MEDOCare Health Systems, Inc.
7th Floor EU State Tower
30 Quezon Avenue, Quezon City
Tel. Nos. 742-18-19 loc. 125; 742-9750 Telefax: 732-44-15

REIMBURSEMENT CLAIM FORM Claim No.: ____________________

[ ] **Group / Corporate Plan** [ ] **Individual / Family Plan** **Others:** ____________________

Principal Member's Information

Name: (First) (Middle) (Last)	Birthdate: (mm-dd-yy) Sex: [ ] Male [ ] Female
Home Address (No., Street, Municipality, City, Province):	Tel. No.: (Home): ________ (Office): ________
Employer's / Company Name:	

Patient's Information

Name: (First) (Middle) (Last)	Birthdate: (mm-dd-yy) Sex: [ ] Male [ ] Female

Patient's Relationship to the Principal Member:
[ ] Self [ ] Spouse [ ] Son/Daughter [ ] Parent [ ] Brother/Sister [ ] Others: ________

Nature of Availment / Claim

[ ] Outpatient	[ ] In-patient / Confinement	[ ] Others: ________

Reason for Filing Reimbursement Claim:

____

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Checklist of Claim Supporting Documents ***(Original Copies Required)***

A. Out-patient Services (For consultation or Emergency Room Treatment)

- Official Receipt issued by the Hospital and/or the Diagnostic Center
- Official Receipt issued by the Doctor for Professional Fees
- Medical Certificate issued by the Attending Physician

B. Inpatient / Confinement

* Clinical Abstract
* Official Receipt issued by the Hospital
* Official Receipt issued by the Doctor/s for Professional Fees
* Hospital's Statement of Account and Charge Slips

A. In addition to the above checklist, the following supporting documents should be submitted depending upon the nature of the claim:

Nature of Claim	***Supporting Documents***	
* Surgical Cases	[/] Operative Record	[/] Histopath Report (if applicable)
* Maternity Availments	[/] DR / OR Report	[/] Certificate of Live Birth (if applicable)
* Others	[/] Additional Documents which may be required as deemed necessary	

Declaration

I, the undersigned, declare that all foregoing information is true and that I have submitted all the required documents relevant to this claim, and the amounts claimed are herein as lawfully due to me under the terms, conditions and exceptions of my health care agreement.
Should I furnish incomplete documents, I agree to submit the additional requirements within fifteen (15) days from receipt of written notice / or advice through telephone call or within six (6) months from the date of availment of benefits. Failure to do so shall automatically invalidate the claim.
I am also fully aware that processing of said claim shall commence only upon completion of all the required supporting documents.
I am also fully aware that MEDOCARE reserves the right to examine the member whose injury or sickness is the basis of the reimbursement of the claim as often as it may be reasonably required during the pendency of the claim in question.

________ Date Signed

________ Signature over Printed Name of Claimant
(Principal Member / Dependent of Legal Age)

Authorization From the Patient to Furnish Medical/Other Related Information

I hereby authorize any hospital, physician or other person who has examined or treated me to furnish Medocare or a representative thereof, any and all information with respect to any illness, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records. A photographic copy of this authorization shall be as valid as the original.

________ Date Signed

________ Signature over Printed Name of Claimant
(Principal Member / Dependent of Legal Age)