PhilCare
Make Health Happen

REIMBURSEMENT CLAIM FORM

Date Submitted: _____
Received by: _____
Processed by: _____

REMINDERS IN FILING REIMBURSEMENT CLAIMS

1. Member should fill-up Part I of this Reimbursement Claim Form and affix signature.
2. Request Attending Physician to fill-up Part II (at the back) of this form or just attach the Attending Physician's Report.
3. Request Employer's HR or Personnel Head to fill-up Part III (at the back) of this form.
4. Prepare the following supporting documents needed to process or evaluate your claim for reimbursement.
   - ❑ Original Official Receipt(s) of Professional Fee(s)
   - ❑ Original Official Receipt(s) of Hospital Bill
   - ❑ Statement of Account from the hospital where member/patient was confined or treated
   - ❑ Individual charge slips or itemized breakdown of charges to support the Statement of Account
   - ❑ For Inpatient Claims, Admitting History Report (to be obtained from the Medical Records Section of the hospital where patient was confined.
   - ❑ Others: _____
5. Submit the accomplished Reimbursement Claim Form with the supporting documents to PhilCare Claims Receiving Personnel.

Part I – TO BE ACCOMPLISHED BY MEMBER

NAME OF PATIENT (Last Name, First Name, Middle Initial)	**AGREEMENT NO./MEMBER I.D.**	**NAME OF COMPANY / OFFICE ADDRESS**	**BIRTHDATE**
ADDRESS	**CONTACT NOS.** (Tel.#, / Cellphone #.) **E-MAIL ADDRESS**	**IF CLAIM IS APPROVED PAYMENT SHALL BE:** ☐ For Pick-up ☐ Mail to Member ☐ Bank Credit Bank Acct.Name/ Acct. No. _____	

PATIENT IS
☐ Principal Member ☐ Dependent of _____ (NAME OF PRINCIPAL)

ARE YOU COVERED BY MEDICARE OR WORKMEN'S COMPENSATION PLAN? ☐ Yes ☐ No

ARE YOU COVERED BY ANY OTHER HEALTH/ INSURANCE PLAN? Yes___ No___
(If yes, please state what company & type of coverage)

IF CLAIM IS DUE TO ACCIDENT
Date & Time of Accident _____
Place of Accident _____

WAS MEMBER AT WORK WHEN THE ACCIDENT HAPPENED? ☐ Yes ☐ No
Give brief description of the accident.

NAME & LOCATION OF HOSPITAL WHERE CONFINED/TREATED
_____
Was PhilCare Notified? ☐ Yes ☐ No
If yes, when _____ who was notified _____

WAS THIS CONFINEMENT/OUTPATIENT AVAILMENT FACILITATED BY PHILCARE WITH A REFERRAL LETTER? Yes ☐ No ☐
If so, what is the expense being claimed for?

WERE YOU PREVIOUSLY CONFINED IN A HOSPITAL FOR THIS AILMENT? ☐ Yes ☐ No If "yes", Name of Hospital _____ Date Admitted _____

DECLARATION

I acknowledge that PhilCare's liability is limited only to that provided for in the Agreement and that this claim may be denied by PhilCare under any of the following circumstances:

1) Material mispresentation or concealment of relevant medical information in the application
2) Illness, which is the reason for concealment, is determined by PhilCare to be pre-existing or is among the general or specific exclusion stated in the agreement.
3) Treatment or procedure recommended by the PhilCare Physician has not been followed.
4) Membership fees are not up to-date in payment at the time of confinement.

I also acknowledge that PhilCare is not responsible, among other things specified in the Agreement, for the payment of additional charges resulting from: (a) having availed of such room accommodation different from that specified in the schedule; (b) incurring additional charges/items that are not form part of the specified room accommodation; (c) availing without PhilCare authority of hospital services after discharge or after the number of days authorized; (d) refusing to transfer to an affiliated hospital as recommended by PhilCare or affiliated physician.

I certify that on the commencement date of the hospitalization for which the benefit is being claimed, the person hospitalized was a member of good standing of the Health Care Plan.

I also certify that the foregoing answers are true and correct to the best of my knowledge and hereby authorize all doctors or other persons who treated me and all the hospitals or other institutions to furnish full information including full copies of their record(s) regarding this claim.

_____ Date

_____ Name & Signature of Claimant
PhilCare Member

Form # CD-004-0600-01

For more information, please contact

24/7 Customer Hotline at (02) 462-1800.
Outside Metro Manila, please contact us at
1-800-1888-3230 toll-free for PLDT and Smart subscribers.

www.philcare.com.ph
/philcareph

PhilCare 360° GoMobile by PhilCare

PhilCare
Make Health Happen

REIMBURSEMENT CLAIM FORM

Part II – TO BE ACCOMPLISHED BY ATTENDING PHYSICIAN

NAME OF PATIENT (Last Name, First Name, M.I.)	WAS PATIENT HOSPITALIZED? ☐ Yes ☐ No If yes, Date & Time Admitted _____. Date & Time Discharged _____.
NATURE OF ILLNESS OR INJURY (COMPLETE DIAGNOSIS)	DATE OF ONSET OF ILLNESS PRIOR TO CONSULTATION/ADMISSION
NATURE OF PROCEDURE DONE, IF ANY (Please describe fully)	

HAS PATIENT BEEN PREVIOUSLY CONFINED TO A HOSPITAL OR TREATED AS AN OUTPATIENT FOR THIS CONDITION OR FOR A CONDITION FOR AVRELATED CAUSE OR CAUSES? ☐Yes ☐No If "Yes", please indicate details below:

NAME OF HOSPITAL	TREATMENT DATES	ATTENDING PHYSICIANS	DIAGNOSIS

I HEREBY CERTIFY THAT THE INFORMATION PROVIDED ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Name of Attending Physician (Please print) _____ Signature _____ Date _____ Contact Numbers (Tel./Cell./Fax) _____

Part III – TO BE ACCOMPLISHED BY EMPLOYER

	MONTH	DAY	YEAR	TIME
LAST FULL DAY WORKED				
WHEN DID EMPLOYEE RETURN TO WORK?				
IF NOT BACK AT WORK, WHEN DO YOU EXPECT EMPLOYEE TO RETURN?				

DID INJURY OR ILLNESS FOR WHICH CLAIM IS BEING MADE ARISE OUT OF PATIENT'S EMPLOYMENT? ☐ Yes ☐ No

Name & Signature of Employer : _____ Date: _____

Position Title : _____
Name of Firm : _____

OTHER NOTES/REMARKS:

Form # CD-004-0600-01