# MINISTRY OF HEALTH MALAYSIA

## MEDICAL PRACTICE DIVISION

## ANNUAL RETURN FORM

**To,**

**THE DIRECTOR GENERAL OF HEALTH**
**MINISTRY OF HEALTH, MALAYSIA**

### A. BASIC INFORMATION ON MANAGED CARE ORGANISATION

1. Name of Managed Care Organisation (MCO):

   ……

2. Address:

   ……

   ……

   Tel. No. : …… Fax. No. : ……

   E-mail : ……

3. Company's Registration No.:

   ……

4. Name of Person-In-Charge

   .....

5. Principal business activity:

   .....

6. Other business activity (if any):

   .....

7. Company Directors:

   .....

8. Apppointed company secretary:

   .....

9. Shareholders:

   .....

10. To be attached with this annual returns is a copy of the latest contractual agreement between MCO and Helathcare service providers. (Anytime there is a change of provisions in the contractual agreements, MOH should be notified)

## B. INFORMATION ON PATIENTS

1. No. of Patient:

| | Existing Patients | New Patients | Total |
|---|---|---|---|
| Total No. of Patients at the End of January | | | |

2. Age of Patients:

| | Age (Years) | | | | | | |
|---|---|---|---|---|---|---|---|
| | <10 | 10 to <20 | 20 to <30 | 30 to <40 | 40 to <50 | 50 to <60 | ≥ 60 |
| Total No. of Patients by Age Group at the End of January | | | | | | | |

3. Category of Patients:

| | Companies | Individuals | Others (Please specify) |
|---|---|---|---|
| Total No. of Patients by Category at the End of January | | | |

## C. INFORMATION ON MEDICAL CARE PROVIDERS OR FACILITIES

1. No. of medical care providers:

| | Private Medical Clinic | | Dentist | Private Hospital | Laboratory | Pharmacy | Others (Please specify) |
|---|---|---|---|---|---|---|---|
| | *GP | Specialist | | | | | |
| Total No. of Medical Care Providers or Facilities at the End of January | | | | | | | |

Note: * refers to general practitioner

2. List of medical care providers:

| | Private Medical Clinic | | Dentist | Private Hospital | Laboratory | Pharmacy | Others (Please specify) |
|---|---|---|---|---|---|---|---|
| | *GP | Specialist | | | | | |
| List of Medical Care Providers or Facilities at the End of January (*Please use appendix, if necessary*) | | | | | | | |

Note: * refers to general practitioner

Declaration:

I hereby declare that all the information given above is true and correct to the best of my knowledge.

Name of Informant (in block letter)

……

……
NRIC No.:

Designation:

Date:

Tel. No.:

Fax. No.:

Kindly return completed forms to:

Via online submission at
mcofee@moh.gov.my or

**Secretariat of Managed Care**
Medical Legislation Section
Medical Practice Division
3rd Floor, Block E1, Parcel E
Presint 1
Federal Government Administration Centre
62590 **PUTRAJAYA**