

# REFUND PAYMENT AUTHORIZATION FORM

## Admission & Registration

### A) Authorization

I, \_\_\_\_\_ (Patient full name) (\*Patient NRIC No. / Passport No. \_\_\_\_\_) give consent and authorise MAHKOTA MEDICAL CENTRE SDN BHD ("MMCSB") to make refund to \*myself / my authorised representative. The details of my authorised representative are as below: -

Full name of the authorised person: \_\_\_\_\_ Contact No. \_\_\_\_\_

IC / Passport No. of the authorised person: \_\_\_\_\_ Email address: \_\_\_\_\_  
(Please provide a copy of a valid IC/ Passport for identification and verification purpose)

Relationship with patient: \_\_\_\_\_ (\*indicate relationship, e.g. extended family member or guarantor)  
(Only one authorised person can be appointed)

The refund will be processed in the following manner: -

For payments made via debit card or credit card, refunds will be credited back to the same debit card or credit card.

Refund to Local Debit / Credit Card No. \_\_\_\_\_ Expiry Date: \_\_\_\_\_

*(Enclosed a photocopy of Debit / Credit Card front page for verification purpose for manual refund).*

*(Note: For the refund method via mail order/telephone order or if payor bring physical card with them and request refund via physical card, the transaction will be cleared immediately once the settlement done)*

For payments made via cash or bank transfer, refunds will be made via cash or bank transfer.

Release the refund by cash

Release the refund by electronic fund transfer

#### Local customers

Bank Account No: \_\_\_\_\_ Bank Name: \_\_\_\_\_

In the event that account above is frozen by the Bank/Government Authority/ Statutory body or rejected for any reason or the above details are supplied wrongly by me, the hospital will not be held responsible for the direct crediting. In addition, the hospital reserves the right to recover any excess amounts erroneously credited into my account and stops the crediting at its discretion.

*(Note: Refund will be processed within 2 weeks to 1 month from final bill date.)*

Authorized by:

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

Date:

- I declare that the information provided is true and correct. The hospital will not be held responsible for any losses or consequences if any of the information above is false or inaccurate.
- I hereby authorize and consent to MMCSB to collect, process, retain, disclose, release and/or destroy the information above in accordance with the Personal Data Protection Act 2010 or any amended thereof for the purpose of this authorisation.
- I further agree to indemnify MMCSB against any cost, fees, expense, damage, claim, proceeding, demand or action or whatever arising from this authorisation.

**For Admission & Registration Office Use:**

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

Patient PRN: \_\_\_\_\_

Payee's Name: \_\_\_\_\_

Payee's IC: \_\_\_\_\_

Payee's Contact Number: \_\_\_\_\_

Payee's Email Address: \_\_\_\_\_

Bill No: \_\_\_\_\_

Excess Amount to be refunded  
(after final bill) (RM): \_\_\_\_\_

Refund No: \_\_\_\_\_

**Attachments:**

1. Bill, 2. Deposit Receipt, 3. Deposit Refund

Processed by: \_\_\_\_\_ Date: \_\_\_\_\_  
(Officer)

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_  
(Executive)

**For Finance Department Use  
(For Electronic Funds Transfer):**

Account Set: Misc Patient

Vendor ID: \_\_\_\_\_

Group Code: Local/ Overseas

Prepared by: \_\_\_\_\_ Date: \_\_\_\_\_

Checked by: \_\_\_\_\_ Date: \_\_\_\_\_

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**For over-the-counter cash or credit card refund use only**

Acknowledge received by:

Released by:

\_\_\_\_\_  
Patient or Authorised Person by Patient

\_\_\_\_\_  
Admission & Registration