

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

| NITIAL CONSILIZATION   PRIVEDAL THERAPY   OTHERS. Please sepoly in the space below.   AUTHORIZO LINIT   NINITAL CONSILIZATION   PRIVAL    |  | PC00400 Cert No. 5443460 ALCANTARA, MARIBETH   | ge 46 Sex MALE OP / Hospital Coordinator Attending Physician thief complaint, diagnosis / impressidicate the chief complaint and diagnosis | 3858                    | MARIBETH other servces. For |
|--|--|--|--|-------------------------|-----------------------------|
| NATIAL CONSULTATION  |  | DIAGNOSTIC AN  | ID OTHER SERVICES  |                         |                             |
| Charges in the excess of the member's coverable amount  PHILALIH POINTON  Member is required to submit Philihealth requirements. Otherwise, member shall shoulder the Philhealth portion  REMARKS / ADDITIONAL INSTRUCTIONS  APPROVAL CODE  2016/0825002000002  ALCANTARA MARIBETH  Name & Signature of Authorized Of Pocerdinator / LOA Issuer  PHILCARE MARATI CLINIC  TO PHYSICANS TO PHYSICANS / OF COORDINATOR  For shirl compliance, please indicate the perfinent physical examination findings and / or dispositor results.  PERTINENT HISTORY / PE PHOINGS / PROCEDURES PERFORMED  RECOMMENDED TESTS / TREATMENT / OPERATION, IF NECESSARY  Name & Signature of Physician / OP Coordinator  RECOMMENDED TESTS / TREATMENT / OPERATION, IF NECESSARY  I advancedage that Philicare's stability is limited only to that provided for in the Agreement and process and received information in the application and any contain claim may be deviced by Price under any of the following circumdiances:  1) Material minuspresentation or conceilanced of relevant medical information in the application and reported or or special consistent with this Letter of Authorization was issued. A) Pyment of marketing minuspresentation or conceilanced of relevant medical information in the application and reported by the conceilance of relevant medical information in the application and records which any of its authorized for special consistent of the purpose of all information in proceidage that the following information in the application and records which any of its authorized for special consistents of the purpose of all information in the purpose of all information and records which any of its authorized for special consistents of the purpose of all information and records which any of its authorized for special consistents of the purpose of all information and records which any of its authorized for which the Letter of Authorized for which the Letter of Authorized for which the letter of procedures or service which the Letter of procedures or service by them: (s)  | O FOLLOW-UP CO   | LTATION O PHYSICAL THERAPY O OTHI  ONSULTATION O DIALYSIS  Y O CHEMOTHERAPHY  OCEDURES O CARDIO-PULMONARY  CLEARANCE   | ERS. Please sepcify in the space below.  | 1                       | INNER LIMITS (if any)       |
| Member is required to submit Philhealth requirements. Otherwise, member shall shoulder the Philhealth portion  REMARIS / ADOITIONAL INSTRUCTIONS  APPROVAL CODE  2016082500200002  ALCANTARA AMARIBETH  North & Squaler Additional and Additional  | O Prosthetic dev   | ice, corrective appliances, and artificial devices   | O Co-payment Arrangement : %   | (percentage) of the to  | tal charges (HB + PF)       |
| Member is not required to submit Philhealth requirements. Otherwise, member shall shoulder the Philhealth portion  REMARKS / ADDITIONAL INSTRUCTIONS  APPROVAL CODE  2016082500200002  ALCANTARA MARIBETH  Natives Signature of Authorized of Piccendinor / LOA Issuer  PHILCARE MARATI CLINIC  Insurance of Physical Procedures Performed  PERTINENT HISTORY / PERMOINGS / PROCEDURES PERFORMED  RECOMMENDED TESTS / TREATMENT / OPERATION, IF NECESSARY  Name & Signature of Physical / OP Coordinator  RECOMMENDED TESTS / TREATMENT / OPERATION, IF NECESSARY  Name & Signature of Physical only to that provided for in the Agreement and that any cortain claim may be devised by PhilCare under any of the following orrandmones:  In Martin in Superior State of the State of Authorization (2,OA) the amount of my provided membershy feet is not updated any of the following orrandmones:  In Martin in Superior State of the State of Authorization (2,OA) the amount of my provided membershy feet is not updated in the Agreement of provided for in the Agreement of provided in the Agreement of provided in the Agreement of provided for internation of provided for internation of provided for internation of pr | O Charges in the   | e excess of the member's coverable amount  | O Others   |                         |                             |
