FORTICARE HEALTH SYSTEMS INTERNATIONAL, INC.
502 DY International Building, 1011 Gen. Malvar St.
Cor. San Marcelino St. Malate, Manila 1004
claimsdept.forticare@gmail.com / (02) 5314 2273 loc 115

REIMBURSEMENT REQUEST FORM

(IMPORTANT: Please Fill out this form and attach all original documents)

MEMBER'S NAME:	
MEMBERSHIP ID NO:	**TOTAL AMOUNT OF CLAIM/S:**
E-MAIL ADDRESS:	**CONTACT NUMBER:**
REASON OF REIMBURSEMENT: ☐ CASH BASIS ☐ NON-ACCREDITED PROVIDER ☐ EMERGENCY CASE	
TYPE OF CLAIM: ☐ OUT-PATIENT/ER ☐ IN-PATIENT (EMERGENCY) ☐ IN-PATIENT (ELECTIVE) ☐ DENTAL ☐ OTHERS (please specify): _____	

MEMBER PATIENT UNDERTAKING AND CONSENT FORM

For purposes of evaluating your medical claim under the Healthcard Contract Provision, Forticare Health Systems International, Inc., seeks your authorization consent, and grant of access to and/or collection, processing and disclosure of your personal information, such as but not limited to, your age, residence, past medical history, results of medical examination, diagnostics, abstracts, treatments, utilizations (collectively referred to as "information") and to be furnished copies thereof.

I shall hold Forticare, and its officers, directors, stockholders, employees, consultants, and doctors free and harmless from all claims, suits, charges, fees, damages or liabilities arising from or connected with the collection, processing and release or disclosure of my information including, but not limited to, my medical records.

By signing this form, I likewise acknowledge that all of the procedures indicated in this form had been done. I promise to pay for any procedure and professional fees not explicitly covered by the provision of the Healthcard Contract Provisions. Furthermore, by virtue of this undertaking, I hereby render Forticare free from any liability on the collection of the acquired non coverable charges (i.e. excess in limits, exclusions etc.). I fully understand that in instances wherein payables were not settled upon availment, I will be subjected to credit documentation and will be charged of administrative fees as applicable.

CONFIDENTIALITY NOTICE: Forticare will not disclose any information obtained in the conduct of the evaluation except as otherwise provided herein, subject to the provisions of the Data Privacy Act. Further, Forticare guarantees that the information that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law.

_____ Signature Over Printed Name

_____ Attending Doctor's Name and Signature

ATTENDING PHYSICIAN'S REPORT

(This will serve as your medical certificate if fully signed/certified by attending doctor. If medical certificate was issued by attending doctor, this portion can be omitted).

BRIEF CLINICAL HISTORY AND PERTINENT PHYSICAL FINDINGS OF THE PATIENT
NATURE OF ILLNESS (Final Diagnosis)
NATURE OF PROCEDURE DONE (If any, please describe fully)

AVAILMENT/ADMISSION DATE:	**DISCHARGE DATE:**

I certify to the best of knowledge and belief that the information provided by me in support of the claims is true and correct. I further agree and understand that declarations for the claim(s) stipulated in this form may be subject to audit/checks if deemed necessary by FORTICARE.

NAME OF ATTENDING DOCTOR	LICENSE NUMBER	SPECIALIZATION	HOSPITAL/CLINIC	CONTACT NUMBER

BASIC REQUIREMENTS

OUT-PATIENT	IN-PATIENT	DENTAL
1. Duly Accomplished Reimbursement Request Form 2. Medical Certificate indicating the diagnosis and procedures done (if any) 3. Original BIR registered Official Receipt with TIN 4. Charge Slips or detailed itemized/breakdown of charges per item paid	1. Duly Accomplished Reimbursement Request Form 2. Medical Certificate and Clinical Abstract indicating the diagnosis and procedure done (if any) 3. Original BIR registered Official Receipt with TIN 4. Statement of Account (Summary of Hospital Bill Charges) 5. Charge Slips or detailed itemized/breakdown of charges per item paid	1. Duly Accomplished Reimbursement Request Form 2. Medical Certificate indicating the diagnosis and procedures done, including tooth number 3. Original BIR registered Official Receipt with TIN 4. Detailed/itemized breakdown of charges

NOTE: In addition to above checklist, the following supporting documents should be submitted depending upon the nature of the claims:

(a) Surgical Cases — * Operative Record — * Histopath Report (if applicable)
(b) Accident/Death Cases — * Certificate of Death — * Police Report — * Medico Legal
(c) Others — * Additional Documents which may be deemed necessary

Notes:

1. Claims will be processed upon submission of complete requirements (basic and additional requirements together with the Authorization to furnish medical/other information are provided on the following page of this form).
2. Claims for reimbursement must be filled using the prescribed claim form and submitted to Forticare Offices within thirty (30) days from the date of availment for out-patient claims and from the date of discharge for in-patient claims.
3. Failure to submit within the time required shall not invalidate nor reduce any claims if it was not reasonably possible to give proof within such time or until the contract was effective.
4. All documents submitted will be returned in case of lacking or non-submission of any required documents depending on the type of claims.
5. Forticare reserves the right to acquire additional documents to justify payment of claims or to deny the claim even upon completion of required documents.

I hereby certify that all foregoing information are true and correct and authorize Forticare to access information and be furnished copies of my medical records for purposes of evaluating my medical claims.

_____ _____
Signature of Claimant Over Printed Name — Date Signed

AUTHORIZATION FROM THE PATIENT TO FURNISH MEDICAL / OTHER RELATED INFORMATION

I hereby authorize any hospital, physician and other person who has examined or treated me to furnish Forticare Health Systems International, Inc. or a Representative thereof, any and all information with respect to any illness, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records.

A certified photocopy will be honored as the original.

_____ _____
Signature of Claimant Over Printed Name — Date Signed