Maxicare Healthcare Corporation

Claims Department, 4th Floor Maxicare Tower, 203 Salcedo Street, Legazpi Village, Makati City
Trunkline: (632)908-6900, Reimbursement Claims Department: (632)553-8833
E-mail: reimbursement@maxicare.com.ph

CLAIMS REIMBURSEMENT FORM

INSTRUCTIONS: *Please fill out this form and attach all original documents. This form should be submitted to Maxicare Healthcare Corporation within 30 days from the date of availment ; otherwise, reimbursement of claim(s) declared in this form will be forfeited. Please ensure that all pertinent information are completely accomplished.*

MEMBER GENERAL INFORMATION

(To be accomplished by the patient/member/representative)

Patient Name: _____ Patient Maxicare ID No.: C 0 1 2 5 1 - X X X X X X X X X X X X

Company: _____ Contact No. of the Patient: _____

Home Address: _____

Principal Member Name: _____

Mobile No. of the Principal *(Required)* : _____ Email Address of Principal: _____

CLAIM TYPE (please check):

- ☐ Out Patient (OP)
- ☐ In Patient (IP)
- ☐ Out Patient Medicines
- ☐ Maternity
- ☐ Dental
- ☐ Optical

REPORT OF THE ATTENDING PHYSICIAN

(To be accomplished by the attending Physician. This will serve as a Medical Certificate if duly certified and signed by the Physician)

Hospital/Clinic: _____

Address: _____

Name of Attending Physician: _____ Contact No.: _____

Type of Availment of the Patient:

- ☐ Emergency
- ☐ Elective

Availment/Admission Date of the Patient: _____

Discharge Date of the Patient: _____

Brief clinical and history and pertinent physical findings of the patient: _____

Final diagnosis of the patient:

Procedure(s) done *(if any)* :

IMPORTANT: *I swear on my professional oath that all declarations and statements mentioned in this document/form are correct and accurate. I further agree and understand that declarations for the claim(s) stipulated in this form may be subject to audit if deemed necessary by Maxicare Healthcare Corporation.*

Signature Over Printed Name of the Physician	Specialization	License Number	Date Signed

BASIC REQUIREMENTS

IMPORTANT REMINDER: *Maxicare Healthcare Corporation reserves the right to require additional documents to justify payment of claim(s). Failure to submit complete requirements within the 30-day filing period will lead to disapproval of claim(s). Submission of ORIGINAL COPY of documents is required. All documents submitted relative to the claim(s) shall become property of Maxicare and will no longer be returned.*

OUT PATIENT

1. Fill out the Claims Reimbursement form.
2. Medical Certificate indicating the diagnosis and procedure(s) done (if any).
3. Original BIR registered Official Receipt(s) with TIN.
4. Charge Slips or detailed itemized/breakdown of charges (charges per item paid).
5. Police report for cases of assault and vehicular accidents.

IN PATIENT

1. Fill out the Claims Reimbursement form.
2. Medical Certificate indicating the diagnosis and procedure(s) done (if any).
3. Original BIR registered Official Receipt(s) with TIN.
4. Statement of Account (summary of Hospital Bill charges).
5. Charge Slips or detailed/itemized breakdown of charges (charges per item paid).
6. Police report for cases of assault and vehicular accidents.
7. Operative report (for surgical cases).
8. Clinical Abstract/History.
9. Certification of non-availability of medicines from hospital pharmacy and original prescriptions signed by the attending physician (for IP medicines bought outside the hospital).

MATERNITY

1. Fill out the Claims Reimbursement form.
2. Medical Certificate indicating the diagnosis and procedure(s) done (if any).
3. Original BIR registered Official Receipt(s) with TIN.
4. Statement of Account (summary of Hospital Bill charges).
5. Charge Slips or detailed/itemized breakdown of charges (charges per item paid).
6. Operative report (for surgical cases).
7. Clinical Abstract/History.
9. Certification of non-availability of medicines from hospital pharmacy and original prescriptions signed by the attending physician (for IP medicines bought outside the hospital).

OPTICAL

1. Fill out the Claims Reimbursement form.
2. Medical Certificate indicating the diagnosis.
3. Original BIR registered Official Receipt(s) with TIN.
4. Prescription for eye glasses or contact lens (with name of patient, date, eye grade, name of doctor, license number, and TIN).
5. Detailed/Itemized breakdown of charges.

DENTAL

1. Fill out the Claims Reimbursement form.
2. Medical Certificate indicating the diagnosis and procedure(s) done, if any, including tooth number.
3. Original BIR registered Official Receipt(s) with TIN.
4. Detailed/Itemized breakdown of charges.

OUT PATIENT MEDICINES

1. Fill out the Claims Reimbursement form.
2. Medical Certificate indicating the diagnosis.
3. Original BIR registered Official Receipt(s) with TIN.
4. Detailed/Itemized breakdown of charges.
5. Prescription for medicines purchased (with date, name of patient, prescribing doctor, license number, TIN, and details of medicines - name, dosage, and quantity).

IMPORTANT: *I agree and understand that personal or excess charge(s) shall be subject to off-setting against the member's reimbursable claim. Personal or excess charges are non-coverable availments of the member based on the account's/member's existing healthcare program, but were initially accommodated and paid for in advance by Maxicare Healthcare Corporation. By signing below, I hereby agree to the terms and conditions contained in this Claims Reimbursement Form and related documents.*

TOTAL AMOUNT OF CLAIM(S):

Signature Over Printed Name of the Claimant	Date Filed