

Medical Claims Authorisation Form (MCAF)

Guide for Individual Signing on Behalf of the Patient
Claiming from Patient's Own Private Integrated Shield
Plan, MediShield Life, or MediSave

MINISTRY OF HEALTH		MEDICAL CLAIMS AUTHORISATION FORM (SINGLE INSTITUTION)		Central Provident Fund Board Singapore
A. - Particulars of Patient		Name: _____		Date of Birth: _____
NRIC / CPF Account No: _____		FIN / Passport No. (for foreigners only)		<input type="checkbox"/> Singapore Citizen (SC) <input type="checkbox"/> Permanent Resident (PR) <input type="checkbox"/> Foreigner
B. - Particulars of the Additional MediSave Payer				
Name: _____		Date of Birth: _____		NRIC / CPF Account No: _____
The Patient is the Additional MediSave Payer's:		<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent		<input type="checkbox"/> Grandparent (Patient must be SC/PR) <input type="checkbox"/> Sibling (Patient must be SC/PR)
C. - Purpose				
(For the Patient)		(For the Additional MediSave Payer)		
I authorise the Medical Institution to:		I authorise the Medical Institution to:		
Y / N Check my healthcare financing coverage;		Y / N Check my healthcare financing coverage;		
Y / N Withdraw from my MediSave;		Y / N Withdraw from my MediSave;		
Y / N Claim from my Health Insurance Policy;		Y / N Claim from my Health Insurance Policy;		
for the Patient's treatment charges incurred at:		Name of the Medical Institution: _____		
Y / N for hospitalisation ¹ / day surgery / treatment period starting on / from: _____		Date: _____		
Y / N for all outpatient treatments				
(a) claimable under				
Y / N Renal dialysis		Y / N Flexi-MediSave		Y / N Cancer scans
Y / N Chemotherapy		Y / N Radiotherapy		Y / N Anti-Retroviral Drugs
Y / N Outpatient scans		Y / N Approved chronic diseases, vaccinations, screenings		
Y / N Other schemes (please specify): _____				
(b) and sought				
Y / N on: _____		Date: _____		Date: _____
Y / N within the limited period ² from: _____		Date: _____		to _____
Y / N for an indefinite period ³ , until revoked in writing, starting from: _____		Date: _____		
1. If the Patient authorises use of MediSave and passes away during this hospitalisation, the Patient's MediSave balance will be used to pay the last hospitalisation bill (and before any withdrawal can be made from the MediSave Account of any Additional MediSave Payer(s)).				
2. Please inform the staff of the Medical Institution during your visit how you would like the bill to be claimed. If you do not do so, the Medical Institution may, as a fallback, claim the bill in full from the Patient's MediSave, the Additional MediSave Payer's MediSave and Health Insurance Policy.				
D. - Authorisation on Behalf of Patient / Additional MediSave Payer				
Name: _____		Date of Birth: _____		NRIC / FIN / Passport Number: _____
I am signing this form on behalf of (please tick):				
<input type="checkbox"/> the Patient, because:		<input type="checkbox"/> the Additional MediSave Payer, because:		
<input type="checkbox"/> I am the parent / legal guardian ⁴ of the Patient who is under 21 years of age;		<input type="checkbox"/> I am the parent / legal guardian ⁵ of the Additional MediSave Payer who is under 21 years of age;		
<input type="checkbox"/> he/she lacks capacity ⁶ , and I am his/her:		3. You are lawfully appointed as a legal guardian by a court or under a will deed (Cap. 177A) (MCA's).		
<input type="checkbox"/> donee / deputy ⁷ ,		4. A person lacks capacity as set out in Section 4 of the Mental Capacity Act (Cap. 177A) (MCA's).		
<input type="checkbox"/> family member ⁸ ,		5. You are acting under a Lasting Power of Attorney registered under the MCA with power to act on behalf of the Patient, or as appointed by the Court under the MCA to act on behalf of the Patient.		
<input type="checkbox"/> he/she is deceased, and I am his/her:		6. You are the spouse, child, or parent of the Patient, are 21 years old and above, and do not lack capacity.		
<input type="checkbox"/> donee / deputy ⁷ ,				
<input type="checkbox"/> family member ⁸ .				
(The section below must be completed by a doctor if the Patient lacks capacity and a doctor's certification or court order has not already been obtained.)				
Doctor's Certification				
I certify that the Patient lacks capacity and is unable to sign this form.				
Name of Doctor: _____		Doctor's MCR: _____		Clinic / Hospital Stamp
Doctor's Signature: _____		Date of Signature (DD-MM-YYYY): _____		

