CLR – FO – 025
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MediCard Philippines, Inc.
8th Floor, The World Centre Bldg., 330 Sen. Gil Puyat Avenue , Makati City, 1200
Telephone No.: 884-9999 / **Fax Nos**.: 810-3855; 848-6454
E-mail: inquiry@medicardphils.com /**Website:** www.medicardphils.com

RxER REIMBURSEMENT CLAIM FORM

Kindly fill out ALL information with ✓marks

✓**DATE FILED :** _____ ✓**TYPE OF CLAIM : OUT PATIENT ☐ MFA ☐**

✓**PATIENT'S NAME :** _____ ✓**RxER MEMBER ID No. :** _____
GIVEN NAME , MI, LAST NAME

✓**NAME OF GUARDIAN** ***(IF PATIENT IS A MINOR) :*** _____
GIVEN NAME, MI, LAST NAME

✓**HOME ADDRESS :** _____ ✓**CONTACT No.:** _____

✓**HOSPITAL NAME:**_____ ✓**E-MAIL ADDRESS:**_____

✓**DATE OF MEDICAL TREATMENT / CONFINEMENT** _____ ✓**TOTAL AMOUNT OF CLAIM : P** _____

**** Please make CHECK payable to : (please check appropriate box)**
☐ Patient ☐ Guardian ☐ Others: *pls.specify:*_____

ATTENDING PHYSICIAN'S REPORT

In lieu of MEDICAL CERTIFICATE, please have this portion accomplished fully by your ATTENDING DOCTOR

CHIEF COMPLAINTS: _____

LABORATORY OR DIAGNOSTIC TEST REQUESTED: _____

FINAL DIAGNOSIS BASED ON TEST RESULTS IF ANY: _____

PROCEDURE DONE (IF ANY) : _____

I certify to the best of my knowledge and belief that the information provided by me in support of the claim are true and correct.

_____ _____
SIGNATURE OF ATTENDING DOCTOR OVER PRINTED NAME **DATE**
SPECIALIZATION : _____
LICENSE No.: _____

PLEASE CHECK APPROPRIATE BOX FOR PREFERRED MANNER OF RELEASE OF CHECK AND / OR MEMO :

☐ FOR PICK UP **☐ THRU COURIER / MAIL (PLEASE PROVIDE MAILING ADDRESS)** **☐ THRU ACCOUNT OFFICER / BROKER**
MAILING ADDRESS: _____
_____

CONSENT

In compliance with Republic Act 10173 also known as the Data Privacy Act of 2012, we need your Consent to allow us to collect and process your information. We will only disclose and share your information with our COMPANY, its officers, directors, employees, and/or other authorized agents/ representatives who may also be responsible in rendering our services to you. Withholding or withdrawal of such Consent shall relieve us from our obligation to deliver the appropriate services to you. You are afforded with certain rights and protection in accordance with the said Act and you may visit www.medicardphils.com/privacy or email privacy@medicardphils.com for more information.

By signing below, we will consider that you agree to give your Consent to us. If in case, applicant/patient/claimant is unable to sign, his/her authorized representative may warrant that he/she has full authority to sign on behalf of the applicant/patient/claimant.

✓_____ ✓_____
SIGNATURE OF PATIENT/GUARDIAN OVER PRINTED NAME AND RELATIONSHIP (IF PATIENT IS UNABLE TO SIGN) **DATE**

Please complete the following BASIC REQUIREMENTS for REIMBURSEMENT
(Failure to do so will invalidate your claim for reimbursement)
**** MediCard reserves the right to request for additional documents needed for further evaluation of claim****

For Emergency cases (Out Patient) :	***For Member Financial Assistance:***
⌗ Fully accomplished MediCard RxEr Reimb. Claim Form (downloadable @ our website) ⌗ Cover letter / Incident report ⌗ Medical Certificate stating chief complaints and final diagnosis ⌗ Emergency room record ⌗ Original Official Receipts ⌗ Results of laboratory / diagnostic examination ⌗ Operative Technique(for OP surgical cases) ⌗ Police report (for accidents) ⌗ Itemized breakdown of charges	⌗ Fully accomplished MediCard RxEr Reimb. Claim Form (downloadable @ our website) ⌗ Fully accomplished First Life Death Claim Form (downloadable @ our website) ⌗ Certified True Copy of Death Certificate ⌗ Photocopy of any valid ID of the deceased ⌗ Duly Notarized Affidavit of Next of Kin / Marriage Contract ⌗ Duly Notarized Attending Physician's Statement Form ⌗ (in the absence of the APR , we require Morgue or Post Mortem Examination) ⌗ Police Report (accidental death) ⌗ Copy of Autopsy report (for death of unknown causes)

GRACE PERIOD FOR FILING OF CLAIMS	-	30 days from date of discharge / medical treatment
PAYMENT PROCESSING FOR OP ER CASES	-	15 days from date of receipt of COMPLETE documents
PAYMENT PROCESSING FOR MFA CLAIMS	-	90 days from date of receipt of COMPLETE documents

Please bring one (1) valid I.D and personally claim your approved reimbursement check at the 15th floor of The World Centre Bldg 330 Sen Gil Puyat Ave. Makati City.