



NOTIFICATION OF CLAIM - MEDICAL

ALL SECTIONS MUST BE COMPLETELY FILLED OUT.

A. PARTICULARS OF CLAIMANT

Patient's Name: _____
Last Name First Name M. I.

Birthday: ____/____/____ The Patient is a Principal Insured Dependent
DAY MONTH YEAR

Policy ID Number (of Principal Insured): _____

Contact Details:

Home Address: _____ Tel. No.: _____
Office Address: _____ Tel. No.: _____
Mobile Phone No.: _____ Fax No.: _____
Email Address: _____

B. AUTHORITY, RELEASE and DECLARATION STATEMENTS

Authority: I hereby authorize Blue Cross Insurance Inc. and / or Blue Cross Health Care Inc. and all persons duly authorized and acting in their behalf to request and receive any information or document and record from any hospital, clinic, laboratory, attending physician and other health service provider, which information or document relates to any medical history, examination, laboratory test results and/or treatment in connection with this claim, and such other matters related thereto. A photocopy of this is considered an original for all intents and purposes.

Release & Subrogation: Payment received by me shall constitute as full, final and complete settlement by me of this claim. I further agree that the Company is subrogated to my rights of recovery on all claims and rights of action to the extent of the payments made and/or on account of the losses incurred or which may be incurred by the Company against any person, corporation or entity in connection with this claim and I further agree to authorize the Company to commence all legal actions and proceedings necessary to enforce my claim or recovery thereof with any undertaking to extend my cooperation or assistance whenever necessary.

Declaration: I declare that all particulars stated on all pages of this form are complete and true, whether written by me or by anyone else on my behalf, shall be binding on me, and that the amounts being claimed herein are lawfully due to me under the terms and conditions of the Policy.

Signature over Printed Name of Patient
or of Principal Insured, if Patient is a Minor

Date

Note: For accidental death claims, or for medical claims leading to death, the signatory of this form should be the Claimant's Beneficiary.

OFFICIAL DOCUMENTS SUBMITTED (If space is insufficient, please attach additional details.)

Official Receipt Number	Details of Payment (professional fees, medicines, laboratory exams, etc.)	Amount		
		Php	\$	Others. Pls. specify currency.
TOTAL				

What is the Patient's Plan?

Select Standard Premier Blue Royale
 Select Plus Blue Chip Blue Royale Premier
 Select Access Others _____

For payment processing, please indicate your preferred mode of payment for approved claims:

CASH Notes: 1. Applicable only for approved amounts of Php 1,000.00 and below.
2. Usual evaluation and processing time of 10 to 14 working days will apply.

ELECTRONIC TRANSFER TO PATIENT'S DEBIT CARD (as provided by Blue Cross)
 Blue Cross - MediLink XP Card Number: [] [] [] [] - [] [] [] [] - [] [] [] [] - [] [] [] []
 Card Holder's Name: _____

DIRECT CREDIT TO MY NOMINATED BANK ACCOUNT
 Metrobank Banco de Oro HSBC (HSBC Savings Bank is a different entity and is NOT included as one of our facilities.)

For Blue Royale Policies, please indicate preferred currency of transfer:
 Peso Dollar (for those with USD Bank Accounts only)

Bank Account Name: _____ Bank Account No.: _____
 Relationship* to the Patient (if bank account is other than the Patient's): _____

Notes: 1. Whenever applicable, cost of interbranch crediting will be deducted from the approved claim amount.
2. A processing fee of Php 100.00 will be deducted from your claim resulting from the incorrect information provided by claimant.

CHECK
 Name of Payee as it should appear on check: _____
 Relationship* to the Patient (if Payee is other than Patient): _____

For Blue Royale Policies, please indicate preferred currency of claim check:
 Peso Dollar

Notes: 1. U.S. Dollar preferred currency will be paid thru US\$ HSBC uncrossed check and are subject to HSBC Bank policies and guidelines, which are available upon request from our Customer Service Officers. Please contact your depository bank to inquire about bank policies on clearing days, bank charges, minimum amount of acceptable Dollar deposit, etc.
2. Requests for check replacement are subject to Php 100.00 processing fee.

* In all payments, Payee should be of legal age (18 years old and above). For Payee other than Patient, acceptable relationships are as follows:

- Employer - Employee
- Immediate family member (parents, spouse, children of legal age)
- Principal Insured of the Policy

FOR OVERSEAS CLAIM (If space is insufficient, please attach additional details.)

Departure Date (from the Philippines):		
Countries Travelled	Arrival Date	Departure Date

To be completed by the Main Attending Physician / Surgeon only.

