PhilCare
Make Health Happen

24/7 Customer Service Hotline: +63 (2) 462 1800
Outside Metro Manila (toll-free for PLDT): 1-800-1888-3230
www.philcare.com.ph

LETTER OF AUTHORIZATION TO PROVIDER FOR OUT-PATIENT SERVICES

OP No. :

Hospital / Clinic _____
Unit / Department _____
Company Name _____
Patient Name _____ Age _____ Sex _____
Agreement No _____ Cert No. _____
Referring Physician _____

Date Issued _____
Valid Until _____
Effectivity Date _____
Expiry Date _____
OP / Hospital Coordinator _____
Attending Physician _____

INSTRUCTIONS TO OP COORDINATOR / LOA ISSUER Please indicate the pertinent chief complaint, diagnosis / impression, and diagnostic and other servces. For availments and procedures requested for the purpose of ruling out a disease, please always indicate the chief complaint and diagnosis

CHIEF COMPLAINT

DIAGNOSIS / IMPRESSION

DIAGNOSTIC AND OTHER SERVICES

- ❍ INITIAL CONSULTATION
- ❍ FOLLOW-UP CONSULTATION
- ❍ RADIOTHERAPY
- ❍ SURGICAL PROCEDURES
- ❍ PHYSICAL THERAPY
- ❍ DIALYSIS
- ❍ CHEMOTHERAPHY
- ❍ CARDIO-PULMONARY CLEARANCE
- ❍ OTHERS. Please sepcify in the space below.

AUTHORIZED LIMIT _____

INNER LIMITS (if any)

	Peso	Count
1		
2		

THE FOLLOWING CHARGES SHOULD BE COLLECTED FROM THE MEMBER

- ❍ Prosthetic device, corrective appliances, and artificial devices
- ❍ Charges in the excess of the member's coverable amount _____
- ❍ Co-payment Arrangement : % (percentage) of the total charges (HB + PF) _____
- ❍ Others _____

PHILHEALTH PORTION

Member is required to submit PhilHealth requirements. Otherwise, member shall shoulder the Philhealth portion

Member is not required to submit PhilHealth requirements.

REMARKS / ADDITIONAL INSTRUCTIONS

APPROVAL CODE

_____
Name & Signature of Authorized OP Coordinator / LOA Issuer

_____
Issuing Hospital / Clinic

INSTRUCTIONS TO PHYSICIANS / OP COORDINATOR. For strict compliance, please indicate the pertinent physical examination findings and / or diagnostic results.

PERTINENT HISTORY / PE FINDINGS / PROCEDURES PERFORMED

FINAL DIAGNOSIS

For PhilCare user only. Classification of diseas is subject to PhilCare's final evaluation.

❍ Chronic ❍ Pre-exisiting ❍ Congenital ❍ Maternity Related

RECOMMENDED TESTS / TREATMENT / OPERATION, IF NECESSARY

_____
Name & Signature of Physician / OP Coordinator

_____
Date Signed

DECLARATION

I acknowledge that PhilCare's liability is limited only to that provided for in the Agreement and that any certain claim may be denied by PhilCare under any of the following circumstances:
1) Material misrepresentation or concealment of relevant medical information in the application for the membership; 2) Illness that caused the confinement is determined by PhilCare to be among the general or specific exclusions stated in the Agreement; 3) Treatment or procedure is not related to the illness for which this Letter of Authorization was issued. 4) Payment of membership fees is not up-to-date. Moreover, PhilCare will not be liable for the payment of expenses or charges resulting from the following: 1) Availment of any hospital and/or clinic services without prior authorization and approval from the PhilCare;2)Services provided by non-affiliated physicians, reliever physicians, and specialists; 3)Treatment of procedures neither related nor coverable relative to my consultation or confinement;4) Use of miscellaneous items outside of my benefit plan; and availment of diagnostic, therapeutic, or any medical services deemed excluded by the service agreement between PhilCare and the member's employer and/or the member; 5) Excess charges beyond my allowable benefit limit in relation to the professional fee of the attending physician; 6) Excess charges of my Annual or Maximum Benefit Limit even if conditionally approved by PhilCare.

In this regard, if at the time of issuance of the Letter of Authorization (LOA) the amount of my previous availment is not reflected yet, **PHILCARE RESERVES THE RIGHT TO THE FINAL ADJUDICATION OF MY COVERAGE** based on the total remaining balance of my benefit limit.

I hereby authorize and grant full freedom to PhilCare to access and receive copies of all information and records which any of its authorized representatives may request from any medical institution or practitioner, in connection with the following services provided to me by them: (a) hospitalization; (b) consultation; (c) examination; (d) treatment; and (e) other relevant medical concerns; Provided, that PhilCare shall use such data or information strictly in connection with providing coverage and services to me, and shall keep the same confidential at all times. A photocopy of this authorization, duly certified by PhilCare, shall be honored as the original.

I hereby authorize PhilCare to collect from me any expenses incurred relative to the items or circumstances indicated in this Declaration, regardless of whether the same were discovered at the time of treatment, or if revealed upon post-verification and confirmation by PhilCare.

A FRIENDLY REMINDER : Please call your provder prior to availment service/s

Room No _____
Schedule _____
Contact No _____

_____
Name and Signature of Member / Date

_____
Guardian of Member / Relation to Member

Original Copy - Must be returned by Doctor / Hospital / Clinic to Philcare **Duplicate Copy** - Must be retained by Doctor / Hospital / Clinic