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Follow this guide if:

You are signing the electronic MCAF on behalf of the Patient to claim from the Patient's own Private Integrated Shield Plan (PMI) / MediShield Life (MSHL) / MediSave (MSV).

Reasons for signing on behalf of the Patient:

- Patient is under 21 years of age, and you are their parent/legal guardian
- Patient lacks mental capacity
- Patient is deceased

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Preparation

Preparation before completing this form

1 PRE-REQUISITES

Please be reminded that you must be over 21 years of age to fill out this form.

2 Gather Email Addresses

Email Addresses for the following (where applicable):

- Patient
- Additional MediSave Payer
- Witness (Cannot be one of the other personnel)
- Person signing on behalf of the Patient and/or Additional MediSave Payer

3 Supporting Documents

Be prepared to upload supporting documents (where applicable):

- Additional MediSave Payer Patient**
NRIC front and back (Source: ICA website)
- Family Member**
Birth Certificate (Source: Todaysonline.com)
- Legal Guardian Donee/Deputy**
Certificate of Appointment of Attorney (COA) / Court Order or Lasting Power of Attorney Document (Source: Office of the Public Guardian)
- Deceased Patient**
Certificate of Death (Source: ICA website)

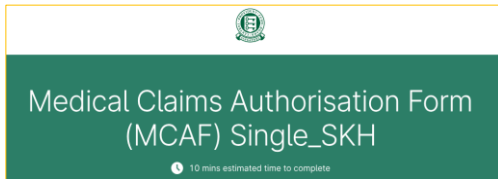
Gentle reminder:

If you do not have the relevant information at the moment, we kindly request that you wait until you have obtained it before completing the form.

Please click "No" in the appropriate fields within the form later if no interpreter was involved.

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1. Individual completing the eMCAF



1a Access e-MCAF portal via: <https://for.sg/skh-bo-mcaf>



1. Do you have the necessary email addresses and documents?
After completing the necessary details in this form, a copy of the document will be sent to all the email addresses you have provided.

Yes
 No

→ **1b** Select 'Yes' to proceed

2. Name of person completing the form

3. Contact number
For SKH staff to contact you in the event that clarifications are required

→ **1c**

Input your name and contact number

Your Contact number will enable SKH staff to reach out to you if further clarifications are needed

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1. Individual completing the eMCAF

4. Does the patient need an Additional MediSave Payer?

- Yes [involves_amp]
- No [does_not_involve_amp]

→ **1d** Select 'No'



Select 'Yes' only if Patient has insufficient MediSave balance and require an Additional MediSave Payer (AMP) for their hospitalisation.

2. Authorisation on behalf of Patient and/or AMP

5. Are you signing on behalf of the Patient and/or Additional MediSave Payer?

- Yes [on_behalf]
- No [not_on_behalf]

→ **2a** Select 'Yes'

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3. Authorisation on behalf of the Patient

6. Are you signing this form on behalf of the Patient? [on_behalf_of_p]

- Yes
- No [on_behalf_of_p_no]

→ **3a** Select 'Yes'

7. What is your reason for signing the form on behalf of the Patient?

- The Patient is under 21 years of age and I am his / her parent / legal guardian¹. [p_under21]
- The Patient lacks capacity². [p_lack_capacity]
- The Patient is deceased. [p_deceased]

→ **3b** Select an option that corresponds to your need



Quick Access to:

- [The Patient lacks capacity](#)
- [The Patient is deceased](#)

1: You are lawfully appointed as a legal guardian by a court or under a will/deed.
2: A person lacks capacity as set out in Section 4 of the Mental Capacity Act (Cap. 177A) ("MCA").

→ **3c** Read the note

Please note the above.

