PROVIDE THE FOLLOWING DETAILS FOR US TO SETTLE YOUR CLAIM:

Via Bank Fund Transfer
Name of Bank: _____
Account Number: _____
Via Gcash /Maya: _____
Account number: _____
Name: _____
Email Address: _____

OUTPATIENT CLAIM FORM

Name of Employee: _____ Policyholder: _____ Total Amount of Official Receipt/s: _____

To be accomplished by Attending Physician:

Name of Patient: _____

Sex: _____ Age: _____ Date of Consultation: _____

Complaints: _____

Recommendation - Laboratory Examination: _____

- Prescribed Medicines: _____

Final Diagnosis: _____

ATTENDING PHYSICIAN'S SIGNATURE _____ CLINIC ADDRESS AND TELEPHONE NO. _____ LICENSE NO. _____

EMPLOYEE'S SIGNATURE _____ EMPLOYER'S SIGNATURE _____

Note: Please attach this form to the ORIGINAL Doctor's Prescriptions and Official Receipt (BIR Registered)

IMPORTANT NOTICE

"Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim."

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