	Main Office: 7/F #108	=	ufino St. Leg	aspi Village	Makati City		
Intellicare	Trunkline: 789-4000/902-3400 Homepage: http://www.intellicare.com.ph						
YOUR INTELLIGENT HEALTH CHOICE		·					
REIMBURSEMENT REQUEST FORM (IMPORTANT: Please fill up this form and attach the required documents)							
PATIENT'S NAME: PRINCIPAL MEMBER'S NAME:							
ACCOUNT NO.:	COMPANY:			E-MAIL ADD:			
CONTACT NUMBERS:	HOSPITAL/CLINIC:			DATE OF TRE	EATMENT:		
REASON FOR REIMBURSEMENT:	Cash Basis		☐ Non acc	redited provi	ders		
	Emergency Case		Others	·			
TYPE OF CLAIM: OUT-PATIENT	IN-PATIENT	MATERNITY AS	SISTANCE	OPD ME	DICINES/OPTICAL/DENTAL		
* PLEASE REFER AT THE BACK FOR REQUI	REMENTS NEEDED.						
NOTE:							
Claims will be processed upon submission of complete requirements.							
 All documents submitted will be returned in case of lacking or non-submission of any required documents depending on type of claim. 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 Ir	tellicare within 10 working da	ays upon receipt of advice	ce, otherwise, yo	ou are waiving	your right for said claim.		
		EMBER UNDERTAK					
For purposes of evaluating your medical claim under the Health Service Agreement, Asalus Corporation ("Intellicare") seeks your authorization, consent, and grant of access to and/or collection, processing, and disclosure of your personal information, such as you medical records including, but not limited to, your age, residence, past medical history, results of medical examinations, diagnosis, abstracts, treatments, utilization (collectively referred to as "Information") and to be furnished copies thereof.							
All Information furnished to, and/or collected by Intellicare shall be used and processed by all personnel, subcontrators, and medical facilities connected with Intellicare including, but not limited to, its doctors, nurses, and consultants, and Intellicare may disclose such Information to its agents and affiliates, including your							
employer,, your employer's broker,, and/or the principal member to which you are a dependent. After every evaluation, Intellicare shall generate reports from the Information collected. For this purpose, your Information will be stored by Intellicare for a period of							
() years, without prejudice to your rights to reasonable access to, upon demand, and correction of your							
Information, as well as your right to lodge a complaint before the National Privacy Commission. Intellicare has ensured the protection of your Information, in accordance with its privacy policy. Should you wish to access, correct or update your Information, or if you have any inquiries, please write us at Asalus Corporation, 7th Floor, Feliza Building, 108 V.A. Rufino St., Legaspi Village, Makati City, addressed to our Data Protection Officer, Mr							
I,, have read the Information and the ways in which said Information		• , ,			processing, and disclosure of my to what information I provide and		
that withholding or falsifying information might my medical claim and for billing purposes							
inaccurate; and (e) if, in exceptional circumstan	ces, access is denied for any	legitimate purposes, th					
I hereby authorize: (a) (hospital or doctor's nam		ie by Intellicare. n and related documents	s, including a su	ımmary thereof	derived from laboratory services		
and medical consultations to Intellicare or its including a summary derived from said laborat							
member to which I am a dependent, if app	,	my medical claim; (iv) lr consultants.	ntellicare's perso	onnel, subcontr	actors, doctors, nurses, and		
I shall hold Intellicare, and its officers, directors,	stockholders, employees, co	nsultants, and doctors f					
or liabilities arising from or connected with the	ne collection, processing and	release or disclosure or records.	t the my Informa	ation including,	but not limited to, my medical		
By signing this form, I likewise acknowledge tha not explicitly covered by the provisions of the He							
true and correct to best of my knowledge and	•	to access information a ig my medical claim.	nd be furnished	copies of my n	nedical records for purposes of		
CONFIDENTIALITY NOTICE: Intellicare will no	t disclose any information ob	tained in the conduct of					
the provisions of the Data Privacy Act. Further, Intellicare guarantees that information that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law.							
SIGNATU	RE OF CLAIMANT	-	DATES	SIGNED			
(Signature Over Printed Name)							
ATTENDING PHYSICIAN'S REPORT							
	our medical certificate if full		=	-			
(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.							
	further agree that audits/ch	-	ed for this clair	m.			
NAME OF ATTENDING PHYSICIAN:	LICENSE NO.:	CLINIC ADDRESS:			CONTACT NO.:		
(Signature Over Printed Name) / Date Signed	<u> </u>						
FOR INTELLICARE USE ONLY							
☐ With Lacking Requirements		REMARKS:					
		l					
☐ Denied/Disapproved							
Reason/s:		l					
		l					
		l					
Evaluated by:		l					
(Signature Over Printed Name) / I	Date Signed	i					

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

OR#	DATE	AMOUNT	ESTABLISHMENT
Ο ΙΛπ	DAIL	AWOUNT	LOTABLISHIVILIAT