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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 illness. 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