LABORATORY AND PROCEDURE FORM

LOE No.:

Provider Name:
Doctor:
Patient Name:
Policy No:
Account Name:

Age:
Plan No.:
Plan Code:
Sex:
Room No.:

Issued Date:
Issued By:

Validity Date:
Visit Date:

LABORATORY, ANCILLARY PROCEDURES AND THERAPIES PROVIDED

DIAGNOSIS

INSTRUCTION TO PROVIDER

IMPORTANT: This space is intended only for clarificatory statements. Use of this space is not authorized for procedure approvals, rate changes or any other information with financial impact. Any such remarks shall not be considered or processed at claims settlement.

Issuer's Signature

WAIVER

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

1. Concealment, whether intentional or not, of relevant medical information in the application of the members 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 Claims Department of Maxicare Healthcare Corporation.

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

1. Examine and obtain copies of my (and/or my 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 dependent's) availment of any benefits under the Service Agreement; and disclose such information to Maxicare, and/or its duty authorized representative/s, sub-contractors and/or 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 dependent/s to sign and execute any and all documents and make representatives 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 field, 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 circumstance be found present.

In lieu of the original record, a certified photocopy will be honored as the original.

REMINDERS

For validation purposes, this document must be signed by the member/guardian of minor members.

The attending physician/service provider must fill up and sign the portion provided.
For claims processing, the duly accomplished document together with the Statement of Account (SOA) must be submitted to Maxicare Healthcare Corporation Office within the agreed period. Late filings will take longer to process and claims field beyond six months may not be processed at all.

Incomplete forms and documentation will be returned to the provider.

Signature of Member/Date

Guardian Name of Minor Member/Relation to Member