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3. Authorisation on behalf of the Patient

If you choose the **1st** option (The Patient is under 21 years of age and I am his/her parent/legal guardian),

7. What is your reason for signing the form on behalf of the Patient?

The Patient is under 21 years of age and I am his / her parent / legal guardian¹. [p_under21]


The Patient lacks capacity². [p_lack_capacity]

The Patient is deceased. [p_deceased]

1. You are lawfully appointed as a legal guardian by a court or under a will/deed.
2. A person lacks capacity as set out in Section 4 of the Mental Capacity Act (Cap. 177A) ("MCA").

Please note the above.

8. Please upload the necessary legal documents for legal guardianship (optional)


Choose file or drag and drop here

3b(i) Read the note

3b(ii) Upload the necessary supporting document if requested by our staff

Then click [here](#) to go to 'Particulars of the Authoriser' page

3. Authorisation on behalf of the Patient

If you choose the **2nd** option (The Patient lacks capacity),

7. What is your reason for signing the form on behalf of the Patient?

The Patient is under 21 years of age and I am his / her parent / legal guardian¹. [p_under21]

The Patient lacks capacity². [p_lack_capacity]

The Patient is deceased. [p_deceased]

1. You are lawfully appointed as a legal guardian by a court or under a will/deed.
2. A person lacks capacity as set out in Section 4 of the Mental Capacity Act (Cap. 177A) ("MCA").

3b(i) Read the note

8. What is your relationship with the Patient?

Donee / Deputy³ [p_donee_deputy]

Family member⁴ [p_family_members]

3b(ii) Select the option accordingly

3. You are acting under a Lasting Power of Attorney registered under the MCA with power to act on behalf of the Patient, or are appointed by the Court under the MCA to act on behalf of the Patient.
4. You are the spouse, child, or parent of the Patient, are 21 years old and above, and do not lack capacity.


3b(iii) Read the note

Please note the above.

3. Authorisation on behalf of the Patient

(Cont.) If you choose the 2nd option (**The Patient lacks capacity**),

9. Please upload the necessary legal documents for donee (LPA) / deputy (Court Order) (optional)



[Choose file](#) or drag and drop here

Maximum file size: 1 MB

→ **3b(iv)** Upload the necessary supporting documents if requested by our staff.

Then click [here](#) to go to 'Particulars of the Authoriser' page

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3. Authorisation on behalf of the Patient

If you choose the 3rd option (**The Patient is deceased**),

7. What is your reason for signing the form on behalf of the Patient?

The Patient is under 21 years of age and I am his / her parent / legal guardian¹. [p_under21]

The Patient lacks capacity². [p_lack_capacity]

The Patient is deceased. [p_deceased]

1: You are lawfully appointed as a legal guardian by a court or under a will deed.
2: A person lacks capacity as set out in Section 4 of the Mental Capacity Act (Cap. 177A) ("MCA").

→ **3b(i)** Read the note

8. What is your relationship with the Patient?

Donee / Deputy³ [deceased_donee_deputy]

Family member⁴ [deceased_family_members]

3: You are acting under a Lasting Power of Attorney registered under the MCA with power to act on behalf of the Patient, or are appointed by the Court under the MCA to act on behalf of the Patient.
4: You are the spouse, child, or parent of the Patient, are 21 years old and above, and do not lack capacity.

Please note the above.

→ **3b(ii)** Select the option accordingly


→ **3b(iii)** Read the note

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3. Authorisation on behalf of the Patient

(Cont.) If you choose the 3rd option (The Patient is deceased),


9. Please upload the necessary legal documents for donee (LPA) / deputy (Court Order) (optional)



[Choose file](#) or drag and drop here

Maximum file size: 1 MB

10. Please provide the death certificate document of the deceased Patient (optional)



[Choose file](#) or drag and drop here

Maximum file size: 1 MB


→ **3b(iv)** Upload the necessary supporting document if requested by our staff

→ **3b(v)** Upload the death certificate of the deceased patient if requested by our staff



4. Particulars of the Authoriser

9. Name of Authoriser [authoriser_name]
As per NRIC

10. Authoriser Date of Birth [authoriser_dob]
dd/mm/yyyy 

11. Authoriser's Nationality

Singapore Citizen (SC) [is_auth_SC]

Permanent Resident (PR) [is_auth_PR]

Foreigner [is_auth_foreigner]

12. Authoriser's NRIC [authoriser_nric]

→ **4a** Input the Authoriser's name and Date of Birth

→ **4b** Select the Authoriser's Nationality


(i) If the Authoriser is a Singapore Citizen or Permanent Resident, input your NRIC/CPF Account No.

