AVEGA
LEADING EDGE HEALTHCARE SOLUTIONS

AVEGA MANAGED CARE, INC.
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REIMBURSEMENT REQUEST FORM

(IMPORTANT: Please fill up this form and attach the required documents)

PATIENT'S NAME:	**AVEGA ACCOUNT NO.:**
PRINCIPAL MEMBER'S NAME:	**COMPANY:**
CONTACT NUMBERS:	**E-MAIL ADDRESS:**
HOSPITAL/CLINIC:	**DATE OF TREATMENT:**

REASON FOR REIMBURSEMENT: ☐ Cash Basis ☐ Non-accredited provider/s ☐ Emergency Case

TYPE OF CLAIM: ☐ **OUT-PATIENT/ER** ☐ **IN-PATIENT** ☐ **MATERNITY ASSISTANCE** ☐ **OPD MEDICINES/OPTICAL/DENTAL**
*** Others please specify:** _____

MEMBER UNDERTAKING AND CONSENT FORM

This Form allows you to provide your explicit and written authorization, consent, and grant of access to and/or collection, processing, and disclosure of your personal and sensitive personal information, such as your medical records including, but not limited to, your age, residence, past medical history, results of medical examinations, diagnosis, abstracts, treatments, utilization (collectively referred to as "Information") and to be furnished copies thereof for the specific purpose of evaluating your medical claim under your applicable Health Plan and to provide health managed care for your employer pursuant to the Health Service /Group Corporate Agreement (Purposes).
Should you have questions or concerns about this form or should you wish to lodge a complaint or correct any information, please email us at dpo@avega.net.ph . For more information on how Avega protects its data and your information, you may visit our website at www.avega.com.ph.
By signing this Form, you agree to:

1. Allow the company, through its agents, representatives, personnel, subcontractors, and/or medical facilities connected with the Company including, but not limited to, physicians, nurses, and consultants, to collect, use and process your personal and sensitive personal information specific only for the purposes mentioned above.
2. Authorize the Company to disclose such Information to its agents and affiliates, including your registered employer, your employer's registered broker if any, and/or the principal member to which you are a dependent, if applicable.
3. Permit the Company to generate reports from the Information collected and share the same to the entities mentioned under item no. 2 above. For this purpose, your Information will be stored by the Company for a period of five (5) years, without prejudice to your rights as a data subject.
4. Give consent to the identified hospital or physician to release your Information and related documents, including a summary thereof derived from laboratory services and medical consultations, to the Company or its authorized representatives for the evaluation of your medical claim and for the Company to disclose such information to entities mentioned under item no. 2 above.

Kindly note that if you decide not to sign this document, AVEGA will not be able to process your requested transaction.

DATA PRIVACY CONSENT & WAIVER

I, the undersigned, have read the foregoing statement and hereby express my consent to the above. I further understand (a) the reasons for the collection, processing, and disclosure of my Information and the ways in which said Information may be used, and I agree to said usage and disclosure; and that (b) it is my choice as to what information I provide and that withholding or falsifying information might act against the best interests of my assessment. I also acknowledge that the Company has and will always take commercially reasonable steps to protect and maintain the confidential nature of my personal information in accordance with its applicable privacy policies. I hereby affirm my right to be informed, object to processing, access and rectify, suspend or withdraw my information, and be indemnified in case of damages pursuant to the provisions of Philippine Data Privacy Law, other applicable laws, rules and regulations.

OTHER UNDERTAKINGS

I, likewise, acknowledge that all of the procedures indicated in this document had been done. I promise to pay for any procedure and professional fees not explicitly covered by the provisions of the Health Service /Group Corporate Agreement. Furthermore, by virtue of this undertaking, I hereby render the Company 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.

_____
Signature Over Printed Name

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.)

NATURE OF ILLNESS (Final Diagnosis)

NATURE OF PROCEDURE DONE, if any. (Please describe fully)

I certify to the best of my knowledge and belief that the information provided by me in support of the claim is true and correct.
I further agree that audits/checks may be conducted for this claim.

NAME OF ATTENDING PHYSICIAN	LICENSE NO.	CLINIC ADDRESS	CONTACT NO.
_____ Signature Over Printed Name / Date Signed			

BASIC REQUIREMENTS:
1) Duly filled up reimbursement request form
2) Detailed Statement of Account from the hospital
3) Itemized Original Official Receipt (with TIN)
4) Medical Certificate

ADDITIONAL REQUIREMENTS (May be required for further validation of claim)

OUT-PATIENT/IN PATIENT/EMERGENCY
1) Operative Record with histopath result (if with operation)
2) Laboratory Result (if with diagnostic procedure)
3) Emergency Room Report / Clinical Resume
4) Incident/Police Report (for cases due to minor injuries/vehicular accident and assaults)
5) History of Present Illness/Medical Abstract

OPD MEDICINES/OPTICAL/DENTAL
1) Doctor's Prescription (for out-patient meds)
2) Optical Prescription (for optical availment)
3) Dental ertificate (for dental cases)

MATERNITY ASSISTANCE
1) Photocopy of Birth Certificate with original authentication
2) Marriage Certificate
3) Delivery Room Record/Operative Record

NOTES:
1. Claims will be processed upon submission of complete requirements.
2. All documents submitted will be returned in case of lacking or non-submission of any required documents depending on the type of claim.
3. The company reserves the right to require additional documents to justify payment of claim or to deny the claim even upon completion of required documents.
4. Additional documents must be submitted to AVEGA within 10 working days upon receipt of advice, otherwise, you are waiving your right for the said claim.

I HEREBY CERTIFY that the foregoing statements are true and correct to the best of my knowledge and authorize AVEGA to access information and be furnished copies of my medical records for purposes of evaluating my medical claim.

_____ Signature of Claimant Over Printed Name
_____ Date Signed

For AVEGA Use Only

☐ **With Lacking Requirements** ☐ **Denied/Disapproved Reason/s:**

_____ _____
_____ _____

Evaluated by: _____
Signature Over Printed Name / Date Signed

REMARKS: