

GUIDING YOU THROUGH CHAS AUDIT: A QUICK REFERENCE

We understand the challenges GPs face daily, juggling patient care and CHAS administration. In a two-part series, we will share a quick reference covering the do's and don'ts of CHAS claims submissions.

PATIENT CONSENT FORM (PCF)

**COMMUNITY HEALTH ASSIST SCHEME ("CHAS")
PATIENT CONSENT FORM**

PART I: PARTICULARS OF PATIENT

Patient Name: _____ Gender: Male / Female
 NRIC No.: _____ Date of birth (dd/mm/yyyy): _____
 Address: _____
 Contact No.: _____ Mobile: _____ Other: _____

PART II: AUTHORIZATION & DECLARATION BY PATIENT FOR INFORMATION DISCLOSURE

A. I authorize my treating doctor/doctor at _____ ("Clinic") to disclose to the Programme, their Affiliates, the Ministry of Health ("MOH") and their authorized agents such information relating to my clinical data, test and reports as may be necessary for the purposes of:

- Assessing and verifying claims and subsidies provided under the CHAS in relation to the treatment that I have received;
- Assessing and auditing the doctor's/doctor's and Clinic's compliance with the terms and conditions of the CHAS; and
- Corresponding with me and my doctor/doctor on my participation under the CHAS.

B. I understand that my clinical data and information on fees and expenses provided by my treating doctor/doctor to the Programme, their Affiliates and MOH (including their authorized agents) will also contribute to the effective monitoring and improvement of the CHAS and the development of appropriate public healthcare finance policies.

C. This authorization applies to and covers all my visits to my treating doctor/doctor at the Clinic for treatment under the CHAS, whether such visits are past or subsequent to the date of this authorization.

D. Notwithstanding Clause C above, I may revoke this authorization at any time for future visits to the Clinic by a notice in writing.

Signature of patient/guardian of patient: _____ Date: _____

PART III: DOCTOR'S/DOCTOR'S CERTIFICATION

A. I certify that I have explained the authorization and disclosure for information disclosure to the above patient who has consented to the submission of clinical and test data to relevant authorities listed in Part I above.

B. I certify that the above patient has personally completed this form before me on the date so stated in the case where the patient is not of legal age or capacity (i.e. below 21 years of age), I certify that his/her parent/guardian has personally completed this form on his behalf before me on the date so stated.

C. I authorize the Programme, their Affiliates and MOH (including their authorized agents) to conduct any and all of the necessary purposes listed in Part I above on the clinical and financial data provided by me under this consent related to the above patient.

Name and Signature of Doctor/Doctor: _____ MOH/DCI No.: _____ Date: _____

MOH 1 (as of 2014)

Patient consent should be obtained at the patient's first visit to your clinic, and the original PCF must be kept either with the case notes or in a separate file.

Please ensure all fields are correctly filled, according to patient's NRIC. If you require postal code information, please go to <http://tinyurl.com/streetindexsystem>¹

If the patient is below 18 years old, a parent/guardian must sign on the patient's behalf. Please indicate the parent's/guardian's name.

If the patient is illiterate, a thumbprint can be taken.

Please ensure all fields are correctly filled. You may use your doctor's name stamp for convenience. The GP signing the PCF would need to be Medisave-accredited. To check your Medisave accreditation status, please go to: <https://www.mediclaim.moh.gov.sg/mmae/Overview>

Ensure all existing and new CHAS patients sign the latest version of the Patient Consent Form, dated 1 January 2014.

The breakdown of consultation, medication (as well as procedures such as wound dressing and ear-syringing), and investigation (e.g. X-ray, blood tests) for claim submission must correspond with the supporting documents, i.e. patient invoices and case notes. Please provide patients with an itemised invoice/receipt at the end of their visit.

The receipt number must correspond with that submitted through CHAS Online.

GPs can use the CHAS subsidy stamp to record the subsidy amount claimed. If your clinic needs one, please contact AIC below.

PATIENT INVOICE

SAMPLE CLINIC INVOICE

Invoice No.
Our Reference
Date

Doctor:

Description	Qty	Fee (S)
DIAMICRON MR 60MG	30.00 tabs	66.00
EXFORGE 10/160MG 28'S	2.00 box	196.00
CONSULTATION		30.00
PIONEER GEN. SUBSIDY - CHRONIC		-90.00

Total Amount Payable	202.00
CASH Payment Received - Receipt No. 123456	202.00
Outstanding Balance	\$0.00

All cheques should be crossed and made payable to:

CHAS Subsidies Given : \$ _____

Look out for our January 2016 issue on clinical notes documentation. If you have a question on CHAS which is not covered above, kindly contact AIC at gp@chas.sg or 6632 1199

¹ This webpage will redirect you to sis.pa-apps.sg/NASApp/sim/AdvancedSearch.jsp, hosted by pa.gov.sg