→ **4c** (ii) If the Authoriser is a Foreigner, input your FIN/Passport No.




4. Particulars of the Authoriser

13. Please upload a document of the Authoriser's NRIC (front)/passport (optional)


[Choose file or drag and drop here](#)

Maximum file size: 1 MB

14. Please upload a document of the Authoriser's NRIC (back) (optional)


[Choose file or drag and drop here](#)

Maximum file size: 1 MB

15. Authoriser's Email Address [authoriser_1_email]
Email is required as document will be sent to this email address for further signatures

(i) If the Authoriser is a Singapore Citizen or Permanent Resident, upload Patient's NRIC (Front and Back) if requested by our staff

4d (ii) If the Authoriser is a Foreigner, upload Patient's applicable identification documents (i.e. FIN card or Passport) if requested by our staff



Authoriser's email address is required to complete and sign the eMCAF document

4e Input Authoriser's email address



5. Particulars of Patient

16. Patient's Name [p_name]
As per NRIC

17. Patient's Date of Birth [p_dob]
dd/mm/yyyy

18. Patient's Nationality

Singapore Citizen (SC) [is_SC]

Permanent Resident (PR) [is_PR]

Foreigner [is_foreigner]

19. Patient's NRIC / CPF Account No. [p_nric_cpf_acc]

5a Input the Patient's name and Date of Birth

5b Select the Patient's nationality


5c a. If the Patient is a Singapore Citizen or Permanent Resident, input your NRIC/CPF Account No.

b. If the Patient is a Foreigner, input your FIN/Passport No.



5. Particulars of Patient


20. Please upload a document of the Patient's NRIC (front) (optional)



[Choose file](#) or drag and drop here

Maximum file size: 1 MB

21. Please upload a document of the Patient's NRIC (back) (optional)



[Choose file](#) or drag and drop here

Maximum file size: 1 MB

(i) If the Patient is a Singapore Citizen or Permanent Resident, upload Patient's NRIC (Front and Back) if requested by our staff

(ii) If the Patient is a Foreigner, upload Patient's applicable identification documents (i.e. FIN card or Passport) if requested by our staff

5d

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6. Purpose (For the Patient)

22. I authorise the Medical Institution to check my healthcare financing coverage.

I agree to the statement above.

23. I authorise the Medical Institution to withdraw my MediSave. [p_medisave]
You may select Medisave and/or Health Insurance Policy

Yes
 No

24. I authorise the Medical Institution to claim from my Health Insurance Policy. [p_claim]
This refers to MediShield Life or Integrated Shield Plan e.g. AIA, GEL, SingLife, NTUC, HSBC Life, RHI, Prudential

Yes
 No

Check the box to allow the hospital to verify if patient has sufficient MediSave balance and medical coverage

6a

6b Select 'Yes'

Select 'No' if the Patient does not wish to withdraw from MediSave

6c Select 'Yes'



Claiming from both your Integrated Shield Plan (PMI) / MediShield Life and your MediSave will help lower your out-of-pocket expenses.

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6. Purpose (For the Patient)

25. Name of Medical Institution [name_of_medical_institution]
For the Patient's treatment charges incurred at

Sengkang General Hospital → **6d** Check 'Sengkang General Hospital'

26. What type of treatment did you receive?

Inpatient [inpatient] → **6e** Select either 'Inpatient' or 'Day Surgery'

Outpatient [outpatient]

Day Surgery [type2]

27. What type of inpatient services did you receive?

Hospitalisation* [type1] → **6f** Select 'Hospitalisation' for Inpatient service

28. Patient's Hospitalisation* / Day surgery treatment date starting on/from
[date_of_hospitalisation_daysurgery_treat]

dd/mm/yyyy → **6g** Input the Admission Date

* If the Patient authorises use of MediSave and passes away during this hospitalisation, the Patient's MediSave balance will be used to pay the last hospitalisation bill first before any withdrawal can be made from the MediSave Account of any Additional MediSave Payer(s).

