Maxicare

Claims Department, Trunkline: (632)908-6900 loc 1420, 1421, 1422
E-mail: reimbursement@maxicare.com.ph; reimbursement_servicedesk@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*** *or as agreed in the Service agreement, otherwise, reimbursement of claim(s) declared in this form will be forfeited. Please ensure that all pertinent information are completely accomplished.*

MEMBER GENERAL INFORMATION *(Required)*

(To be accomplished by the patient/member/representative. The information below is important and required so we can communicate the status of your reimbursement.)

Patient Name:_____

Company: _____

Patient ID No:

1	1	6	8	0	1	1	0							

Contact number of the patient: _____

Principal Member Name:_____
(Payment will be credited through the Principal member)

Email Address of Principal:_____

Mobile No. of the Principal:

0	9			--							

CLAIM TYPE (please check): ☐ Out-patient (OP) ☐ In-patient (IP) ☐ OP medicines ☐ Maternity ☐ Dental ☐ Optical

REPORT OF THE ATTENDING PHYSICIAN *(Required)*

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

Hospital/Clinic:

Name of Attending Physician:

Contact Number:

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: *(not required for dental claims)*

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* ***15 days*** *from receipt of request shall 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)/Sales Invoice 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)/Sales Invoice 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.

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)/Sales Invoice with TIN.
4. Statement of Account (Summary of Hospital Bill charges).
5. Charge Slips or detailed itemized/breakdown of charges (charges per item paid)

OPTICAL
1. Fill out the Claims Reimbursement form.
2. Medical Certificate indicating the diagnosis.
3. Original BIR registered Official Receipt(s)/Sales Invoice 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 procedure(s) done, including tooth number.
3. Original BIR registered Official Receipt(s)/Sales Invoice 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)/Sales Invoice 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

For purposes of this reimbursement claim, 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.

To ensure the accuracy of the details provided to Maxicare Healthcare Corporation for purposes of evaluating this reimbursement claim, I hereby irrevocably authorize Maxicare Healthcare Corporation, being my healthcare and maintenance services provider, as my attorney-in-fact to examine and obtain copies of my and/or my dependents' medical records as well as any information relating to my (and/or my dependents') hospitalization, consultation, treatment or any other medical advice; and (b) disclose such information to Maxicare Healthcare Corporation, and/or its duly authorized representative/s, sub-contractors and/or brokers, if necessary, and my employer and/or its authorized representatives, upon request. In lieu of the original record, a certified photocopy will be honored as the original.

I agree and understand that in the course of providing services to me, MAXICARE shall engage the services of, and/or interact with, other third parties, such as, but not limited to its parent company, affiliated companies, subsidiaries, financial advisors, affiliated third parties or independent/non-affiliated third parties and service providers, whether local or foreign (collectively referred to as "Representatives"). In connection with the foregoing, I hereby irrevocably authorize MAXICARE and its Representatives, being my healthcare maintenance services provider, as my attorney-in-fact to:

a. *Obtain, collect, examine, process, and store my and/or my dependents personal information, including sensitive personal information and privileged information, medical records, or any other information relative to my and my dependents' hospitalization, consultation, and treatment or any medical advice in connection with the benefit/claim availed under the Service Agreement, as may be deemed necessary by MAXICARE.*

b. *Disclose the aforementioned information to my employer, its representatives, agents and brokers, MAXICARE and its Representatives, including the service providers which will perform the services contemplated in the agreement, for any legitimate business purpose as MAXICARE may deem appropriate, including but not limited to outsourced processing of MAXICARE transactions, profiling or historical statistical analysis, providing advice or information which MAXICARE and its Representatives believe may be of interest to me, to effectively administer or manage my account, enhance customer services, or to communicate with me for any purpose.*

Processing would include both manual and automated handling of personal information and storage and data transfers using physical methods as well as electronic via information and communications systems employed by MAXICARE and its Representatives. I retain the right to be informed, to object, access, complain, and rectify, to request for filtering of certain information, and to the corresponding damages in case of violation of your rights within the corresponding limitations as set forth in the pertinent laws. The authorities herein provided shall be valid and existing during the term of the agreement, including any extensions thereof, and until necessary for the establishment, exercise or defense of any claims arising from the said agreement.
For purposes hereof, I hereby warrant that I have been duly authorized by my dependent/s to sign and execute any and all documents and make representations for and in his/their behalf as if the same were personally done by him/them. I understand my rights and obligations pursuant to the Data Privacy Act and its implementing rules and regulations, as the same may be amended. I further agree to hold MAXICARE and its Representatives free and harmless from and against any and all suits or claims, actions, or proceedings, damages, costs, and expenses, including attorney's fees, which may be filed, charged, or adjudged against MAXICARE or any of its directors, stockholders, officers, employees, agents, or Representatives in connection with or arising from the use, processing and disclosure by MAXICARE or its Representatives of the aforementioned information.

_____
Signature Over Printed Name of the Claimant **Date Filed**

TOTAL AMOUNT OF CLAIM/S: