COCOLIFE HEALTHCARE

REIMBURSEMENT CLAIM FORM

Instructions: Fill up completely Section I below and have the Attending Physician accomplish Section II. This form together with the official receipt/s and other pertinent bill/s should be submitted to Cocolife Healthcare Office within 30 days from the date of consultation or admission for which the claims expenses were incurred. Please submit the following together with this form (original copies):

- Official Receipts (Hospital/ Clinic/ Doctors/ Medicine, etc.)
- Clinical Summary/ Medical Certificate
- Statement of Account-itemized and final SOA (Hospital/ Clinic/ Doctor)
- Individual Charge Slips
- Birth Certificate (for maternity claim)
- Death Certificate (for financial assistance)
- Other Documents which are necessary to support claim reimbursement (e.g. police report in case of vehicular accident, marriage contract/ birth certificate for financial assistance, operative report for surgical cases, medicine prescriptions, etc.)

Only duly accomplished claim form with complete supporting documents will be processed. Failure to complete the claim within the said period may be deemed an abandonment of the claim.

SECTION I *(To be accomplished by the Principal Member)*

GENERAL DATA:

Patient's Name:			ID No.:
Age:	Sex: ☐ M ☐ F	Civil Status: ☐ S ☐ M ☐ W _____	Expiry:
Relationship to the Principal Member:			
Name of Principal Member:			
Company:			
Policy Number:	Contact Numbers: *(Landline/Mobile)*		

SECTION II *(To be accomplished by the Attending Physician)*

ATTENDING PHYSICIAN'S REPORT:

Name of Hospital:			
Address:			Contact Nos.: *(Landline/Mobile)*
Nature of Availment: **A.** ☐ Out-Patient ☐ In-Patient		**B.** ☐ Emergency ☐ Non-Emergency	
Date of Admission / Consultation:		Date of Discharge *(if admitted)*:	

BRIEF CLINICAL HISTORY AND PERTINENT MEDICAL FINDINGS: *(Please attach extra sheet if necessary)*

RESULTS OF X-RAY, LABORATORY AND/OR SPECIAL DIAGNOSTIC EXAMINATIONS: *(Please attach extra sheet if necessary)*

FULL DESCRIPTION OF TREATMENT OR SURGICAL PROCEDURES DONE: *(Please attach extra sheet if necessary)*

FINAL DIAGNOSIS:

I ATTEST TO THE TRUTH OF MY FOREGOING STATEMENTS.

_____ Name of Attending Physician	_____ Specialty
_____ Signature of Attending Physician	_____ License Number

ADDITIONAL REMARKS: *(Ex.: Reason for Reimbursement, other significant information pertinent to the evaluation of the claim, etc.)*

*** To be accomplished by the principal member/patient ***

Principal Member's Signature Over Printed Name

(Please attach additional sheet if necessary.)

Date

AUTHORIZATION TO RELEASE INFORMATION

To: Medical Records Section

Hospital:

I hereby authorize any hospital, physician or other person who has examined or attended me to furnish to COCOLIFE or a representative thereof, any and all information with respect to any illness, medical history, consultation, prescription or treatment and copies of all hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original.

Principal Member's Signature Over Printed Name

Date

Date

COCOLIFE HEALTHCARE

8th Floor FELIZA Building, 108 V.A. Rufino Street, Legaspi Village, Makati City 1229

Telephone Number: 813-3000