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:

Email: Website:

A – PARTICULARS OF THE CLAIMANT/PATIENT

Name of Claimant/Patient		Residential Address
Name of Parent Member		Cellphone No.
Date of Birth (MM/DD/YY) Sex:		Office/Department/Agency
☐ Impatient 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

_______________________ (Signature of Patient (or parent if a 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 for 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 anyway 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 or maternity claims:
(i) Name and Nature of surgical of obstetrical 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 : ______________________________

Licence No. ______________________________

PTR No. ______________________________

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Telephone No. : ______________________________

Signature of Attending Physician with Stamp

TO BE FILLED UP BY THE MRO

CLIENT ID / ACCOUNT NO. ____

DATE OF ENROLLMENT/RENEWAL : ____________________________________

CONTRIBUTIONS :

PAID ( )

UNPAID ( )

Less than 30 days ( )

Less than 90 days ( )

LAST PAYMENT RECORDED

Date : _________________________________

Amount :______________________________

I certify to the correctness of the above information.

____

Signature Over-Printed Name

NOTICES

1. If the contributions are already overdue for more than 90 days, 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 120 days the account remained unpaid.

3. Claims submitted after 60 days will no longer by accepted/entertained.

REQUIREMENTS

A. Admission/ Hospitalization on Refund

1. Notice of Claim Form (page 1 & 2 only)
2. Medical Certificate
3. Medical Abstract
4. Full Copy of Hospital Bill/Statement of Account
5. Official Receipts
6. Laboratory Results

B. Consultation/ Dental Refund

1. Notice of Claim Form (page 1 only)
2. Medical Certificate
3. Official Receipts

C. OPD Procedures/ Laboratory Tests Refund

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

ADDITIONAL REQUIREMENTS INVOLVING ACCIDENTS

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

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