Liberty Insurance
#LiveWorryFree

Liberty Insurance Corporation
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REIMBURSEMENT CLAIM FORM

Please ensure that all pertinent information is completed. This form and original documents shall be submitted to your HR Department within 30 days from the date of availment. Otherwise, reimbursement shall be forfeited.

DATE FILED _____ TYPE OF CLAIM ☐IN PATIENT ☐OP CONSULT ☐OP LABORATOR ☐ER ☐OTHERS: _____

PATIENT'S NAME: _____ AMAPHIL ID No.: _____
GIVEN NAME MI LAST NAME

NAME OF PRINCIPAL MEMBER (IF PATIENT IS A DEPENDENT MEMBER): _____ AMAPHIL ID No.:_____
RESIDENT ADDRESS: _____ MOBILE No.:_____
COMPANY NAME: _____ OFFICE TEL. No.:_____ E-MAIL ADDRESS:_____
HOSPITAL NAME: _____ DATE OF MEDICAL TREATMENT/CONFINEMENT:_____
TOTAL AMOUNT OF CLAIM: _____

Please provide your bank details for e-transfer (minimum bank charge of PHP 25.00)
Name of Bank/Branch: _____
Account Name: _____
Account Number: _____

I certify that the above information is correct. I hereby certify that these hospital expenses have not been previously reimbursed.

Please enclose legible copies of the following documents:
☐Official Receipts
☐Medical certificate to include final diagnosis *(For IP and OP Laboratory)*
☐Medical abstract; if applicable
☐Doctor's order for laboratory tests
☐Doctor's prescription for outpatient medicines
☐Itemized Statement of Account *(inpatient/confinement)*
☐Police report *(vehicular accident)*/Affidavit of Accident *(for other incidents)*

ATTENDING PHYSICIAN'S REPORT In lieu of MEDICAL CERTIFICATE. Please have this portion accomplished fully by your ATTENDING DOCTOR
CHIEF COMPLAINTS: _____LABORATORY OR DIAGNOSTIC TEST RESULTS IF ANY: _____
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 THE ATTENDING DOCTOR OVER PRINTED NAME DATE

SPECIALIZATION: _____ LICENSE No.: _____

WAIVER

I _____, hereby consent to the disclosure by and its representative of any or all of my medical utilization / diagnosis to my COMPANY, its officers, directors, employees, and/or other authorized agents/representatives, which the result in the course of providing their medical services to me, as PATIENT. I understand that any information which they may acquire and/or receive relating to the said utilization/diagnosis will no longer be covered as confidential/privileged communication upon execution of this waiver. Thus, I hereby waive any claim of confidentiality/privileged communication against LIBERTY INSURANCE CORPORATION, its officer, directors, employees, and/or other authorized agents/representatives, its Medical Service Units/Teams and its Accredited hospital/Clinics, and hereby release them from any liability which may arise as an incident of the said disclosure to my COMPANY.

_____ _____
SIGNATURE OF THE PATIENT/EMPLOYEE OVER PRINTED NAME DATE

_____
COMPANY NAME

A&H2024