→ **6h** Read the note

Please note the above.

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7. Patient's Interpreter

29. Do you have an interpreter for the Patient?

Yes

No → **7** Select 'No'

💡 If you require an interpreter, please select 'Yes' and provide the name and NRIC No of the interpreter.

8. Consent to Data-Sharing & Use of Information

Consent to Data-Sharing & Use of Information

- I allow the Government of the Republic of Singapore and its appointed agencies, the Central Provident Fund Board ('CPF Board'), my Insurer and its appointed agencies, the Medical Institution, and healthcare professionals at any medical institutions who have cared for the Patient ('the Parties'), as applicable, to collect, share and use my Information (a) to facilitate the Patient's treatment, (b) for the purposes I indicated in Part C, and (c) for data analysis, evaluation, and policy-making and review by the Government and CPF Board.
- If I have also applied to withdraw from my MediSave or claim from my Health Insurance Policy in Part C, I agree to provide any information necessary to any of the Parties in paragraph 1 to process and administer the Claims. I further understand and agree that any Information may be collected, shared and used by any of the Parties to process and administer the Claims resulting from the Patient's treatment charges, to assess and audit the Claims, and adjudicate Claims-related disputes.

Claims Authorization

- If I have applied to withdraw from my MediSave or claim from my Health Insurance Policy to pay for the Patient's treatment charges at the Medical Institution for the treatments indicated in Part C:
 - I authorise CPF Board and my Insurer to do all things necessary to process and administer the Claims;
 - I accept that the Claims will be subject to CPF Board's and my Insurer's approval, and the approved Claims amounts will depend on (i) the treatment charges submitted by the Medical Institution, (ii) my MediSave balance, (iii) the relevant Acts & Regulations, and (iv) the terms of my Health Insurance Policy, if applicable; and
 - I agree to immediately refund to my MediSave Account and my Insurer any payment which I receive as reimbursement for the treatment charges.
- I agree that this authorisation will be valid for claims submitted (i) within 12 months after the date of signature, (ii) within 12 months after the end date indicated in Part C (for authorisations for a limited period), or (iii) by the revocation date (for authorisations for an indefinite period), whichever is later. I acknowledge that I may have to provide further authorisation if any Claims are submitted by the Medical Institution after this authorisation expires.

General

- I have read and understood this form fully, including the Definitions below, and I declare that the information that I have provided is accurate.

Please read the following carefully.

→ **8a** Read the Consent to Data-Sharing & Use of Information carefully

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8. Consent to Data-Sharing & Use of Information

Definitions
I understand and agree that these phrases used in this form shall have the following meanings:

a. "Information" refers to the following information in relation to both the Patient and the Additional MediSave Payer:

- personal data (e.g. name, NRIC No. address, age, date of birth);
- MediSave balance and withdrawal limits;
- any other administrative information as the Government and its appointed agencies, CPF Board, the Insurer and its appointed agencies, the Medical Institution, and healthcare professionals at any medical institution who have cared for the Patient may consider necessary for the purpose of processing, administering, assessing, and auditing the Claim;

and additionally the following healthcare information in relation to the Patient only:

- hospitalisation and bill records;
- medical information and information relating to the Patient's medical condition and treatment; and
- Health Insurance Policy information (e.g. policy details, benefits, exclusions, start and end dates);

For the avoidance of doubt, "Information" may relate to information on both past and present matters.

b. "Health Insurance Policy" and the corresponding "Insurer" refer to the following:

Health Insurance Policy	Insurer		
MediShield & MediShield Life	Central Provident Fund Board		
MediSave-approved Integrated Shield Plan*	Income Insurance Limited	AIA Singapore Private Limited	Prudential Assurance Co
	Singapore Life Ltd.	Great Eastern Life Assurance Co	HSBC Life (Singapore) Pre. Ltd.
	Raffles Health Insurance	Any other insurer as approved by the Minister of Health	

