



MediCard PHILIPPINES, INC.
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Provider Relations - Exam Request Form
Rev. 15
20 July 2016

LABORATORY / DIAGNOSTIC EXAMINATION REQUEST FORM

Date: _____

This form is valid up to _____ only.

Approval No: _____

Name: _____ Age: _____ Sex: _____

Company: _____ I.D. No.: _____

Effectivity Date: _____ Validity Date: _____ Limit: _____

Requesting Physician: _____

Diagnosis: _____

Examination Requested: _____

Examination to be done at: _____

(Hospital / Clinic)

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/Clinic are hereby released from any liability by reason of such disclosure.

Signature of the patient

**MediCard Authorized Signatory
Signature over printed name**

NOTE TO THE HOSPITAL: *Please submit original copy of this form together with your billing/statement of account to MediCard Claims Department.*