

## BENEFIT AVAILMENT GUIDELINES

# Select



### What's Inside:

- How to use your Pacific Cross Health Card
- Using the no-cash-outlay facility in the Philippines
- What to submit when filing a claim



Please call our Customer Service Hotline at +63 2 8230-8511 or  
E-mail [client\\_services@pacificcross.com.ph](mailto:client_services@pacificcross.com.ph) for more details.

It is important for you to know how to access medical treatment and how the costs of treatments are paid. This booklet will provide these essential pieces of information. However, as we understand that it is easier to call or e-mail us to obtain assistance or to get answers to your specific questions, we have formed quick response teams to handle specific concerns. These teams are outlined below.

Directory of Important Information	
PACIFIC CROSS MEMBER HOTLINE	
Tel. No.: +63 2 8230-8511	Fax No.: +63 2 8230-8570
Mobile No.: +63 998 964-6649 (for messaging applications such as Viber and WhatsApp)	
client_services@pacificcross.com.ph	
<b>Nature of Concern:</b> To know about your benefits and availment procedure, to check on the status of your claim or to understand the extent of your cover before you incur any treatment costs.  If you are about to avail of medical benefits or are already at any Pacific Cross accredited medical facility within the Philippines and have concerns about your Pacific Cross health card.  <i>Available 24/7</i>	
WORLDWIDE EMERGENCY ASSISTANCE BENEFITS	
+63 2 8230-8511	+63 998 964-6649 (for messaging applications such as Viber and WhatsApp)
client_services@pacificcross.com.ph	
<b>Nature of Concern:</b> If you require emergency assistance anywhere in the world such as transport services and medical evacuation.  <i>Available 24/7</i>	
www.pacificcross.com.ph	
For information on medical insurance, healthcare coverage and travel insurance products, for downloadable forms and brochures or to check on the accredited providers network list.	

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# Availment Mode

Your Pacific Cross Peso Medical Plan allows flexibility in how you avail of your treatment – either via no-cash-outlay (Pacific Cross pays the expenses directly to the accredited providers or Pacific Cross partially pays the expenses directly to the accredited providers if doctors is not accredited) or through reimbursement (you pay for the expenses first and then claim from Pacific Cross. Claims can be settled either way depending on the type of services (In-patient or Emergency Outpatient) and on whether or not the hospital and doctor are accredited with Pacific Cross.

The table below shows when you can access medical availments via no-cash-outlay.

TYPE OF SERVICES	IF AVAILMENT IS IN AN ACCREDITED HOSPITAL OR CLINIC IN THE PHILIPPINES, IS NO-CASH-OUTLAY ALLOWED?
Emergency Room Out-Patient (ER-administered medicines, professional fees, diagnostic tests and procedures)	Yes
Out-Patient (doctors' professional fees, diagnostic tests or procedures and medicines)	No
In-Patient (doctors' professional fees and hospital bills)	Yes, if both doctor(s) and hospital are accredited.  Yes, Pacific Cross covers the hospital bills and Insured Person pays the doctor's fees, then file for reimbursement* with Pacific Cross.

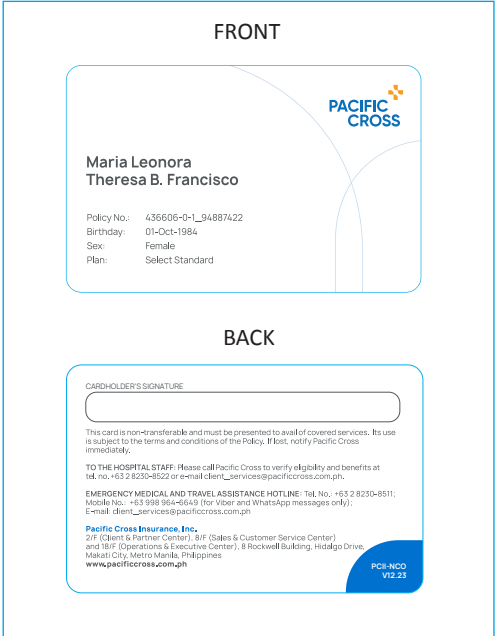
*\*Filing for reimbursement means submission of basic requirements as indicated in the Notification of Claim (NOC) Form. This form is included in your Policy Kit or may be requested from Pacific Cross Customer Service Department (client\_services@pacificcross.com.ph) or downloaded from [www.pacificcross.com.ph](http://www.pacificcross.com.ph).*

## Your Pacific Cross Health Card

### What is the Pacific Cross Health Card?

The Pacific Cross Health Card serves as your membership card and your network access health card.

Below is a picture of your Pacific Cross Health Card:



## Your Pacific Cross Health Card as a **NETWORK ACCESS HEALTH CARD**

### How does my Pacific Cross Health Card function as a Network Access Health Card?

Being a Network Access Health Card, this card must be presented to the Pacific Cross accredited medical provider together with a valid ID (e.g., company ID, SSS ID, driver's license or other ID cards bearing your photo and signature).

After presenting your card, the medical provider staff will call Pacific Cross to verify your eligibility for the services you wish to avail of.

For In-Patient cases, final approval will depend on the issuance of a Letter of Authority (LOA) by Pacific Cross Liaison Officers.

For Out-Patient cases, the medical facility will proceed with providing you the necessary services based on the approval secured from Pacific Cross.

### Some More Things You Should Know About your Pacific Cross Health Card

#### What should I do if I want the name appearing on the card changed (e.g., for newly married women)?

Call Pacific Cross Customer Service and submit a Letter of Request.

For newly married women, you are required to submit a copy of your duly-registered marriage contract.

A new Electronic Pacific Cross Health Card will be issued 4 to 5 days upon submission of all pertinent documents.

#### What if I am no longer a Pacific Cross Policyholder, what happens to my Pacific Cross Health Card?

Your Pacific Cross Health Card will be cancelled after the expiry date of the policy. For Insured Persons of a group account, your Pacific Cross Health Card is co- terminus with your employment.

## Availment Procedures Within the Philippines

### A. NO-CASH-OUTLAY IN-PATIENT TREATMENT AND EMERGENCY CASES LEADING TO CONFINEMENT



**Step 1:** Proceed to a Pacific Cross accredited medical provider.\*



**Step 2:** Present your Pacific Cross health card together with a valid ID (e.g., company ID, SSS ID, driver's license or other ID cards bearing your photo and signature).



**Step 3:** The medical provider staff will call Pacific Cross to verify your eligibility.



**Step 4:** Upon confirmation of your eligibility, you may now receive medical treatment and focus on getting well. While confined, our Liaison Officer will monitor the treatments and visit you to provide updates on your benefit coverage.



**Step 5:** Prior to discharge, you have the option to secure and submit a PhilHealth Member Data Record (MDR) and other necessary PhilHealth documents.



**Step 6:** Settle the charges, if any (other incurred medical expenses not covered by your Pacific Cross Plan). The Billing Department will advise you of the charges once they receive the Final Endorsement and Letter of Authority (LOA)\*\* from Pacific Cross.

*\* A copy of the provider's list is available for download from our website ([www.pacificcross.com.ph](http://www.pacificcross.com.ph)). You may also request a soft copy from our Customer Service Team. Please e-mail [client\\_services@pacificcross.com.ph](mailto:client_services@pacificcross.com.ph).*

*\*\* Please note that the LOA will be issued only if the case is eligible for coverage.*

**B. NO-CASH-OUTLAY EMERGENCY ROOM TREATMENT**

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**Step 1:** Proceed to a Pacific Cross accredited medical provider’s\* E.R. Department.



**Step 2:** Present your Pacific Cross health card together with a valid ID (e.g., company ID, SSS ID, driver’s license or other ID cards bearing your photo and signature).



**Step 3:** The medical provider will call Pacific Cross to verify your eligibility and secure approval for the services to be availed.



**Step 4:** The E.R. Staff on Duty will attend to you and conduct Laboratory tests and/or treatments.



**Step 5:** Sign the necessary documents and settle the charges, if any (other incurred medical expenses not covered by your Pacific Cross Plan).

*\*A copy of the provider’s list is available for download from our website ([www.pacificcross.com.ph](http://www.pacificcross.com.ph)). You may also request a soft copy from our Customer Service Team. Please e-mail [client\\_services@pacificcross.com.ph](mailto:client_services@pacificcross.com.ph).*

Always include an NOC  
each time you file a claim.



## NOTIFICATION OF CLAIM - MEDICAL

☒ Select Standard ☐ Select Plus ☐ Premier

☐ Blue Royale ☐ Blue Royale Premier ☐ BC Flexi Baby Group

ALL SECTIONS MUST BE COMPLETELY FILLED OUT.

Please write legibly  
and use block letters  
whenever possible.

