MediCard Philippines, Inc.
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CLR-FO-010
Rev. 01
01 JUNE 2020

REIMBURSEMENT CLAIM FORM

Kindly fill out ALL information with ✓marks

✓**DATE FILED :**_____ ✓**TYPE OF CLAIM : OUT PATIENT ☒ IN PATIENT ☐**

✓**PATIENT'S NAME**
_____ ✓**MEDICARD ID No. :** _____
GIVEN NAME , MI, LAST NAME

✓**NAME OF PRINCIPAL MEMBER** ***(IF PATIENT IS A DEPENDENT MEMBER) :*** _____
GIVEN NAME, MI, LAST NAME

✓**COMPANY NAME :**_____ ✓**TELEPHONE No:** _____

✓**HOSPITAL NAME :**_____ ✓**E-MAIL ADDRESS :** _____

✓**DATE OF MEDICAL TREATMENT / CONFINEMENT**_____ ✓**TOTAL AMOUNT OF CLAIM : P** _____

ATTENDING PHYSICIAN'S REPORT

In lieu of MEDICAL CERTIFICATE, please have this portion accomplished fully by your ATTENDING DOCTOR

CHIEF COMPLAINTS: _____

LABORATORY OR DIAGNOSTIC TEST REQUESTED: _____

FINAL DIAGNOSIS BASED ON TEST RESULTS IF ANY: _____

PROCEDURE DONE (IF ANY) : _____

I certify to the best of my knowledge and belief that the information provided by me in support of the claim are true and correct.

_____ _____
SIGNATURE OF ATTENDING DOCTOR OVER PRINTED NAME **DATE**
SPECIALIZATION : _____
LICENSE No.: _____

PLEASE CHECK APPROPRIATE BOX FOR PREFERRED MANNER OF RELEASE OF CHECK AND / OR MEMO :

☐ **FOR PICK UP** ☐ **THRU ACCOUNT OFFICER / BROKER** ☐ **THRU COURIER / MAIL (PLEASE PROVIDE MAILING ADDRESS)**
MAILING ADDRESS: _____

☐ **OTHER REMARKS :** _____ _____

CONSENT

In compliance with Republic Act 10173 also known as the Data Privacy Act of 2012, we need your Consent to allow us to collect and process your information. We will only disclose and share your information with our COMPANY, its officers, directors, employees, and/or other authorized agents/ representatives who may also be responsible in rendering our services to you. Withholding or withdrawal of such Consent shall relieve us from our obligation to deliver the appropriate services to you. You are afforded with certain rights and protection in accordance with the said Act and you may visit www.medicardphils.com/privacy or email privacy@medicardphils.com for more information.

By signing below, we will consider that you agree to give your Consent to us. If in case, applicant/patient/claimant is unable to sign, his/her authorized representative may warrant that he/she has full authority to sign on behalf of the applicant/patient/claimant.

_____ _____ _____
SIGNATURE OF PATIENT/CLAIMANT OVER PRINTED NAME AND RELATIONSHIP (IF PATIENT IS UNABLE TO SIGN) **DATE** **COMPANY NAME**

Please complete the following BASIC REQUIREMENTS for REIMBURSEMENT
(Failure to do so will invalidate your claim for reimbursement)
**** MediCard reserves the right to request for additional documents needed for further evaluation of claim****

Out Patient Reimbursement : ⌗ Fully accomplished Reimbursement Claim Form ⌗ Cover letter / Incident report (stating the reason for filing of Reimbursement) ⌗ Medical Certificate stating chief complaint and final diagnosis ⌗ Emergency room record ⌗ Original Official Receipts ⌗ Results of laboratory / diagnostic examination ⌗ Operative Technique (for surgical cases) ⌗ Police report (for accidents) ⌗ Itemized breakdown of charges ⌗ Subrogation Form (for accidents)	**For Member Financial Assistance: (Death Claim)** ⌗ Fully accomplished Reimbursement Claim Form ⌗ Certified True Copy of Death Certificate ⌗ Certificate of Employment of the Principal member ⌗ MediCard ID or photocopy of any ID of the deceased ⌗ Duly Notarized Affidavit of Next of Kin / Marriage Contract ⌗ Duly Notarized Attending Physician's Statement Form (in the absence of the APR , we require Morgue or Post Mortem Examination) ⌗ Police Report (for accidental death) ⌗ Copy of Autopsy report (for death of unknown causes)
In Patient Reimbursement: ⌗ Fully accomplished Reimbursement Claim Form ⌗ Cover letter / Incident report (stating the reason for filing of Reimbursement) ⌗ History of Present Illness ⌗ Clinical Abstract ⌗ Discharge Summary ⌗ Original Official Receipt of Hospital bills and/or Prof. fees ⌗ Statement of account ⌗ Itemized breakdown of charges or charged slips ⌗ Operative Technique (for surgical cases) ⌗ Police Report (for accidents) ⌗ Certificate of Live birth and/or Marriage Contract (for maternity claim) ⌗ Results of laboratory / diagnostic examinations ⌗ Subrogation Form (for accidents)	***FOR SELECTED ACCOUNTS ONLY:*** **OP Medicine Reimbursement:** ⌗ Fully accomplished Reimbursement Claim Form ⌗ Original Official Receipts of medicines ⌗ Doctor's medicine prescription with diagnosis or with a separate medical certificate ⌗ Itemized breakdown of charges **Optical Wear Reimbursement:** ⌗ Fully accomplished Reimbursement Claim Form ⌗ Original Official Receipts ⌗ Prescription for eyeglasses / contact lenses ⌗ Itemized breakdown of charges

STANDARD GRACE PERIOD FOR FILING OF CLAIMS - 30 days from date of discharge / medical treatment

(may vary for selected accounts based on their contract provision)