REIMBURSEMENT REQUEST FORM

(IMPORTANT: Please fill up this form and attach the required documents)

PATIENT'S NAME:	**ACCOUNT NO.:**
PRINCIPAL MEMBER'S NAME:	**COMPANY:**
CONTACT NUMBERS:	**E-MAIL ADD:**
HOSPITAL/CLINIC:	**DATE OF TREATMENT:**

REASON FOR REIMBURSEMENT:
☐ Cash Basis ☐ Non accredited providers
☐ Emergency Case ☐ Others _____

TYPE OF CLAIM: ☐ OUT-PATIENT ☐ IN-PATIENT ☐ MATERNITY ASSISTANCE ☐ OPD MEDICINES/OPTICAL/DENTAL

BASIC REQUIREMENTS:

1) Duly filled up reimbursement request form
2) Detailed Statement of Account from the hospital
3) Itemized Original Official Receipt (w/ TIN)
4) Medical Certificate

ADDITIONAL REQUIREMENTS: (may be required for further validation of claim)

OUT-PATIENT/IN-PATIENT/ER
1) Operative Record w/ histopath result (if with operation)
2) Laboratory Result (if w/ diagnostic procedure)
3) Emergency Room report/Clinical Resume
4) Incident/Police Report (for cases due to minor injuries/vehicular accident and assaults)
5) History of Present Illness/Medical Abstract

OPD MEDICINES/OPTICAL/DENTAL
1) Doctor's prescription (for out-patient meds)
2) Optical Prescrition (for optical availment)
3) Dental Certificate (for dental cases)

MATERNITY ASSISTANCE
1) Photocopy of Birth Certificate with original authentication
2) Marriage Certificate
3) Delivery Room Record/Operative Record

NOTE:

1. Claims will be processed upon submission of complete requirements.
2. All documents submitted will be returned in case of lacking or non-submission of any required documents depending on type of claim.
3. The company reserves the right to require additional documents to justify payment of claim or to deny the claim even upon completion of required documents.
4. Additional documents must be submitted to Intellicare within 10 working days upon receipt of advice, otherwise, you are waiving your right for said claim.

I HERBY CERTIFY that the foregoing statements are true and correct to best of my knowledge and heryby authorize Intellicare to access information and be furnished copies of my medical records for purposes of evaluating my medical claim.

_____   _____
SIGNATURE OF CLAIMANT   **DATE SIGNED**
(Signature Over Printed Name)

ATTENDING PHYSICIAN'S REPORT

(This will serve as your medical certificate if fully signed/certified by attending doctor)
(If medical certificate was issued by attending doctor, this portion can be omitted)

NATURE OF ILLNESS (Final Diagnosis)

NATURE OF PROCEDURE DONE, if any. (Please describe fully)

I certify to the best of my knowledge and belief that the information provided by me in support of the claim is true and correct.
I further agree that audits/checks may be conducted for this claim.

NAME OF ATTENDING PHYSICIAN:	**LICENSE NO.:**	**CLINIC ADDRESS:**	**CONTACT NO.:**
(Signature Over Printed Name) / Date Signed			

FOR INTELLICARE USE ONLY

☐ **With Lacking Requirements**

_____
_____
_____

☐ **Denied/Disapproved**
Reason/s: _____

_____
_____

REMARKS:

_____
Evaluated by:
(Signature Over Printed Name) / Date Signed