### A. PATIENT'S INFORMATION

Patient's Name: **Stephanie Marie K. Villagarcia**  
 Address: **No. 56, ABCD Village, San Bernardo St., Fairview, Quezon City**  
 Tel. No.: **456-9876** Mobile No. **(0944) 567-8901** E-mail Address: **steph.villagarcia@gmail.com**  
 Patient's Date of Birth (dd/mm/yy): **01/30/1980** Age: **43** Gender: ☐ Male ☒ Female  
 If claiming under group account, Company/Employer's Name: \_\_\_\_\_  
 Describe the illness, injury, or symptom leading to consultation with your doctor: **Irregular menstruation,  
weight gain, acne**

### B. AUTHORITY, RELEASE, and DECLARATION STATEMENTS

**Authority:** I hereby authorize Pacific Cross Insurance, Inc. and/or Pacific 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:** Any payment made by Pacific Cross or any payment received by me shall constitute as full, final, and complete settlement 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. 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.

**Non-Waiver Clause For Express Claims:** It is understood that the examination/evaluation of the above claim and payment thereof is purely based on the Company's liberality and gesture of promptly and religiously paying the said claim but subject to the condition that any and all future claims arising out of the same condition on the fast-tracked claims should be subject to the Terms and Conditions of the Policy (i.e., limits of the liability, general exclusion, pre-existing conditions, concealed conditions) and the Company, therefore reserves the right to require the Insured to submit documentary proofs in connection thereof.

It is furthermore understood that any payment of a fast-tracked claim shall not be construed as a waiver by the COMPANY to determine the compensability or non-compensability of subsequent/future claims covering the same condition for the fast-tracked claims paid.

**Fraud Warning:** It is understood that Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim.

**Data Privacy Consent:** I understand that Pacific Cross collects and uses my personal data to service and administer my insurance policy, to provide appropriate and timely Medical Services, and for the purposes provided in the Pacific Cross Privacy Statement (available at [www.pacificcross.com.ph](http://www.pacificcross.com.ph)). By signing this form, I acknowledge that I have read and agree to the terms of the Privacy Statement, and understand that my data may be collected, shared, disclosed, transferred, used or otherwise processed by Pacific Cross in accordance with the Data Privacy Act of 2012, its implementing rules and regulations, and the Privacy Statement. Nothing in this form is intended to revoke or supersede any prior consent that I have given to Pacific Cross in respect of the processing activities involving my personal data.

**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.

**Stephanie Marie K. Villagarcia**

**2/14/2023**

Signature over Printed Name of Patient or of Principal Insured (if Patient is a Minor)  
or the Beneficiary (if the Patient/Principal Insured is incapacitated by illness)

Date

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

Here For You

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**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	US\$	Others. Pls. specify currency.
1245	Medicine Diane 35	2,500		
102281	Professional Fee OB Gyne	1,200		
010256758	Medicine Metformin	500		
15725	Trans V Ultrasound	3,400		
Provide a breakdown of the documents you submitted.		TOTAL	7,600	

**Please provide a breakdown of the documents you submitted.**

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

**DIRECT CREDIT TO YOUR NOMINATED BANK ACCOUNT**

☒ BDO
 ☐ Metrobank
 ☐ BPI
 ☐ Eastwest
 ☐ UnionBank

☐ Other Banks (except Rural Banks)

Bank and Branch of Account: **Fairview**

Bank Address: \_\_\_\_\_

Account Name: **Stephanie Marie K. Villagarcia**

Account No.: **SA # 12345 6789 19**

Account Type: ☒ S/A ☐ C/A

SWIFT Code: \_\_\_\_\_

Account Holder's Address: **No. 56, ABCD Village, San Bernardo St., Fairview, Quezon City**

**For Blue Royale Policies, please indicate preferred currency of transfer:**

☐ Peso
 ☐ Dollar (for those with USD Bank Accounts only)

Bank and Branch of Account: \_\_\_\_\_

Bank Address: \_\_\_\_\_

Account Name: \_\_\_\_\_

Account No.: \_\_\_\_\_

Account Type: ☐ S/A ☐ C/A


SWIFT Code: \_\_\_\_\_

Account Holder's Address: \_\_\_\_\_

**Notes:**

1. Whenever applicable, cost of interbranch crediting will be deducted from the approved claim amount.
2. In some cases, nominated banks may deduct fees from the approved claim amount.
3. A processing fee of PHP 100.00 will be deducted from your claim resulting from the incorrect information provided by claimant.

**Tell us how you want to receive your claims payment.**

	<h2>GCASH</h2> <p><b>Note:</b> 1. Please fill out the GCash Registration Form. Copies are available for request from the reception area of our Head Office. Soft copies may also be downloaded from the website.</p>
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TO BE COMPLETED BY THE MAIN ATTENDING PHYSICIAN/SURGEON ONLY

NOTIFICATION OF IN-PATIENT CLAIM

1. Admitted FROM: \_\_\_\_\_ TO: \_\_\_\_\_
2. Complete diagnosis/es of medical condition(s): \_\_\_\_\_ Month and year when symptoms first appeared: \_\_\_\_\_
  - a. \_\_\_\_\_
  - b. \_\_\_\_\_
  - c. \_\_\_\_\_
  - d. \_\_\_\_\_
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): \_\_\_\_\_
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. Maintenance medication prior to first consult: \_\_\_\_\_

Whenever possible, request your attending physician to accomplish and sign the NOC. However, should this not be possible, we will refer to the medical certificate and other documents you submitted.