| ALEX D. PANGANIBAN/25/08/2016  REMARKS / ADDITIONAL INSTRUCTIONS  REMARKS / ADDITIONAL INSTRUCTIONS  REMARKS / ADDITIONAL INSTRUCTIONS  REMARKS / ADDITIONAL INSTRUCTIONS  APPROVAL CODE  ALCANTARA MARIBETTI PHILCARE MAKATICLINIC  Insuring inoposal claim PHILCAR |  | PHILHEAI   | TH PORTION   |                         |                             |
| REMARKS / ADDITIONAL INSTRUCTIONS  20160825002000002  ALCANTARA MARIBETH PHILCARE MARIBETH OF STRUCTIONS TO PHYSICIANS / OP COORDINATOR  For strict compliance, please indicate the pertinent physical examination findings and / or diagnostic results.  FINAL DIAGNOSS  FOR PRICare user only. Clearification of disease is subject to PhilCare's final evakuation. O Chronic O Pre-existing O Congenital Maternity Related  RECOMMENDED TESTS / TREATMENT / OPERATION, if NECESSARY  Name 6. Signature of Physician / OP Coordinator  Date Signed  RECOMMENDED TESTS / TREATMENT / OPERATION, if NECESSARY  Date Signed  Date Signed |  |  | Member is not required to sub  | mit PhilHealth requirer | ments.                      |
| ALEX D. PANGANIBAN/25/08/2016    ALCANTARA MARBETH PHILCARE MAKATI CLINIC   Date of Suprame of Submitted OP Coordinator / LOA Issuer   PHILCARE MAKATI CLINIC   Date of Suprame of Submitted OP Coordinator / LOA Issuer   PHILCARE MAKATI CLINIC   Date of Submitted OP Coordinator / LOA Issuer   PHILCARE MAKATI CLINIC   Date of Submitted OP Coordinator / LOA Issuer   PHILCARE MAKATI CLINIC   Date of Submitted OP Coordinator   Date of Submitted OP Coordinator   Date of Submitted OP Proceedings of the Submitted  | shall shoulder   | TOWARD CONTROL OF THE |  | ADDROVAL CODE           |                             |
| ALEX D. PANGANIBAN/25/08/2016  INSTRUCTIONS TO PHYSICIANS / OP COORDINATOR  For strict compliance, please indicate the pertinent physical examination findings and for diagnostic results.  Instructions To PHYSICIANS / OP COORDINATOR  For strict compliance, please indicate the pertinent physical examination findings and for diagnostic results.  For PRICare user only. Classification of diseas is subject to PrilCare's final evaluation.  O Chronic O Pre-existing O Congenital O Maternity Related  RECOMMENDED TESTS / TREATMENT / OPERATION, If NECESSARY  Name & Signature of Physician / OP Coordinator  Date Signed  Details  |  | REMIARRS / ADDITIONALINSTRUCTIONS  |  | APPROVAL CODE           |                             |
| Name & Signature of Physician / OP Coordinator / LOA issuer  PRICARE MAKATICLINIC  Insuring Hospital / Condended of Physician / OP Coordinator / LOA issuer  For PRICare user only, Classification of diseas is subject to PhiCare's final evaluation.  Chronic Pre-existing Congenital Maternity Related  RECOMMENDED TESTS / TREATMENT / OPERATION, IF NECESSARY  Name & Signature of Physician / OP Coordinator  Date Signed  Name & Signature of Physician / OP Coordinator  Date Signed  RECOMMENDED TESTS / TREATMENT / OPERATION, IF NECESSARY  Name & Signature of Physician / OP Coordinator  Date Signed  Date Signed  Date Signed  RECOMMENDED TESTS / TREATMENT / OPERATION, IF NECESSARY  Date Signed  Da |  |  | 201608250020000  | )2                      |                             |
| PERTINENT HISTORY / PE FINDINGS / PROCEDURES PERFORMED  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  Date Signed |  |  | Name & Signature of Authorized OP Coordinator / LOA Issuer PHILCARE MAKATI CLINIC  |                         |                             |
| For PhiCare user only, Classification of diseas is subject to PhiCare's final evaluation.   Chronic   Pre-exisiting   Congenital   Maternity Related   | INSTRUCTIONS TO  | PHYSICIANS / OP COORDINATOR. For strict compliance, please i   | ndicate the pertinent physical exami   | nation findings and / o | r diagnostic results.       |