* MediSave-approved Integrated Shield Plan refers to the MediSave-approved integrated medical insurance plan as stated in the Central Provident Fund (MediShield Scheme) Regulations and the Central Provident Fund (Private Medical Insurance Scheme) Regulations, and the attached rider plans.

c. "Claims" refers to all claims from the Health Insurance Policy or all withdrawals from MediSave, as authorised in Part C.

d. "Acts & Regulations" refers to all relevant legislation governing the use of MediSave, MediShield and MediShield Life, including the Central Provident Fund Act, Central Provident Fund (MediSave Account Withdrawals) Regulations, Central Provident Fund (MediShield Scheme) Regulations, Central Provident Fund (Private Medical Insurance Scheme) Regulations, and the MediShield Life Scheme Act 2015 and its regulations, and any amendments or re-enactments thereof.

Please read the following Definitions carefully.

30. Acknowledgement

I have read and understood this form fully, including the Definitions above, and I declare that the information that I have provided is accurate.

8b Read through the Definition carefully

Check the box under 'Acknowledgement' once you have fully read and understood the form, and ensured that all the provided information is accurate

9. Witness



A witness is required to sign off the form for it to be considered valid and completed.

The witness cannot be the patient or the individual signing on behalf of the patient.

Kindly note that this MCAF authorisation form requires a witness to sign off for it to be considered complete. The fields are stated as optional as you may have arranged for a witness from the healthcare institution.

Requirements for Witness:

- Different person from Patient / Additional MediSave Payer / Person signing on behalf of Patient or Additional MediSave Payer
- 21 years old and above
- Does not lack capacity
- Singapore Citizen or Permanent Resident

Please note form is complete only with witness sign off.

31. Name of Witness [name_of_witness] (optional)
As per NRIC

32. NRIC of Witness [nric_of_witness] (optional)

33. Witness' Email Address [witness_email] (optional)
Email is required as document will be sent to this email address for further signatories. If the witness is a staff, please indicate the staff's email address.

34. Before submitting the form, please take a moment to review your entries above and ensure ALL the information provided is accurate and complete.
You will have to resubmit the form if there is any inaccurate information for this submission.

Yes, I have checked through the form.

Submit now

9a Read the requirements for Witness

9b Input the Name, NRIC, Email Address of Witness

9c Check the box once you have checked through the form

9d Click 'Submit now'

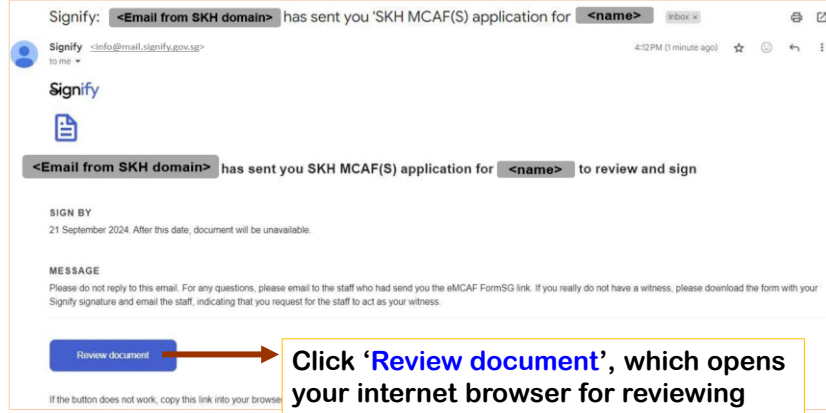


10. Acknowledge Email from Signify for Document Review

The Authoriser and the Witness will each receive an email from Signify <info@mail.signify.gov.sg> to review and sign the eMCAF document

“Signify is a document hub that provides collaborative SES (Secured Electronic Signing) capability in accordance with Electronic Transactions Act.”

“Signify is powered by Sign by SingPass where signing certificates are issued by the National Certification Authority. Signatures made using the Sign with SingPass will be regarded as secure electronic signatures under Singapore’s Electronic Transactions Act. More details on Sign with SingPass are available on the SingPass website.”



