CEBU CFI COMMUNITY COOPERATIVE

NOTICE OF INPATIENT / OUTPATIENT CLAIM FORM

Please complete the following **Sections A to C for Outpatient Claims** or **Section A to D** for **Inpatient claims** and attach this form with your claims. One form is required for each claimant (Patient).

Please send all claims and inquiries to: **Cebu CFI Community Cooperative**
Medical Clinic Department
Capitol Compound, Capitol Site, Cebu City
Phone: (032) 255 - 2525 Website: https://cficoop.com

A – PARTICULARS OF THE CLAIMANT/PATIENT

Name of Claimant/Patient:	Residential Address
Name of Parent Member (if patient is a dependent):	Cellphone No.
Date of Birth (MM/DD/YY): Sex:	Office/Department/Agency
☐ Inpatient Claims	☐ Outpatient Claims

B – STATEMENT BY THE INSURED PERSON / PATIENT (by parent if patient is minor)

1. If as a result of an accident: (a) When and where did the accident occur?
(b) Please state the occurrence of the incident:
(c) Which part(s) of the body was injured?
2. If as a result of an illness, when did the symptom first appear?
3. Have you ever filed or are you going to file this claim under any other insurer? ☐ Yes ☐ No If "Yes" please provide claims settlement report.

C – AUTHORIZATION & DECLARATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility who has attended me to furnish to Cebu CFI Community Cooperative and permit the said cooperative to review any and all information requested with respect to any illness or accident, medical history, consultation, prescription or treatment and copies of all hospital or medical records and the records of any government agency with which a report of any such accident or illness is lodged. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original.

I hereby declare to the best of my knowledge and belief that the particulars stated on this form to be true and correct.

I understand that if I fail to provide any information requested in this form, it may result in the inability of the Cooperative to accept or process this claim.

______________________ Date of Submission

______________________ (Signature of Patient (or parent of minor))

ATTENDING PHYSICIAN'S REPORT (to be completed by attending physician / surgeon only)

SECTION 1

a) What was the exact diagnosis?

Date diagnosis was made:______(dd/mm/yy)

b) If hospitalization was required, please state the diagnosis for which hospitalization was required

c) (i) When did the symptom first appear?
(ii) When did patient first consult you on this condition?
(iii) To the best of your knowledge, has the patient ever had a similar condition or symptoms or been hospitalized or the same condition or symptoms?
If "Yes", please give the dates and details:

(iv) To your knowledge, has the patient previously consulted any other doctors regarding these symptoms?
If "Yes", please give names and address of the Doctors:

d) Was/were the symptom(s) a secondary condition of some other illness(es)? If "Yes", please give details:

e) Was the condition caused by or in any way associated with conditions mentioned below:

(i)	Disease of the Heart	☐ Yes	☐ No
(ii)	AIDS	☐ Yes	☐ No
(iii)	Diabetes	☐ Yes	☐ No
(iv)	Cosmetic or plastic surgery	☐ Yes	☐ No
(v)	Disease of kidney	☐ Yes	☐ No
(vi)	Disease of Liver	☐ Yes	☐ No
(vii)	Suicide, insanity or self-inflicted injury	☐ Yes	☐ No

f) Did the patient's condition arise due to:

(i)	Accident?	☐ Yes	☐ No
(ii)	Illness or injury due to patient's employment?	☐ Yes	☐ No
(iii)	Pregnancy?	☐ Yes	☐ No

If "Yes" state approximate date of commencement of pregnancy:

SECTION 2

a) Admission date: Discharge date:

b) Type of Treatment given to the patient:

c) For surgical claims:
(i) Name and Nature of surgical procedure(s):

(ii) Date(s) of procedure(s):

Discharge summary report:

SECTION 3

Is it possible to provide this treatment on an outpatient basis? If "Yes", please give reason of performing this treatment on an inpatient basis.

Name of Attending Physician: ______________________________

License No.: _______________

PTR No.: ________________

Telephone No.: _____________

Signature of Attending Physician with Stamp:

TO BE FILLED UP BY THE MRO

CLIENT ID / ACCOUNT NO.:______________
DATE OF ENROLLMENT/RENEWAL:______________ CONTROL NO:______________
CONTRIBUTIONS
PAID ( ) Date Received From Member:______________
UNPAID ( )
Less than 30 days ( ) Date Uploaded To Activity Builder: ______________
Less than 90 days ( )

LAST PAYMENT RECORDED
Date: ______________
Amount: ______________

I certify to the correctness of the above information.

______________________________ ______________________________
MRO's Signature Over-Printed Name Verified By

NOTICES

1. If the contributions are already overdue for more than 6 months, the member is disqualified from claiming payment for medical or hospital expense incurred as a result of sickness, illness or accident during the entire period the contributions were unpaid.
2. Further, the participation of the member in the Health Care Program of the COOP is deemed canceled after 12 months the account remained unpaid.
3. Claims submitted after 90 days will no longer be accepted/entertained.

REQUIREMENTS

A. Admission/ Hospitalization Refund

1. Notice of Claim Form (page 1 & 2 only)
2. Medical Certificate from the Hospital
3. Medical Abstract
4. Summarized Copy of Hospital Bill/Statement of Account
5. Itemized Copy of Hospital Bill/Statement of Account
6. Service Invoice
7. Laboratory Results

B. Consultation/ Dental Refund

1. Notice of Claim Form (page 1 only)
2. Medical Certificate (with diagnosis)
3. Service Invoice

C. OPD Procedures/ Laboratory Tests Refund

1. Notice of Claim Form (page 1 only)
2. Medical Certificate (with diagnosis)
3. Service Invoice
4. Itemized List of Labs with Prices
5. Laboratory Results/ Procedure Findings

D. Admission/ Hospitalization (Double Claims)

1. Notice of Claim Form (page 1 & 2 only)
2. Certified True Copy of Medical Certificate from the Hospital
3. Medical Abstract
4. Certificate of Payment from the HMO
5. Certified True Copy of Hospital Bill/Statement of Account (HMO payment should be reflected within the bill)
6. Itemized Copy of Hospital Bill/Statement of Account
7. Certified True Copy of the Laboratory Results
8. HMO ID or HMO Certification of Membership

E. OPD Procedures/ Laboratory Tests (Double Claims)

1. Notice of Claim Form (page 1 only)
2. Medical Certificate (with diagnosis)
3. Certificate of Payment from the HMO
4. Certified True Copy of Hospital Bill/Statement of Account (HMO payment should be reflected within the bill)
5. Itemized list of labs with prices
6. Laboratory Results
7. HMO ID or HMO Certification of Membership

ADDITIONAL REQUIREMENTS INVOLVING ACCIDENTS AND SURGERY PROCEDURES

1. Police Report
2. Incident Report (for all other accident claims where no police report can be secured or is necessary)
3. Operative Record

Note: Such other supporting documents that the Medical Department of the COOP will require in order to validate and complete the claim.