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Provider Relations - MACE Consultation Form
Rev. 0
15May2017

Out-Patient Consultation Form

_____

Date: _____ **This request is valid from** _____ **until** _____ **Reference No.:** _____

Doctor: _____ **Hospital:** _____

Member Name: _____ **Member ID:** _____ **Age:** _____ **Gender:** _____

Company: _____

Effectivity Date: _____ **Validity Date:** _____

Chief Complaint:

History of Present Illness:

Past/Family History:

Review of Systems (ROS):

Vital Signs: **BP:** _____ **HR:** _____ **RR:** _____ **Temp:** _____

Physical Examination:

Primary Diagnosis/ Working Impression:

Prescribed Test/s for Primary Diagnosis:

ICD 10 CODE:
Other Diagnosis Contributory to Chief Complaint:

Prescribed Test/s for Other Diagnosis:

Other Diagnosis Non-Contributory to Chief Complaint:

Prescribed Test/s for Other Diagnosis:

Type of illness (if applicable): ☐ **Congenital** ☐ **Maternity Related** ☐ **Medico Legal**

Plan of Management/Notes:

Procedure(s) Done in Clinic Approval No.:

WAIVER: Consent is hereby given by the patient or by the next kin (if patient cannot sign) to the disclosure and processing of the patient's medical/health information by MediCard and its representatives, its Medical Service Units/Teams and its Accredited Hospitals/Clinics which is determinative for the assessment of the patient's coverage and necessary for the treatment of his/her ilness. MediCard and its representatives are also free to disclose the said information including utilization data of the patient to its concerned Company upon demand of the latter for such other legal purpose it may have including for the proper administration of the Company's health benefits program. MediCard and its representatives, its Medical Service Units/Teams and its Accredited Hospitals/Clinics are hereby released from any liability by reason of such disclosure.

_____ _____

Signature of Patient/Member **Signature of Attending Physician**