medicare plus

REIMBURSEMENT FORM

Part I: To be filled up by the member		
Company Name:	**Filed Date:**	**Filed Amount:**
	Bank name **EXCEPT: Gcash, Landbank(payroll) and all Digital Bank :**	
Company Address:	**Bank Account name**	
	Bank Depository Account Number:	
Patient's Name:	**Patient's 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 in a non-accredited hospital.
- ☐ Accredited Medical Provider in the area but no accredited Medical Specialist.
- ☐ Suspended Provider | HMO on Hold
- ☐ Others. Please specify:

Part II: Reference for required document in filing reimbursement

☐ **CONFINEMENT**

- Letter of Authorization (LOA)
- Service Invoice Issued in the name of Medicare Plus, Inc
- Clinical Discharge Summary | Medical Abstract with Diagnosis
- Summary Statement of Account
- Itemized or Detailed Statement of Account
- Operative record (if operation was done)
- Police Report (If vehicular accident).
- Photocopy of Medicare Plus ID Card and any valid ID with picture and signature

☐ **OUT-PATIENT**

- Letter of Authorization (LOA)
- Service Invoice Issued in the name of Medicare Plus, Inc
- Medical Certificate with Diagnosis
- Itemized or Detailed Statement of Account
- Charge slip
- Operative record (if operation was done)
- Police Report (If vehicular accident).
- Photocopy of Medicare Plus ID Card and any valid ID with picture and signature

☐ **Emergency**

- Letter of Authorization (LOA)
- Service Invoice Issued in the name of Medicare Plus, Inc
- Medical Certificate and for ER Record with Diagnosis
- Summary Statement of Account
- Itemized or Detailed Statement of Account
- Charge Slip
- Photocopy of Medicare Plus 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:** Member Name – (Surname, First Name)

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:**

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Acknowledge Receipt	
Member / Patient Name:	**Received by:**
For inquiries: ***Please Call MPI Concierge Trunkline At (09190585858)*** **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:**