaysia (KKM) menjalankan Skim Peduli Kesihatan B40 (PeKa B40) sebagai projek perintis untuk B40 berumur 50 tahun dan ke atas.

3. PeKa B40 menawarkan saringan kesihatan, bantuan alat kesihatan, bantuan tambang pengangkutan dan insentif bagi melengkapkan rawatan kanser. Ia ditawarkan kepada ketua isi rumah dan pasangan serta individu yang layak. Sekiranya melalui pemeriksaan kesihatan tersebut, pesakit didapati menghidap penyakit yang memerlukan rawatan susulan, pengamal perubatan swasta akan merujuk pesakit berkenaan ke fasiliti KKM untuk rawatan selanjutnya.

4. Berdasarkan perenggan 12 pada Perintah Fi (Perubatan) 1982, seorang individu yang mendapatkan perkhidmatan kesihatan daripada pengamal perubatan swasta dan dirujuk ke fasiliti KKM akan dikenakan caj kelas pertama.

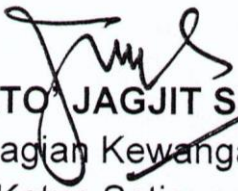
5. Walau bagaimanapun, selaras dengan kuasa yang diberi di bawah Seksyen 16 Perintah Fi (Perubatan) 1982, **Ketua Setiausaha Perbendaharaan telah bersetuju supaya pengecualian caj kelas pertama diberikan kepada golongan B40 yang dirujuk oleh pengamal perubatan swasta ke fasiliti KKM di bawah Skim Peduli Kesihatan B40 (PeKa B40) mulai 1 April 2019.**

6. Kerjasama pihak YBhg. Datuk / Dato' / Tuan / Puan untuk memaklumkan perkara ini kepada semua PTJ di bawah seliaan masing-masing amatlah dihargai dan diucapkan terima kasih.

Sekian, terima kasih.

**"BERKHIDMAT UNTUK NEGARA"**

Saya yang menjalankan amanah,

  
(DATO' JAGJIT SINGH)  
Bahagian Kewangan  
b.p Ketua Setiausaha  
Kementerian Kesihatan Malaysia

s.k KSU  
KPK  
TKSU(K)  
 TKPK (Perubatan)  
TKPK (KA)