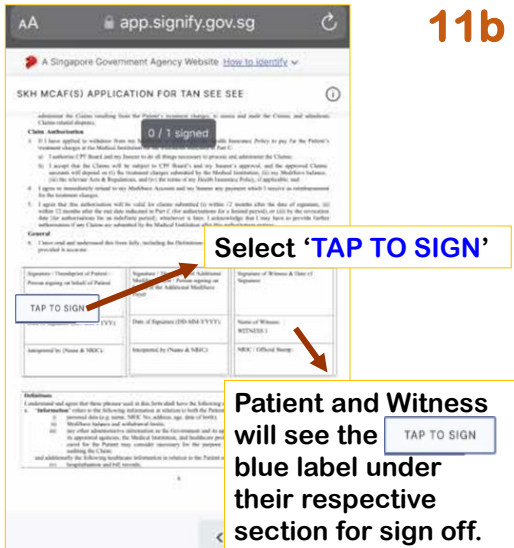
Link for more info: [Signify | Signify User Guide](#)

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11. Review and Sign via Signify with singpass

11a



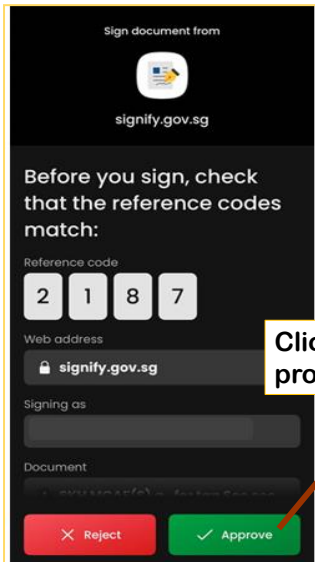
11b



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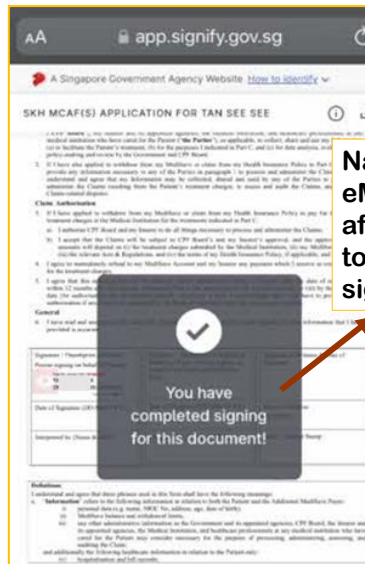
11. Review and Sign via Signify with singpass

11c



Click 'Approve' to proceed

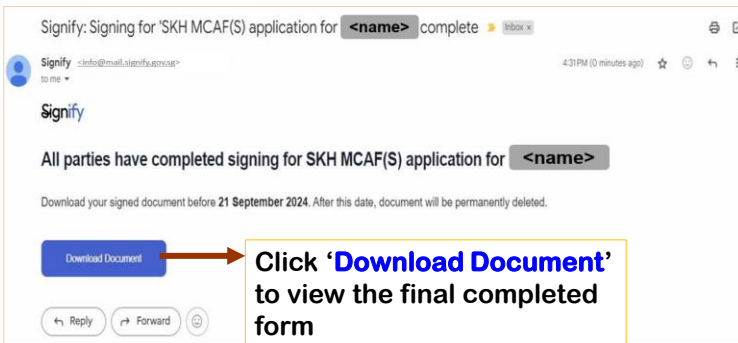
11d



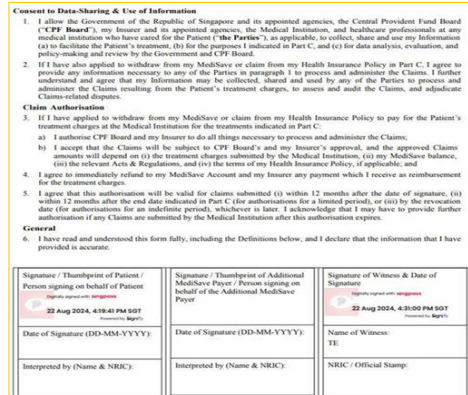
Navigate back to the eMCAF document, after being prompted to have successfully signed the document

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12. Completion Email from Signify



Click 'Download Document' to view the final completed form



A sample of a completed signed document with the necessary timestamps of each individual involved.

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