Unit 304 Aralco Building, J.P. Rizal Street Poblacion, Makati City
Telephone No.: 809-5360 / **Fax Nos**.: 809-5360
Website: www.amaphil.com.ph

REIMBURSEMENT CLAIM FORM

Please ensure that all pertinent information are completed. This form and original documents shall be submitted to your HR Department <u>within 30 day from the date of availment</u>. Otherwise, reimbursement shall be forfeited

✓**DATE FILED :** ______________ ✓**TYPE OF CLAIM :** ☐ **IN PATIENT** ☐ **OP – CONSULT** ☐ **OP – LABORATORY** ☐ **ER** ☐ **OTHERS:** ____________________

✓**PATIENT'S NAME**

____ ✓**AMAPHIL ID No. :** _____________________________________

GIVEN NAME , MI, LAST NAME

✓**NAME OF PRINCIPAL MEMBER** ***(IF PATIENT IS A DEPENDENT MEMBER) :***

____ ✓**AMAPHIL ID No. :** _____________________________________

GIVEN NAME, MI, LAST NAME

✓**COMPANY NAME :** ____ ✓**OFFICE TEL. No.:**____

✓**E-MAIL ADDRESS :**____ ✓**MOBILE No.:**____

✓**HOSPITAL NAME :**____ ✓**DATE OF MEDICAL TREATMENT / CONFINEMENT** ______________

✓**TOTAL AMOUNT OF CLAIM : P** ____ ____

ATTENDING PHYSICIAN'S REPORT

In lieu of MEDICAL CERTIFICATE, please have this portion accomplished fully by your ATTENDING DOCTOR

CHIEF COMPLAINTS: ____

LABORATORY OR DIAGNOSTIC TEST REQUESTED: ____

FINAL DIAGNOSIS BASED ON TEST RESULTS IF ANY: ____

PROCEDURE DONE (IF ANY) : ____

I certify to the best of my knowledge and belief that the information provided by me in support of the claim are true and correct.

____ ____________________________

SIGNATURE OF ATTENDING DOCTOR OVER PRINTED NAME **DATE**

SPECIALIZATION : __________________________________

LICENSE No.: _____________________________________

WAIVER

I ✓_________________________________, hereby consent to the disclosure by AMAPHIL and its representatives of any or all of my medical utilization / diagnosis to my COMPANY, its officers, directors, employees, and/or other authorized agents/representatives, which may result in the course of providing their medical services to me, as PATIENT. I understand that any information which they may acquire and/or receive relating to the said utilization/diagnosis will no longer be covered as confidential/privileged communication upon execution of this waiver. Thus, I hereby waive any claim of confidential/privileged communication against AMAPHIL, its officers, directors, employees, and/or other authorized agents/representatives, its Medical Service Units/Teams and its Accredited hospital/Clinics, and hereby release them from any liability which may arise as an incident of the said disclosure to my COMPANY.

✓____ ✓____________ ✓_____________________________

SIGNATURE OF PATIENT/EMPLOYEE OVER PRINTED NAME **DATE** **COMPANY NAME**

Please complete the following BASIC REQUIREMENTS for REIMBURSEMENT

(Failure to do so will invalidate your claim for reimbursement)

**** AMAPHIL reserves the right to request for additional documents needed for further evaluation of claim****

STANDARD PAYMENT PROCESSING: 15 working days from date of receipt of COMPLETE documents