CLAIMS REIMBURSEMENT FORM

INSTRUCTIONS: *For faster processing of your reimbursement claim, please submit your documents at* [**https://membergateway.maxicare.com.ph**](https://membergateway.maxicare.com.ph).
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 is completely accomplished..*

M E M B E R G E N E R A L I N F O R M A T I O N *(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:____

Email address of the Principal member:___________________________

Hospital/Clinic/Provider where the member availed:

____

Maxicare ID number:

1	1	6	8											

Mobile No. of the Principal:

0	9			--							

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

B A S I C R E Q U I R E M E N T S

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.*

MANDATORY SUPPORTING DOCUMENT REQUIREMENTS:

1. Charge slips or detailed itemized breakdown of charges (charges per item paid)
2. BIR-registered Sales Invoice, Service Invoice or Cash Invoice with TIN.
   Please note that Official Receipt with no stamped "Invoice", Acknowledgement receipt, provisional receipt, trust receipts are not acceptable since these are not valid for claiming Input VAT.

ADDITIONAL REQUIREMENTS PER CLAIM TYPE

Inpatient	Out-patient	Optical	Dental	Out-Patient Medicine
1.Medical Certificate indicating the diagnosis & procedure done 2. Statement of Account 3. Police Report (for cases of assault & vehicular accidents	1. Medical Certificate indicating the diagnosis & procedure done 2. Police Report (for cases of assault & vehicular accidents	1. Prescription for eyeglasses or contact lens (with name of patient, date, eye grade,name of doctor, license number, TIN)	1. Dental certificate indicating the procedure done, including the tooth number (not required if the breakdown of charges already indicates the procedure & tooth number)	1. Medical Certificate indicating the diagnosis. 2. Prescription for medicines purchased (with date, name of patient, prescribing doctor, license number, TIN and details of medicines - name, dosage, quantity.

FOR ACCOUNTS UNDER MRC:

1. ***Customer Information form (downloadable at Maxicare website: www.maxicare.com.ph or at Member Gateway: https://membergateway.maxicare.com.ph***
2. ***Copy of valid ID with signature***

IMPORTANT

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.

(APPLICABLE TO MRC ACCOUNTS*) I hereby authorize Equicom Savings Bank ("EqB") to load the reimbursement amount to my Maxicare Card based on the instructions of Maxicare Healthcare Corporation and hereby renders EqB free and harmless from any liabilities that may arise relative to this authority. By signing below, I acknowledge having read, understood and agree to be bound by the Terms and Conditions regarding the Maxicare reimbursement claim contained in this form as well as the Terms and Conditions governing the Cash Card feature of this Card as stated in the Customer Information Form.*

TOTAL AMOUNT OF CLAIM/S:

______________________________ ______________________

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