

PRE-EMPLOYMENT MEDICAL EXAMINATION (PEME)
LETTER OF AUTHORIZATION

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

This is to certify that Maxicare Healthcare Corporation (MAXICARE) will pay for the coverable fees of the PEME endorsed availment named herein. You shall not hold MAXICARE liable for any unpaid PEME charges outside of the endorsed validity and shall not be part of any reconciliation item/s on future billings. Any requests not included on the list of procedures shall not be covered.

PERSONAL INFORMATION

Examinee:	Gender:	Age:
Company:	Birthday:	Civil Status:
Mobile No.:	Email:	
Clinic/Hospital Name:	Policy No.:	

RESULTS TO BE FORWARDED TO

Contact person:	Contact No.:
Address:	

INSTRUCTIONS

- 1. For validation purposes, this document must be signed by the examinee.
- 2. The attending physician / service provider must fill out 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 (MAXI-CARE) office within the agreed period. Late filing shall not be processed. Incomplete forms and documentation shall be returned to the provider.

PROCEDURES

REMINDERS TO EXAMINEE

- 1. Valid ID with Picture should be presented together with this form.
- 2. Thumb-size stool should be collected at home; not more than one (1) hour prior assigned schedule.
- 3. Urine sample should be collected 15 minutes prior to submission.
- 4. Proper labeling of specimen bottles should be done to avoid switching of specimen and error on test results.
- 5. In the event that the examinee is unable to finish all the specified procedures within the day, the examinee should accomplish the remaining procedures within the validity period.
- 6. Additional examination/s not specified above shall be charged directly to the examinee.

Issued By:

THIS IS ELECTRONICALLY GENERATED, NO SIGNATURE REQUIRED.

CONFORME

I accept all the terms and conditions of the letter of authorization (LOA) that is issued by Maxicare for approved PEME availments. I further agree that any availment may be denied by MAXICARE HEALTHCARE CORPORATION (MAXICARE) under the following circumstances, the determination of the existence of which shall be reasonably made by MAXICARE and which shall be final, binding, and conclusive upon me.

- 1. Concealment of relevant medical information, whether intentional or not, and whether related to the current availment or not.
 - 2. Unrelated Treatment or Procedures with respect to the illness for which this document was issued as determined by MAXICARE.
- Further, MAXICARE is not responsible for the payment of charges/expenses resulting from:
- 1. Availment of the following medical services/procedures: (i) those rendered by Non-affiliated Provider; (ii) those not related to this availment as determined by the Claims Department of MAXICARE; (iii) those without prior authorization of MAXICARE; (iv) those miscellaneous items outside of the endorsed PEME availment.
 - 2. PEME availment found to be not covered and deemed excluded by the Service Agreement executed by and between MAXICARE and the Applicant's employer, including concealment, whether intentional or not, of relevant medical information, and those in excess of the agreed PEME cost.

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

- 1. Obtain, examine and process my personal information, including the medical records of my hospitalization, consultation, treatment, PEME availment or any other medical advice in connection with the benefit or claim and disclose such information to my employer and its representatives. Any information obtained relative to the authority herein given shall be confidential and shall not be disclosed, except to my employer and/or MAXICARE's authorized representative/s. In lieu of the original record, a certified photocopy will be honored as the original; and
- 2. Collect from me the expenses incurred relative to any availment, if upon post verification by MAXICARE, any of the above-mentioned circumstances shall be found present.

Signature Over Printed Name of the Examinee

Date Signed