REIMBURSEMENT FORM

Part I: To be filled up by the member		
Company Name:	**Filed Date:**	**Filed Amount:**
	Bank name:	
Company Address:	**Bank Account name:**	
	Bank Depository Account Number:	
Patient's Name:	**Member Birthday:**	
Patient's Address:	**Contact Number:**	
Medicare Plus Card Number:	**Email Address:**	

Filling reimbursement information

Date & Time Reported to Medicare Plus:	**Reported to:**

Reason for Reimbursement:

☐ No Accredited Medical Provider in the area.
☐ Emergency case at the nearest accredited hospital.
☐ With Accredited Medical Provider in the area but no accredited Medical Specialist.
☐ Others. Please specify:

Part II: Reference for required document in filing reimbursement

☐ CONFINEMENT	☐ OUT-PATIENT	☐ Emergency
• Original Official receipts (Hospital bill & Professional Fee) • Clinical Abstract with Final Diagnosis • Statement of account • Itemized Breakdown of hospital charges • Operative record (if operation was done) • Police Report (If vehicular accident) • Photocopy of MedPlus ID Card and any valid ID with picture and signature.	• Original Official receipts (Hospital &/or Professional fee) • Medical certificate with diagnosis • Itemized Breakdown of charges • Operative record (if operation was done) • Police Report (If vehicular accident) • Photocopy of MedPlus ID Card and any valid ID with picture and signature.	• Original Official Receipts (Hospital & Professional fee) • Medical Certificate and/or ER Record with Diagnosis • Statement Of Account (S.O.A) • Itemized Breakdown of charges • Photocopy of MedPlus ID Card and any valid ID with picture and signature.

NOTE: Once completed send reimbursement form with required documents via email:
To: reimbursement@medicareplusinc.com **Subject:** Juan Dela Cruz – Reim – Current date

Declaration

I acknowledge that Medicare Plus's liability is limited only to that provided in the Health Care Agreement, and that this claim may be denied by Medicare Plus.
I certify that the information declared in this Reimbursement Form is true and correct to the best of my knowledge, and that all medical documents attached herewith were issued by the Medical Provider based on their medical records.
By signing this form, I/we grant my/our free, voluntary and unconditional consent to the collection and processing of all Personal Data and my/our medical records and other Sensitive Personal Information, relating to me/us/disclosed/transmitted by me/us in person or by my/our authorized agent/representative/s to Medicare Plus and/or any of its authorized agent/s or representative/s, by whatever means in accordance with Republic Act (R.A.) 10173, otherwise known as the "Data Privacy Act of 2012" of the Republic of the Philippines, including its Implementing Rules and Regulations (IRR) as well as all other guidelines and issuances by the National Privacy Commission (NPC).

Name and Signature of Claimant: _____
Date Signed: _____

Part III: Attending Physician's Statement	
Hospital Name:	**Hospital Contact Number:**
Final Diagnosis:	**Procedure (RVU use):**
Laboratory work up: **(Only related to diagnosis)**	**Doctor's Contact Number**
Name of the Doctor:	**Doctor's Specialization:**

Acknowledge Receipt	
Member / Patient Name:	**Received by:**
For inquiries: ***Please Call Claims Department at 09088182190*** **Note:** Reimbursement claims must be submitted within 30 calendar days from the last date of outpatient care, or the date of discharge for inpatient confinement.	**Received Date:**