REIMBURSEMENT REQUEST FORM

(IMPORTANT: Please fill-up this form and attach the required documents)

PATIENT'S NAME

CARD/ID NUMBER

COMPANY

PRINCIPAL MEMBER'S NAME

CONTACT NUMBERS

DATE OF TREATMENT ( ) OUT PATIENT ( ) IN PATIENT

HOSPITAL/CLINIC

REASON FOR REIMBURSEMENT _____

_____

BASIC REQUIREMENTS:

☐ **OUT-PATIENT**

1) Fill up reimbursement request form/
Letter of request if form not available
2) Statement of Account from the hospital
3) Itemized Original Official Receipt (w/ TIN#)
4) Medical Certificate
5) Laboratory Result
(if w/ diagnostic procedure)

☐ **IN-PATIENT**

1) Fill up reimbursement request form/
Letter of request if form not available
2) Statement of Account from the hospital
3) Itemized Original Official Receipt (w/ TIN#)
4) Medical Certificate
5) Operative Record w/ Histopath Result
(if w/ operation)
6) Police Report and Medico Legal Report
(if case is secondary to vehicular accident
and assaults like mauling or stab wounds)

☐ **MATERNITY ASSISTANCE**

1) Fill up reimbursement request form/
Letter of request if form not available
2) Statement of Account from the hospital
3) Itemized Original Official Receipt (w/ TIN#)
4) Medical Certificate
5) Xeroxed Birth Certificate with original authentication
6) Delivery Room Record
7) Histopath Result
(if case is abortion/miscarriage)

☐ **DENTAL**

1) Fill up reimbursement request form/
Letter of request if form not available
3) Itemized Original Official Receipt (w/ TIN#)
4) Dental Certificate
5) X-ray Result
(if w/ x-rayprocedure)

☐ **OPD MEDICINES**

1) Fill up reimbursement request form/
Letter of request if form not available
2) Itemized Original Official Receipt (w/ TIN#)
3) Doctor's prescription

☐ **INTERNMENT ASSISTANCE (death claim)**

1) Fill up internment assistance form
2) Fill up Certificate of Attending Physician's form
3) Xeroxed Death Certificate with original authentication
4) Xeroxed Birth Certificate with original authentication
* Deceased * Beneficiary
5) Xeroxed Marriage Contract with original authenticatic
6) Certificate of Employment
7) Latest DTR
8) Police Report and Autopsy (if accidental death)

NOTE:

1. All documents submitted will be returned in case of non-submission of any of the above basic requirements.
2. The company reserves the right to require additional documents to justify payment of claim.
3. The company reserves the right to deny any claim even with the complete submission of basic requirements or any additional documents to further justify the claim.

_____ _____

SIGNATURE OF CLAIMANT **DATE SIGNED**
(Signature Over Printed Name)

ATTENDING PHYSICIAN'S REPORT

(This will serve as your medical certificate if fully signed/certified by attending doctor)
(If medical certificate was issued by attending doctor, this portion can be omitted)

NATURE OF ILLNESS (Final Diagnosis)

_____

NATURE OF PROCEDURE DONE, if any. (Please describe fully)

_____

_____

I certify to the best of my knowledge and belief that the information provided by me in support of the claim is true and correct.
I further agree that audits/checks may be conducted for this claim.

_____ _____ _____

NAME OF ATTENDING PHYSICIAN **LICENSE NO.** **DATE SIGNED**
(Signature Over Printed Name)

Contact number of Attending Physician : _____

Clinic Address of Attending Physician : _____