OUTPATIENT LETTER OF AUTHORIZATION
CONSULTATION

LOE No.
LOA No.
Date Issued:
Validity Date:

This is to certify that Maxicare Healthcare Corporation (MAXICARE) will pay for the coverable hospital bills and professional fees of bona fide MAXICARE member named herein, up to the benefit limit indicated herein, with the exception of below-specified charges to be collected from the same Member by your Medical Institution prior to discharge. The HOSPITAL shall not hold MAXICARE liable for any unpaid Member charges beyond the date of discharge and shall not be part of any reconciliation item/s on future billings.

TYPE OF CONSULTATION: ☐ Initial ☐ Follow-up ☐ Clearance

MEMBER INFORMATION

Name of Patient:
Contact Info:
Company:
Attending Doctor:
Clinic/Hospital Name:
Referring Doctor:

Sex: Age:
Plan:
Policy No.:
Effectivity / Expiry:
Date of Availment:
PHIC: ☐ Required ☐ Not Required

INSTRUCTIONS

1. For validation purposes, this document must be signed by the member / guardian of minor members.
2. The attending physician / service provider must fill up and sign the portion provided.
3. For claims processing, the duly accomplished document together with the Statement of Account (SOA) must be submitted to Maxicare Healthcare Corporation (MAXICARE) office within the agreed period. Late filings will take longer to process and claims filed beyond forty five (45) days shall not be processed at all. Incomplete forms and documentation will be returned to the provider.
4. FOR STRICT COMPLIANCE OF THE MD: Please indicate the pertinent chief complaint, history of present illness, past medical or family history, physical examination findings, and diagnosis on the boxes provided below. For availments and procedures requested for the purpose of ruling out a disease entity, please always indicate your primary diagnosis, rule out <disease> will not be accepted.

(I) CHIEF COMPLAINT	(II) HISTORY OF PRESENT ILLNESS
(III) PAST MEDICAL / FAMILY HISTORY	**(IV) PHYSICAL EXAMINATION FINDINGS**

THE FOLLOWING HOSPITAL CHARGES SHOULD BE COLLECTED BY THE MEDICAL INSTITUTION FROM THE PATIENT DURING DISCHARGE

☐ Prosthetic device, corrective appliances and artificial deavices
☐ Co-payment arrangement: % (Percentage) of the total charges (HB + PF): _____ Amount: _____
☐ Others: _____

Attending Physician:

_____
Signature Over Printed Name

Issued By:

THIS IS ELECTRONICALLY GENERATED, NO SIGNATURE REQUIRED

CONFORME

I agree that any availment may be denied by MAXICARE HEALTHCARE CORPORATION (MAXICARE) under the following circumstances:

1. Concealment, whether intentional or not, of relevant medical information whether related to the current availment or not.
2. Treatment or Procedures not related to the illness for which this document was issued as determined by the MAXICARE.

Further, MAXICARE is not responsible for the payment of charges/expenses resulting from:

1. Availment of the following hospital or medical services/treatment/procedures (diagnostic and therapeutic): (i) those rendered by Non-affiliated Physicians/ Specialists and/or a Non-affiliated Reliever Physician; (ii) those not related to this confinement as determined by MAXICARE; (iii) those without prior authorization of MAXICARE; (iv) those miscellaneous items outside of the healthcare benefit plan; or (v) room accommodation beyond my benefit plan limits.
2. Failure to file philhealth benefit claim to cover all Philhealth costs incurred during my confinement.
3. Personal preference to prolong confinement beyond my Attending Physician's prescribed duration of hospitalization.
4. Amount in excess of my allowable benefit limit in the professional fee of Attending Doctor/s with whom I have prior agreement.
5. Benefit availment found to be not covered and deemed excluded by the Service (2) Agreement executed by and between MAXICARE and the Member's employer and/or the Member (the "Service Agreement "), including concealment, whether intentional or not, of relevant medical information, and those in excess of my Annual Benefit Limit (ABL) / Maximum Benefit Limit (MBL), even if conditionally approved by MAXICARE. In this regard, if at the time of issuance of the Letter of Authority (LOA) the amount of my previous availment is not reflected yet, MAXICARE RESERVES THE RIGHT TO THE FINAL ADJUDICATION OF MY COVERAGE based on the total remaining balance of my benefit limit.
6. Other expenses and charges analogous to the foregoing.

In connection with the foregoing, I hereby irrevocably authorize MAXICARE, being my healthcare maintenance services provider, as my attorney-in-fact to:

1. Examine and obtain copies of my (and/or dependents') medical records as well as any information relating to my (and/or my dependents') hospitalization, consultation, treatment or any other medical advice from whatever source as a condition to my (and/or my dependents') availment of any benefits under the Service Agreement; and disclose such information to Maxicare, and/or its duly authorized representative/s, sub-contractors and/or brokers, if brokers, if necessary, and my employer and/or its authorized representatives, upon request. In lieu of the original record, a certified photocopy will be honored as the original.

   For purposes hereof, I hereby warrant that I have been duly authorized by my dependents to sign and execute any and all documents and make representations for and in his/their behalf as if the same were personally done by him/them. I further agree to hold Maxicare free and harmless from and against any and all suits or claims, actions, or proceedings, damages, costs and expenses, including attorney's fees, which may be filed, charged or adjudged against Maxicare or, in connection with or arising from the disclosure of such information; and
2. Collect from me the expenses incurred relative to any availment, if upon post verification by MAXICARE, any of the above-mentioned circumstances be found present.

I understand that the benefits and coverage requiring the services of a physician shall only be performed by an Accredited Physician or Specialist referred by MAXICARE. I am aware that there is an agreed standard Professional Fee/s for specific medical services between the Physician and MAXICARE. Should I undertake a private arrangement with the Physician or Specialist for higher Professional Fee/s, I shall be personally liable to pay for the amount resulting from said balance billing and other additional charges. In no case may I demand for reimbursement from MAXICARE for the balance billing charged by the Accredited Physician or Specialist.

_____ _____
Signature Over Printed Name of Member, Relative, or Guardian — Date Signed
If Relative, relationship to member:_____
Contact No.:_____