| Name & Signature of Physician / OP Coordinator  DecLARATION  I acknowledge that PhiCare's liability is limited only to that provided for in the Agreement and that any certain claim may be deried by PhiCare under any of the following groum stances:  1) Material misrepresentation or concealment of relevant medical information in the application for the membership: 2) liness that caused the confinement is determined by PhiCare is ability in similar or procedure is not related to the illness for which this Letter of Authorization was issued. 4, Payment to respect to the illness for which this Letter of Authorization was issued. 4, Payment of membership: 2 lines that caused the confinement is determined by PhiCare is a ADUDICATION OF MY COVERAGE based on the total remaining balance of my benefit limit.  I hereby authorize and grant full freedom to PhiCare to access and receive copies of all information and records which any of its authorized representatives may request copies of all information and records which any of its authorized representatives may request from any medical exervices without prior authorization and approval from the PhiCare; Siervices provided by providing concerns; Provided, that PhiCare shall use such data or information strictly in connection with hospitalization; (c) examination; (d) treatment; and (e) other relevant mental exervices to me, and shall keep the same consided or my benefit plan; and availment of diagnostic, interapeuble, or any medical services deemed excluded by the service agreement between PhiCare and the member's employer and/or the member's employer and/or the member's employer and/or the member's Excess charges beyond my allowable benefit limit relation to the professional fee of the attending physician, (b) Excess charges of my Annual or Maximum Benefit Limit even if conditionally approved by PhiCare.  ALEX D. PANGANIBAN/25/08/2016   | PERT   | NENT HISTORY / PE FINDINGS / PROCEDURES PERFORMED  | _  | FINAL DIAGNOSIS         |                             |
| I acknowledge that PhilCare's liability is limited only to that provided for in the Agreement and that any certain claim may be deried by PhilCare under any of the following circumstances:  I) 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 expenses or charges resulting from the PhilCare will not be liable for the payment of expenses or charges resulting from the following: 1) Availment of any hospital and/or clinic expenses or charges resulting from the philCare;2)Services provided by non-affiliated physicians, reliever physicians, and specialists; 3)Treatment of procedures previous terms 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 physicians for the philocare physicians and availment of diagnostic, therapeutic, or any medical services deemed excluded by the service agreement between PhilCare and the member's physicians and availment of diagnostic, therapeutic, or any medical services deemed excluded by the service agreement between PhilCare and the member's physicians; 6) Excess charges beyond the pentil faint relation to the professional fee of the attending physician; 6) Excess charges boyond the pentil faint 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.  ALEX D. PANGANIBAN/25/08/2016  |  | RECOMMENDED TESTS / TREAT  | O Chronic O Pre-e  |                         |                             |
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| 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:  I) 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 of procedure 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 without prior authorization and approval from the PhilCare; 2)Services provided by non-affiliated physicians, reliever physicians, and specialists; 3)Treatment of procedures and the 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 my benefit plan; and availment of diagnostic, therapeutic, or any medical services deemed excluded by the service agreement between PhilCare and the member's peniloger and/or the member; 5) Excess charges beyond my allowable benefit limit 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.  ALEX D. PANGANIBAN/25/08/2016  |  |  | * <del>-</del>   | Date Signed             |                             |
| ALEX D. PANGANIBAN/25/08/2016  Room No Schedule Contact No   | 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 of procedure or membership fees is not up-to-date. Moreover, PhilCare will not be liable for the 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 critic 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 physicians; 6) Excess charges of my Annual or Maximum Benefit Limit even if conditionally approved by PhilCare. |  |  |                         |                             |
| Name and Signature of Member / Date Guardian of Member / Relation to Member  | ALEX   |  |  | Room No _<br>Schedule _ |                             |

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