Intellicare
YOUR INTELLIGENT HEALTH CHOICE

Main Office: 7/F #108 Feliza Bldg. V.A. Rufino St. Legaspi Village Makati City
Trunkline : 789-4000/902-3400
Homepage : http://www.intellicare.com.ph

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 TREATMENT:**

REASON FOR REIMBURSEMENT: ❑ Cash Basis ❑ Non accredited providers ❑ Emergency Case ❑ Others

TYPE OF CLAIM: ❑ **OUT-PATIENT** ❑ **IN-PATIENT** ❑ **MATERNITY ASSISTANCE** ❑ **OPD MEDICINES/OPTICAL/DENTAL**

PAYMENT OPTION FOR CREDITING: Preferred bank: ❑ Metrobank ❑ BPI ❑ BDO ❑ Security Bank ❑ Other Banks _____
Bank details: Account name _____ Account no. _____

**** PLEASE REFER AT THE BACK FOR REQUIREMENTS NEEDED.***

NOTE:

1. Claims will be processed upon submission of complete requirements.
2. All documents submitted will be returned in case of lacking or non-submission of any required documents depending on type of claim.
3. 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 Intellicare within 10 working days upon receipt of advice, otherwise, you are waiving your right for said claim.

PATIENT MEMBER UNDERTAKING

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 above information and understand the following: (a) the reasons for the collection, processing, and disclosure of my Information and the ways in which said Information may be used, and I agree to said usage and disclosure; (b) it is my choice as to what information I provide and that withholding or falsifying information might act against the best interests of my assessment; (c) the Information I provide will be processed for the evaluation of my medical claim and for billing purposes thereof; (d) I can access my Information on request and if necessary, correct the Information that I believe to be inaccurate; and (e) if, in exceptional circumstances, access is denied for any legitimate purposes, the reasons for this and possible remedies will be made available to me by Intellicare.

I hereby authorize: (a) (hospital or doctor's name) to release any Information and related documents, including a summary thereof derived from laboratory services and medical consultations to Intellicare or its authorized representatives for the evaluation of my medical claim; and (b) Intellicare to release such Information, including a summary derived from said laboratory services and medical consultations to: (i) my employer/principal; (ii) my employer's broker; and (iii) the principal member to which I am a dependent, if applicable, for the evaluation of my medical claim; (iv) Intellicare's personnel, subcontractors, doctors, nurses, and consultants.

I shall hold Intellicare, and its officers, directors, stockholders, employees, consultants, and doctors free and harmless from all claims, suits, charges, fees, damages or liabilities arising from or connected with the collection, processing and release or disclosure of the my Information including, but not limited to, my medical records.

By signing this form, I likewise acknowledge that all of the procedures indicated in this form had been done. I promise to pay for any procedure and professional fees not explicitly covered by the provisions of the Health Service Agreement. Furthermore, by virtue of this undertaking, I hereby certify that the foregoing statements are true and correct to best of my knowledge and hereby authorize Intellicare to access information and be furnished copies of my medical records for purposes of evaluating my medical claim.

CONFIDENTIALITY NOTICE: Intellicare will not disclose any information obtained in the conduct of the evaluation except as otherwise provided herein, subject to 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.

_____ **SIGNATURE OF CLAIMANT**
(Signature Over Printed Name)

_____ **DATE SIGNED**

ATTENDING PHYSICIAN'S REPORT

(This will serve as your medical certificate if fully signed/certified by attending doctor)
(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.
I further agree that audits/checks may be conducted for this claim.

NAME OF ATTENDING PHYSICIAN:	**LICENSE NO.:**	**CLINIC ADDRESS:**	**CONTACT NO.:**
(Signature Over Printed Name) / Date Signed			

FOR INTELLICARE USE ONLY

❑ **With Lacking Requirements**

_____
_____
_____

❑ **Denied/Disapproved**

Reason/s: _____
_____
_____

_____
Evaluated by:
(Signature Over Printed Name) / Date Signed

REMARKS:

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