Signature over Printed Name of the Main Attending Physician/Surgeon

Physician's Address: \_\_\_\_\_  
Physician's Tel. No.: \_\_\_\_\_

NOTIFICATION OF OUT-PATIENT CLAIM

1. Complete diagnosis/es of medical condition(s): **Polycystic Ovarian Syndrome** Month and year when symptoms first appeared: **March 2020**
  - a. \_\_\_\_\_
  - b. \_\_\_\_\_
  - c. \_\_\_\_\_
  - d. \_\_\_\_\_
- Name of surgical procedure involved: \_\_\_\_\_ Place where surgery was performed: \_\_\_\_\_
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 indicate confinement date: \_\_\_\_\_
6. Is the condition maternity related? ☐ Yes ☒ No  
If yes: Patient is pregnant for \_\_\_\_\_ weeks at consultation.
7. Indicate maintenance medication prior to first consult: \_\_\_\_\_

**Dr. Josefina Perlas - Santimas**

Signature over Printed Name of the Main Attending Physician/Surgeon

Physician's Address: **Makati Medical Center, Room 5678**  
Physician's Tel. No.: **858-1234**

REMINDER TO PATIENT:

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 (NOC) form
- ☐ 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) and 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
- ☐ Incident report

#### In the event of Death of the Member:

- ☐ 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 (e.g., airline ticket of the actual flight taken, boarding pass, immigration stamps in the passport or proof of entry and exit tickets where immigration stamps are not applicable)

### II. FOR OUT-PATIENT CLAIMS

#### BASIC REQUIREMENTS:

- ☐ Duly-accomplished Notification of Claim (NOC) form
- ☐ 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-rays and therapeutic services
- ☐ Copy of results of laboratory, X-rays and therapeutic services

#### In case an Out-Patient operation was done:

- ☐ Copy of Operative Report (includes description of surgical procedure done) and 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
- ☐ Incident 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)

#### For Optical claims:

- ☐ Basic requirements for Out-Patient claims
- ☐ Prescription from Ophthalmologist or Optometrist with the required quantity must be indicated if claiming for disposable contact lenses

**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 Agreement.

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

**NOTE:** If the patient has other medical insurance or healthcare coverage, a certification of Claim Settlement/Payment from other insurer or HMO company must be attached to this Notification of Claim (NOC) form along with all applicable requirements listed herein.

**Always review the checklist before submitting your claim to make sure you've given us all the required documents.**

#### HEAD OFFICE

2nd Floor (Client & Partner Center), 8th Floor (Sales Center) and 18th Floor (Operations & Executive Center),  
8 Rockwell Building, Hidalgo Drive, Makati City, Metro Manila, Philippines  
Tel. No.: +63 2 8230-8511 Fax No.: +63 2 8230-8570 E-mail: info@pacificcross.com.ph

#### CEBU

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#### CLARK

Room 217, 2nd Floor, The Medical City Clark, 100 Gatwick Gateway, Clark Global City,  
Clark Freeport Zone, Pampanga, 2023, Philippines  
Mobile No.: 63 917 174-0149; +63 956 759-6256 E-mail: clark@pacificcross.com.ph

#### DAVAO

2<sup>nd</sup> Floor, Left Wing, Door No. 6, Matina Town Square, Mac Arthur Highway, Matina, Davao City, Philippines  
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## **HEAD OFFICE**

2nd Floor (Client & Partner Center),  
8th Floor (Sales Center) and  
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E-mail: [info@pacificcross.com.ph](mailto:info@pacificcross.com.ph)

## **PROVINCIAL OFFICES**

### **CEBU**

Unit 1 Mercedes Benz Tower, Mindanao Avenue, Cebu Business Park,  
Cebu City, Philippines  
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### **CLARK**

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### **DAVAO**

2<sup>nd</sup> Floor, Left Wing, Door No. 6, Matina Town Square,  
Mac Arthur Highway, Matina, Davao City, Philippines  
Tel. Nos.: +63 82 297-7314  
Telefax: +63 82 297-7151  
E-mail: [davao@pacificcross.com.ph](mailto:davao@pacificcross.com.ph)

**We also have Agency Offices in Luzon and VisMin.**

For more information, visit [www.pacificcross.com.ph](http://www.pacificcross.com.ph).

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