**INSULAR HEALTH CARE, INC.**
2/F Insular Health Care Bldg., 167 Dela Rosa cor. Legazpi Sts.,
Legazpi Village, 1229 Makati City, Metro Manila, Philippines
Telephone No. (632) 8813-0131

## GUIDELINES ON FILING OF CLAIMS

The claims for reimbursement from Insular Health Care, Inc. (InLife Health Care) shall be governed by the following guidelines:

**VALIDITY PERIOD:**

1. A claim for reimbursement **must be filed and received by InLife Health Care within sixty (60) days** from (i) the date of availment for outpatient benefits; or (ii) the date of discharge for inpatient benefits.
2. The period for processing shall be thirty (30) days from the date of receipt by InLife Health Care of the said claim; provided that the member has submitted all the necessary documents. In case an additional requirement is needed, the thirty (30) day period shall be reckoned from the date when said additional requirement is submitted.

**REQUIREMENTS:**

1. All claims for reimbursement must be submitted together with a **photocopy of the patient's valid identification document (ID)** and **original copies** of the following documents:

**OUTPATIENT**

- ☐ Medical Certificate from the attending Physician or any document that would reflect the diagnosis.
- ☐ Official Receipts of payments to the Hospital and/or the Physician
- ☐ Charge Slips with breakdown of charges

**MEDICAL/ DENTAL BENEFIT**

- ☐ Medical Certificate from the attending Physician/Dentist
- ☐ Prescription
- ☐ Official Receipt indicating the medicines purchased

**INPATIENT**

- ☐ Medical Certificate from the attending Physician
- ☐ Clinical Abstract/Clinical History
- ☐ Official Receipts of payments to the Hospital and/or the Physician
- ☐ Charge Slips with breakdown of charges
- ☐ Statement of Account
- ☐ Operative Record including histopathological report (when applicable)
- ☐ Police Report and/or Incident Report (for accidents and when applicable)

**DATA PRIVACY NOTICE:** For purposes of properly administering our services particularly the processing of your claims, we shall collect, record, organize, store, update or modify, retrieve, consult, use, and in some restricted instances, consolidate, block, erase, disclose (collectively, "process") your personal information (name, address, sex and contact information) and sensitive personal information (age, bank information, medical history, results of medical examinations, diagnosis, abstracts, treatments, utilization, records and information, medication, and other information relevant or connected with your HMO coverage from, or of your diagnosis, treatment or availment of health care services through InLife Health Care).

By signing this form, you are specifically:

1. Consenting to making your personal and sensitive personal information available to InLife Health Care, its affiliates, related entities and partner/ accredited hospitals, clinics, and wellness centers (including their officers, employees, service providers, subcontractors as well as members of their medical staff, house staff, doctors, nurses, allied health care personnel and other clinical staff – "InLife Health Care Related Entities"), and permitting InLife Health Care and InLife Health Care Related Entities to make your personal and sensitive personal information available to (i) third parties who provide products and services to InLife Health Care for the purposes described above; (ii) regulatory authorities and government agencies; and (iii) other third parties such as, but not limited to, (**for those under a Corporate account; may be excluded hereunder)** your employer (including its agent or broker), your principal member and/or your principal member's employer, where required or permitted by law or contract. Provided, that the sharing of personal and sensitive personal information to InLife Health Care Related Entities shall be subject to (i) the principles of *transparency, legitimate purpose, proportionality and data quality* and to (ii) appropriate data privacy agreements and the implementation of organizational, physical, technical, administrative, procedural and security measures that are similar or greater than that being observed by InLife Health Care.

   **[Please check only if you are (1) under a Corporate account and (2) you object to the disclosure of your personal and sensitive personal information to your employer, your principal member and/or your principal member's employer]**

   ☐ I do not allow InLife Health Care to make available my personal and sensitive personal information to my employer, my principal member and/or my principal member's employer. As a consequence of this objection, I authorize InLife Health Care to inform my employer, my principal member and/or my principal member's employer that I have made such objection.

2. Authorizing InLife Health Care to release the personal and sensitive personal information stated in the immediately preceding number to (i) your employer; (ii) the principal member to whom you are a dependent, if applicable, for the evaluation of your medical claim; and (iii) InLife Health Care Related Entities.

3. Authorizing your doctor and/or the hospital, clinic or wellness center that have provided you treatment to release any information and related documents (including a summary thereof derived from laboratory services and medical consultations) to InLife Health Care or its authorized representatives for the evaluation of your claims.

4. Consenting to the processing of your personal and sensitive personal information as provided under applicable laws, regulations, and InLife Health Care's Privacy Policy, as stated in its website (www.insularhealthcare.com.ph/privacy-policy/).

