ValuCare You can count on us	Value Care Health Systems, Inc.	Document Code: CAF-01	Page No. 1
	REQUEST FOR REIMBURSEMENT	Effectivity Date: May 29, 2021	Revision No. 0
Department:	CLAIMS DEPARTMENT		
Section:	REIMBURSEMENT		

NAME OF EMPLOYER / COMPANY:		**TEL NO (S):**
COMPANY ADDRESS:		**FAX NO.:**
NAME OF EMPLOYEE / CLAIMANT:		**Cellphone No (S):**
EMPLOYEE / CLAIMANT'S ADDRESS:		
EMPLOYEE / CLAIMANT'S BIRTHDAY:	**VALUCARE ID NO.:**	**Email address:**

INSTRUCTIONS:

1. The EMPLOYEE/CLAIMANT and ATTENDING PHYSICIAN should completely and legibly accomplish the appropriate portion of the Claim Form.

2. **Please attach the following documents:** (You will be notified of additional required documents, if necessary)

☐ **MATERNITY BENEFITS**
- Original Invoice/s
- Statement of account
- Operative record indicating type of delivery
- Marriage certificate
- Birth Certificate of Child
- Itemized breakdown
- Bank details for payment crediting

☐ **CONFINEMENT**
- Original Invoice/s (Hospital bill & Professional Fee)
- Statement of account
- Itemized Breakdown of hospital charges
- Clinical Abstract
- Operative record-(if operation was done)
- Police Report (If vehicular accident)
- Bank details for payment crediting

☐ **OUT-PATIENT**
- Original Invoice/s
- Medical certificate
- Itemized Breakdown of charges
- Police Report (If vehicular accident)
- Bank Details
- Bank details for payment crediting

☐ **FINANCIAL ASSISTANCE**
- Death Certificate
- Certificate from the Company declaring the beneficiary.
- Surrender ValuCare ID

FOR THE CLAIMANT:
- Marriage certificate-(Spouse)
- Birth certificate-(Child)
- Accomplished Quit Claim Form
- Bank details for payment crediting

AUTHORIZATION FOR RELEASE OF INFORMATION

To: Medical Record Section
Hospital:

I hereby authorize the hospital, physician or other person who has examined or attended me to furnish VALUE CARE HEALTH SYSTEMS, INC., or its representative any and all information with respect to any illness, medical history, consultation, prescriptions or treatment, and copies of perinent hospital or medical records. A photo copy of this authorization shall be considered as effective and valid as original.

EMPLOYEE/CLAIMANT'S SIGNATURE: **DATE:**

ATTENDING PHYSICIAN'S STATEMENT

(Please print or type)

NAME OF PATIENT	**LAST NAME**	**FIRST NAME**	**MIDDLE NAME**	**DATE OF BIRTH:**
NAME OF HOSPITAL				
HOSPITAL ADDRESS				**TEL NO:**
MEDICAL HISTORY				
PERTINENT PHYSICAL EXAMINATION				
LABORATORY/ ANCILLARY WORK-UP				
DISCHARGE/ FINAL DIAGNOSIS				
SURGERY	**SURGERY PERFORMED:**			**DATE PERFORMED:**

Name of Attending Physician:	**Doctor's Specialization:**	**Doctor's Signature:**	**Date:**
Address:	**Tel. No(s):**		**License No.**

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Batch No. _____

REIMBURSEMENT

ACKNOWLEDGEMENT RECEIPT

Name of Employee/Claimant: _____ Date Received: _____

☎For inquiries please call:
(02) 8 702-3355

Received By: _____

***All claims for reimbursement must be submitted to VALUCARE Head Office within thirty (30) and (60) calendar days after the discharge from the hospital for NCR & PROVINCIAL, respectively. Failure to do so shall invalidate the claim.