AMAPHIL Advanced Medical Access Philippines, Inc.
Better healthcare. Better innovation.

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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 days 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** _____ _____

PLEASE PROVIDE YOUR BANK DETAILS FOR E-TRANSFER
(minimum bank charge of PHP25.00)

Name of Bank: ✔ _____

Account Name: ✔ _____

Account Number: ✔ _____

I certify that the above information is correct. I hereby certify that these hospital expenses have not been previously reimbursed.

Please enclose legible copies of the following documents:

- ☐ Official Receipts *(Original)*
- ☐ Medical certificate to include final diagnosis *(For inpatient and outpatient Laboratory)*
- ☐ Medical abstract; if applicable
- ☐ Doctor's order for laboratory tests
- ☐ Doctor's prescription for outpatient medicines
- ☐ Itemized Statement of Account *(inpatient/confinement)*
- ☐ Police report *(vehicular accident)* / Affidavit of Accident *(for other incidents)*

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