5. Acknowledging that the personal and sensitive personal information that you have provided will be retained by InLife Health Care and InLife Health Care Related Entities as prescribed by law, or as long as necessary for the purpose of maintaining your medical records and to comply with applicable laws, rules and regulations. Through this form, you have been made aware that you and your next of kin, dependent or legal representative are entitled to certain rights in relation to the personal and sensitive personal information that may be collected from you and your next of kin, dependent or legal representative, including the right to access, correction, and to object to the processing of the same. You have been made aware that a more detailed description of your rights under **Republic Act No. 10173** or the **Data Privacy Act of 2012** and its Implementing Rules and Regulations may be accessed and downloaded at www.privacy.gov.ph. You have likewise been made aware that should you have any privacy concern regarding your personal data, you may consult InLife Health Care's Data Protection Officer at dataprivacy@insularheathcare.com.ph or Tel: 8813-0131 loc 8505, or the National Privacy Commission at www.privacy.gov.ph

6. You understand that the consent you are giving through this form is in addition to any other consent that you may have already given InLife Health Care and InLife Health Care Related Entities regarding the processing of your personal and sensitive personal information (e.g. in relation to your HMO coverage/ availment, examination, diagnosis, treatment or procedure). You also understand that the consent you have given shall remain in full force for a period of one (1) year unless revoked in writing except to the extent that action has already been taken based therein.

7. Confirming that you understand the foregoing and that you are voluntarily giving your consent to the processing of your personal and sensitive personal information under the terms and conditions provided above. **You also understand that you may withhold consent by specifying below the particular number to which you are objecting. You are, however, informed that withholding consent may affect the proper administration of our services including the processing of your claims or, in instances where processing of your claims is rendered impossible, denial of your claims.**

   ☐ I am withholding my consent for number(s) _____ above.

**CONFIDENTIALITY NOTICE:** InLife Health Care will not process or disclose any information obtained from you except as otherwise provided herein, subject to the provisions of the Data Privacy Act of 2012 and laws, rules and regulations affecting our Company. InLife Health Care warrants that your personal and sensitive personal information will remain confidential and will be disclosed only with your permission or when required or authorized by law or contract.

## CLAIMS REIMBURSEMENT FORM

**CLAIMANT'S GENERAL INFORMATION:**

| | |
|---|---|
| Name: | Member ID No: |
| Address: | Age: |
| | Sex: |
| Telephone & Mobile No: | Inclusive Date of Availment: |
| Plan Type: | Hospital: |
| Unionbank Account No. & Branch: | Email Address: |
| Other Bank Account No. & Branch: | Bank Name: |
| Payee/Check Payable to: | |

**NATURE OF CLAIM:**

☐ Inpatient
☐ Outpatient
☐ Others. Please specify: _____

☐ Medical Benefit
☐ Dental Benefit

**REASON FOR REIMBURSEMENT:**

_____

_____

**AMOUNT IN WORDS:** _____ **AMOUNT IN FIGURES:** _____

**DECLARATION:**

I declare that the above information and the supporting documents that I have submitted are true, genuine and accurate. I further declare that the amount herein claimed is lawfully due me under the terms and conditions (including the exclusions and limitations) of my Health Care Agreement with InLife Health Care. I hereby release InLife Health Care and its officers, employees and agents from any liability arising from any action taken based on this declaration.

**[Maaaring humingi ng tulong kung hindi nakakaunawa ng Ingles. Huwag sumang-ayon kung mayroong hindi naiintindihan.]**

I confirm that I have read and fully understood the above terms and conditions. (Kinukumpirma ko na aking nabasa at lubusang naintindihan ang mga nakasaad na tuntunin at kundisyon)

I agree with the above terms and conditions and explicitly consent to the processing of my personal and sensitive personal information in accordance with the above purposes. (Ako ay sumasang-ayon sa mga nakasaad na tuntunin at kundisyon.)

_____ _____

**CLIENT'S NAME OVER PRINTED NAME** **DATE SIGNED**
(Thumbmark if unable to sign)

## PHYSICIAN'S MEDICAL STATEMENT

**(This will serve as your Medical Certificate if duly certified by the Attending Physician. No need to accomplish if a separate Medical Certificate has been issued)**

| |
|---|
| Nature of Illness (Final Diagnosis): |
| Nature of Procedure Performed (Pls. describe in full): |
| I hereby certify, to the best of my knowledge and ability, that the information I have provided in support of the foregoing claim is true and correct. I understand that validations and/or audits may be conducted in relation to this claim.<br>Name: _____ Date Signed: _____<br>License No: _____ Clinic Address: _____<br>Signature: _____ Contact No. _____ |