MediCard Philippines, Inc.
15th Floor, The World Centre Bldg., 330 Sen. Gil Puyat Avenue , Makati City, 1200
Telephone No.: 884-9999 / **Fax Nos.**: 810-3855; 848-6454
E-mail: inquiry@medicardphils.com /**Website:** www.medicardphils.com

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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** _____

✓ **REASON FOR REIMBURSEMENT (Please only select one (1) option below):**

- ☐ **Medicine**
- ☐ **Non-Accredited Facility/Doctor**
- ☐ **Unreported Availment/Admission**
- ☐ **Optical**
- ☐ **Dental**
- ☐ **Others, please specify:** _____

_____

- ☐ **Vaccine**
- ☐ **Items/Fees on Cash Basis**
- ☐ **Annual Physical Exam/Pre-Employment Medical Exam**
- ☐ **Maternity Assistance**
- ☐ **Ambulance**

ATTENDING PHYSICIAN'S REPORT

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

CHIEF COMPLAINT/S: _____

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 SELECT APPROPRIATE BOX FOR PREFERRED MANNER OF RELEASE OF APPROVED AMOUNT AND / OR MEMO:

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

MAILING ADDRESS: _____

☐ **OTHER REMARKS (e.g. if thru online payment):** _____ _____

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
- ☐ Medical Certificate stating chief complaint and final diagnosis
- ☐ Original Official Receipt/s of Facility and/or Prof. fees
- ☐ Itemized Breakdown of Charges/Charge Slips
- ☐ Emergency Room Record (if emergency case)
- ☐ Operative Technique (for surgical cases)
- ☐ Police Report and Subrogation Form (for major accidents)
- ☐ Driver's license and/or OR/CR (for vehicular accidents)

In Patient Reimbursement:

- ☐ Fully accomplished Reimbursement Claim Form
- ☐ Clinical Abstract/Discharge Summary
- ☐ Original Official Receipt/s of Hospital bill and/or Prof. fees
- ☐ Hospital Statement of account
- ☐ Itemized breakdown of charges or charged slips
- ☐ Operative Technique (for surgical cases)
- ☐ Certificate of Live birth and/or Marriage Contract (for maternity assistance)
- ☐ Police Report and Subrogation Form (for major accidents)
- ☐ Driver's license and/or OR/CR (for vehicular accidents)

FOR SELECTED ACCOUNTS ONLY:

OP Medicine Reimbursement:

- ☐ Fully accomplished Reimbursement Claim Form
- ☐ Original Official Receipt or Sales Invoice of Medicines
- ☐ Itemized breakdown of charges
- ☐ Doctor's medicine prescription with diagnosis or with a separate medical certificate

Optical Wear Reimbursement:

- ☐ Fully accomplished Reimbursement Claim Form
- ☐ Original Official Receipt or Sales Invoice of Optical Wear
- ☐ Prescription for eyeglasses / contact lenses
- ☐ Itemized breakdown of charges

Vaccine Reimbursement:

- ☐ Fully accomplished Reimbursement Claim Form
- ☐ Original Official Receipts of vaccine
- ☐ Medical certificate (if due to animal bite: with animal bite category)
- ☐ Itemized breakdown of charges per dose given

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)