NOTIFICATION OF IN-PATIENT CLAIM

- 1. a. Date Admitted: _____ Time Admitted: _____
b. Date Discharged: _____ Time Discharged: _____
- 2. Complete diagnosis/es of medical condition(s): _____ Month and year when symptoms first appeared: _____
1. _____
2. _____
3. _____
4. _____
- 3. Reason for admission: _____
- 4. When did the patient first consult you on his/her condition? _____
- 5. If it is a complication, when did the symptoms of its cause start? _____
- 6. Did the patient's condition require surgery? Yes No
If yes, please state: Name of surgical procedure involved: _____
Number of in-patient to bedside visits (visits/days): _____
Were post operative consultations required? Yes No
If yes, please specify consultation dates: _____
- 7. Is the condition accident-related? Yes No
If yes: When did the accident happen? _____ At around what time? _____
What was the nature of the accident? _____
- 8. Were the services of a private nurse required? Yes No If yes, how many days? _____

NOTE: Please attach the patient's Discharge Summary, including a report of the patient's admitting history and photocopy of medication list provided by the hospital. Blue Cross reserves the right to request for additional documents as deemed necessary.

Signature over Printed Name of the Main Attending Physician/Surgeon _____ Physician's Address: _____
Physician's Tel. No.: _____

NOTIFICATION OF OUT-PATIENT CLAIM

Please check applicable out-patient benefits.

- A. Dental Optical (Notes: 1. Please attach treatment details and official receipts.
2. If disposable contact lense is prescribed, please attach prescription with the required quantity.)
- B. Prescribed Medicines (Please attach doctor's prescriptions and official receipts.)
- C. Out-Patient Treatments (To be completed by the Main Attending Physician/Surgeon only.)
1. Complete diagnosis/es of medical condition(s): _____ Month and year when symptoms first appeared: _____
 Medical: 1. _____
2. _____
3. _____
4. _____
 Surgical: 1. _____
2. _____
3. _____
4. _____
Name of surgical procedure involved: _____ Place where surgery was performed: _____
 Maternity: _____
Patient is pregnant for _____ weeks at consultation
- 2. When did the patient first consult you on his/her condition? _____
- 3. Is the condition accident-related? Yes No
If yes: When did the accident happen? _____ At around what time? _____
What was the nature of the accident? _____
- 4. Is the illness or injury related to the patient's employment? Yes No
If yes, state reason(s) _____
- 5. Is the illness or injury related to a previous confinement? Yes No
If yes, please specify confinement date _____

NOTE: Please attach a report of the patient's medical history, services, laboratory and other diagnostic tests requested, including test results, medicines prescribed as well as any relevant referral documents. Blue Cross reserves the right to request for additional documents as deemed necessary.

Signature over Printed Name of the Main Attending Physician/Surgeon _____ Physician's Address: _____
Physician's Tel. No.: _____

Please refer to back portion (Claims Reimbursement Checklist) for other documents required in filing a claim.

CLAIMS REIMBURSEMENT CHECKLIST

I. FOR IN-PATIENT CLAIMS

BASIC REQUIREMENTS:

- Duly-accomplished Notification of Claim form (NOC)
- Original official receipt(s) of all payments made
- Drug prescription from the attending physician
- Admitting Medical history (includes detailed history of present illness; family, personal and past medical history)
- Discharge summary report (includes patient's course in wards, diagnostic tests requested and medications given)
- Statement of Account (summarized and itemized)
- Supporting charge slips of statement of account in cases where hospital has no itemized SOA
- Copy of results of laboratory, x-ray, other diagnostic exams and therapeutic services

If surgical procedure was done:

- Copy of Operative Report (includes detailed description of surgical procedure done) or Histopathology Report (includes information on the nature, extent and stage of illness which may not be seen in other documents submitted)

If a Private Duty Nurse was deemed necessary:

- Referral letter/slip from the attending physician

For Maternity Claims:

- Basic Requirements for In-Patient claims

For injury as a result of an accident:

- Basic Requirements for In-Patient claims
- Copy of police report

In the event of Death of the Insured:

- Copy of Registered Death Certificate

If applicable:

- Requirements for In-Patient claims
- Copy of police report

For Overseas claims:

- Basic Requirements for In-Patient claims
- Proof of Overseas stay (airline ticket, boarding pass or immigration stamps in the passport)

II. FOR OUT-PATIENT CLAIMS

BASIC REQUIREMENTS:

- Duly-accomplished Notification of Claim form (NOC)
- Original official receipt(s) of all payments made (with itemized summary of charges)

If applicable:

- Copy of the drug prescription from the attending physician
- Copy of request for laboratory, x-ray, other diagnostic exams and therapeutic services
- Copy of results of laboratory, x-ray, other diagnostic exams and therapeutic services

In case an Out-patient operation was done:

- Copy of Operative Report (includes detailed description of surgical procedure done) or Histopathology Report (includes information on the nature, extent and stage of illness which may not be seen in other documents submitted)

For injury as a result of an accident:

- Basic requirements for Out-Patient claims
- Copy of police report

For Overseas claims:

- Basic requirements for Out-Patient claims
- Proof of Overseas stay (e.g. airline ticket, boarding pass or immigration stamps in the passport)

Disclaimer:

Kindly note that the submission of the above-mentioned documents does not guarantee approval of your claim. Your claim will be reviewed and evaluated based on available documents submitted and subject to the limits and the terms and conditions of your existing policy.

Blue Cross reserves the right to request for additional documents as deemed necessary.

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