AVEGA
LEADING EDGE HEALTHCARE SOLUTIONS

AVEGA MANAGED CARE, INC.
14th Floor, Philippine Axa Building, Senator Gil Puyat Avenue
corner Tindalo St., Brgy. San Antonio, Makati City
Website: www.AVEGAcare.com.ph

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 PATIENT UNDERTAKING AND CONSENT FORM

For purposes of evaluating your medical claim under the Health Service Agreement, AVEGA Managed Care Inc. seeks your authorization, consent, and grant of access to and/or collection, processing, and disclosure of your 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.

All Information furnished to, and/or collected by AVEGA shall be used and processed by all personnel, subcontractors, and medical facilities connected with AVEGA including, but not limited to, its doctors, nurses, and consultants, and AVEGA may disclose such Information to its agents and affiliates, including your employer, _____ your employer's broker,_____and/or the principal member to which you are a dependent. After every evaluation, AVEGA shall generate reports from the Information collected. For this purpose, your Information will be stored by AVEGA for a period of (_____) years, without prejudice to your rights to reasonable access to, upon demand, and correction of your Information, as well as your right to lodge a complaint before the National Privacy Commission. AVEGA has ensured the protection of your Information, in accordance with its privacy policy. Should you wish to access, correct or update your Information, or if you have any inquiries, please write us at AVEGA Managed Care Inc., 14th Floor, Phil. AXA Building, Sen. Gil Puyat Avenue cor. Tindalo Street, Barangay San Antonio, Makati City, addressed to our Data Protection Officer, Mr. _____.

I, _____, have read the above information and understand the following: (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; (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; (c) the Information I provide will be processed for the evaluation of my medical claim and for billing purposes thereof; (d) I can access my Information on request and if necessary, correct the Information that I believe to be inaccurate; and (e) if, in exceptional circumstances, access is denied for any legitimate purposes, the reasons for this and possible remedies will be made available to me by AVEGA.

I hereby authorize: (a) (hospital or doctor's name) to release any Information and related documents, including a summary thereof derived from laboratory services and medical consultations to AVEGA or its authorized representatives for the evaluation of my medical claim; and (b) AVEGA to release such Information, including a summary derived from said laboratory services and medical consultations to: (i) my employer/principal; (ii) my employer's broker; and (iii) the principal member to which I am a dependent, if applicable, for the evaluation of my medical claim; (iv) AVEGA's personnel, subcontractors, doctors, nurses, and consultants.

I shall hold AVEGA, 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 the 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 provisions of the Health Service Agreement. Furthermore, by virtue of this undertaking, I hereby render AVEGA free from any liability on the collection of the acquired noncoverable 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: AVEGA 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, AVEGA 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.)

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

IMPORTANT: Please fill-out below needed information.

Release of approved reimbursement claim will be through:

Check ☐

Please indicate to whom the check will be payable:

Last Name: _____

First Name: _____

Middle Initial: _____

Release of approved reimbursement claim will be through:

Bank Deposit ☐

Please provide the following information:

Name of Bank: _____
Bank Account Number: _____
Branch: _____
Name of Account
Last Name: _____
First Name: _____
Middle Initial: _____