Maxicare

E-mail:customercare@maxicare.com.ph

CLAIMS REIMBURSEMENT FORM (for MRC)

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's card)

Email Address of Principal:_____

Mobile No. of the Principal:

0	9			--							

Note: To avoid delays in reimbursement, submit the Customer Information Form (CIF) requirements along with your reimbursement. The CIF is a one-time requirement for Maxicare's reimbursement process. If you have not completed the CIF, you may complete your CIF online at https://membergateway.maxicare.com.ph/ and send the original signed CIF to Maxicare.

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.

(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.*

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

TOTAL AMOUNT OF CLAIM/S:

TERMS AND CONDITIONS

1. **Definition of Terms**

   a) Maxicare Card ("Card"). This Card is a personal and non-transferable health card distributed by Maxicare to its members as Maxicare membership ID. At the same time, said Card has a cash card feature which may be loaded with funds through the EqB-Medilink XP facility. As a cash card, it functions both as an ATM and purchase card to the extent of the maximum value/amount loaded into the Card, subject to the limits set forth by EqB.

   The amount loaded into the Card shall not earn interest, and shall not be subject to rewards or other similar incentives convertible to cash, nor be purchased at a discount. It is understood that the Card is not a deposit account; hence, it is not insured with the Philippine Deposit Insurance Corporation.

   b) Automated Teller Machine (ATM). A designated teller machine that dispenses cash and provides account related services once the Card is inserted and the correct Personal Identification Number (PIN) associated with the Card is entered and verified by the machine.

   c) Electronic Data Capture (EDC) Terminal. A Point of Sale (POS) terminal that reads the card details on the Card magnetic stripe when the card is swiped through the terminal, without the need of a manual imprinter and/or having merchant's representatives manually enter the information.

   Ang Maxicare Card (Card) ay isang Prepaid card na mula sa Equicom Savings Bank (EqB) sa pamamagitan ng MediLink. Ang Card ay nakapangalan sa taong nagmamay-ari nito at hindi maaaring ipagamit sa iba. Ito ay magagamit na pangwithdraw ng cash mula sa ATM at pambili ng anuman hanggang sa buong halaga na napakaloob dito. Ito ay hindi kumikita ng interest o magagamit na pambali ng may anumang diskwento. Hindi ito ordinaryong deposito sa bangko kaya hindi ito nakaseguro sa Philippine Deposit Insurance Corporation.

2. **Responsibilities of the Cardholder -** The Cardholder should sign the Card immediately upon receipt thereof. The Cardholder should remember his PIN and shall be fully responsible for the security, custody and possession of the Card and PIN as well as any transaction made using the said Card. Further, it is the responsibility of the Cardholder to report lost/stolen Card immediately to the Maxicare Hotlines or Equicom 24/7 Customer Service.

   The Cardholder undertakes to provide the necessary KYC documents and information required or which will be required by EqB.

3. **Loss or Theft of Card** – In case the Card is lost or stolen, the Cardholder shall immediately report it to Equicom 24/7 Customer Service or Maxicare Customer Service. Likewise, the Cardholder shall submit a duly notarized Affidavit of Loss as a pre-requisite for the Card replacement. However, purchases and ATM transactions made prior to reporting to Equicom 24/7 Customer Service or Maxicare shall be for the sole account of the Cardholder. Further, as the Cardholder is responsible for the security of the Card and the PIN, any unauthorized withdrawals shall be charged to the Cardholder as long as the Card used matches with the PIN registered in EqB's system. Applicable fees shall be charged accordingly for the replacement of the Card. The remaining balance left on the declared lost Card shall be transferred to the new/replacement Card. The Cardholder shall render EqB and Maxicare free and harmless for any losses due to theft or fraud that have occurred prior to the reporting required herein.

4. **Expiry of the Card –** The Card shall be valid until the last day of the contract with Maxicare. Following the last day of the contract with Maxicare, the cash card feature of said Card shall also be terminated. The period may be shortened: (a) when the Cardholder voluntarily cancels and surrenders the Card to EqB or (b) when Maxicare cancels the Card. The Card shall be allowed for renewal upon approval of Maxicare, and in compliance with EqB's requirements and terms and conditions. Following the renewal, a new Card with a different Card number and PIN shall be issued to the Cardholder.

   EqB shall terminate the cash card function of the Card due to zero card value, and may be reactivated upon the loading of funds.

5. **Card Acceptability –** The Card functions as a regular ATM Card such that the Cardholder can access their account at EqB ATMs or any Megalink, Expressnet and Bancnet ATMs in the Philippines thru PIN verification. It also functions as a purchase card up to the value loaded into the Card and is honored at Bancnet merchants nationwide. Each time the Card is used at ATMs or participating merchants, the transaction amount is immediately deducted from the remaining value of the Card. It is the responsibility of the Cardholder to keep track of the available balance on the Card. Merchants will not be able to determine the available balance on the Card. The available balance and card transaction details can be obtained at www.equicomsavings.com or via Equicom 24/7 Customer Service, internet banking quick inquiry or via the EqB Mobile Banking (text "INQ <card number that starts with 116801> to 0918-818-EQUI (3784)".

6. **ATM Transaction Fees-**Transaction fees shall be imposed on the following ATM transactions using the Card: (a) applicable fees shall apply for every successful ATM transaction done at any ATM other than EqB ATMs in the Philippines. The said ATM transaction fees shall be deducted immediately from the remaining card balance and shall be subject to change without prior notice.

7. **Transaction Receipt –** For purchases using the Card, the transaction receipt shall be provided by the merchants after every successful POS transaction. The Cardholder shall sign the transaction receipt and retains a copy thereof. An ATM transaction receipt is likewise provided for every ATM transaction. It is the responsibility of the Cardholder to monitor and review all his transactions. Disputed transactions should be reported immediately within 10 calendar days from transaction date; otherwise, the transactions will be considered as valid.

8. **Denied/Declined Transaction** – A transaction may be declined/denied based on the following: (a) Card has no sufficient balance; (b) POS terminal at the merchant establishment is off-line; or (c) the Card is either suspended or blocked. The Cardholder expressly holds EqB, Maxicare, and Medilink free and harmless from any liability for these denied/declined transactions. The Cardholder shall be responsible for ascertaining the remaining balance of contained in the Card.

9. **Erroneous Loading- T**he Cardholder hereby authorizes EqB, through the instructions of Maxicare to automatically debit an amount erroneously loaded into the Card. The cardholder acknowledges that any issues that may arise in relation to said erroneous loading shall be taken up with Maxicare. The Cardholder shall render EqB free and harmless for this debiting.

10. **Issuance of Manager's Check and Transfer of Funds** - The Cardholder authorizes EqB to execute the instructions of Maxicare and automatically debit the remaining balance in the Card, if any, and issue a Manager's Check or transfer funds to new EqB card of member covering the remaining balance in favor of the Cardholder in the following instances:

    - Termination of employment/resignation/separation of the Cardholder from Maxicare's Client.
    - Cancellation of the Card due to the non-renewal of the Maxicare Health plan by the client of Maxicare or cancellation of the Card by Maxicare for any other reasons.
    - Expiration of the Card as stated in paragraph 4.
    - In cases when withdrawal of funds through ATM and purchase through POS is not feasible.
    - In case the card was reported lost or stolen as stated in paragraph 3, and no renewal or card replacement was made.
    - In case the cash card feature was suspended due to Cardholder's failure to comply with the requirements of EqB.

    The Cardholder acknowledges that for the issuance of a Manager's Check, a processing fee, in the amount as applicable and as posted in the bank's website shall be deducted from the remaining balance in the Card. Such processing fee may be subject to change without prior notice to the Cardholder.

    The Cardholder authorizes EqB to release said Manager's Check to Maxicare and the Cardholder shall claim said manager's Checks from Maxicare. The Cardholder shall render EqB free and harmless from any liabilities that may arise in effecting this authority and acknowledges that any possible issues on the remaining balance shall be taken up with Maxicare."

11. **Non-transferability Clause** – The Card is the sole property of Equicom Savings Bank. The cash card privileges and health card functions may be terminated by either EqB and/or Maxicare at any time for whatever cause. The Cardholder agrees to hold EqB and Maxicare free and harmless from any claim for damages arising from such termination

12. **Amendments –** EqB, Medilink, and Maxicare may at any time and for whatever reason, amend, revise or modify this Agreement when deemed necessary and shall inform the Cardholder by publication, posting or any other means that EqB deems proper. Following this, the Cardholder's continuous usage of the Card shall be deemed as acceptance of said amendment/s.

13. **Venue of Action, Attorney's Fees, Damages –** Should judicial action be necessary to enforce this Agreement, or to collect the Cardholder's obligation under this Agreement, venue of all actions shall be in Makati City. In case the account is referred to a collection agency or law firm, Cardholder agrees to pay the cost of collection and attorney's fees.

14. **Separability Clause –** Should any provision of this Agreement be declared unconstitutional, invalid or unenforceable by a court of competent jurisdiction, such declaration shall not affect in any manner whatsoever the constitutionality, validity or enforceability of other provisions.

15. In case of death of the Cardholder, the rules and policies on deceased account holder shall be applicable.

16. **Acknowledgement**- By using the Card, the Cardholder acknowledges having received a copy of, read, understood and agree to be bound by the terms and conditions also set out herein.