Reimbursement Form

WellCare Health Maintenance

4th Floor, Casa Marinero II Building,
551 Cabildo St., Intramuros, Manila

TO : **WellCare Health Maintenance**

FROM : _____

DATE : _____

REQUIREMENTS FOR REIMBURSEMENT

Please attach the following documents:

- **[ ]** All Original Official Receipts of the Clinic/Hospital
- **[ ]** Clinic/Hospital Statement of Account(Summary &Itemized)
- **[ ]** All Original Official Receipts for the Physician's Professional Fees
- **[ ]** Operative Report for Surgical Cases
- **[ ]** Diagnostic Request Form from Physician
- **[ ]** Result of Diagnostic Laboratories & Procedure
- **[ ]** Police Report for Medico-Legal Cases & Incident Report
- **[ ]** **Medical Certificate with Final Diagnosis or Medical/Clinical Diagnosis Only**

CLAIMANT'S DECLARATION

<table>
<tr><td colspan="2">COMPANY NAME :</td><td>PLAN:</td></tr>
<tr><td>NAME OF PATIENT: Last</td><td>First</td><td>M.I.</td></tr>
<tr><td rowspan="2">CLINIC / HOSPITAL :</td><td>Bank Account Name/Branch:</td><td rowspan="2">Birth date:</td></tr>
<tr><td>Bank Account Number:</td></tr>
<tr><td colspan="2">TREATMENT DONE:</td><td>Age:</td></tr>
<tr><td colspan="3">FINAL DIAGNOSIS:</td></tr>
<tr><td colspan="3">THIS AUTHORIZES AND HOLDS HARMLESS WELLCARE HEALTH MAINTENANCE AND THE CLIENT COMPANY FOR ACCESS AND DISCLOSURES OF INFORMATION RELATED TO THIS CLAIM</td></tr>
<tr><td colspan="3">_____
SIGNATURE OVER PRINTED NAME OF EMPLOYEE
Contact Number: _____
Email Address: _____
_____
DATE</td></tr>
</table>