PACIFIC CROSS

NOTIFICATION OF CLAIM
FLEXISHIELD

ALL SECTIONS MUST BE COMPLETELY FILLED OUT.

A. PATIENT'S INFORMATION

Patient's Name: _____

Address: _____

Tel. No.: _____ Mobile No.: _____ E-mail Address: _____

Patient's Date of Birth (dd/mm/yy): _____ Age: _____ Gender: ❑ Male ❑ Female

If claiming under group account, Company/Employer's Name: _____

Describe the illness, injury, or symptom leading to consultation with your doctor: _____

_____

Name of existing HMO: _____ Existing HMO's Maximum Benefit Limit: _____

Existing HMO's Active Coverage Period (Effective Date and Expiry Date): _____

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). 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.

_____ _____

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 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	USD	Others. (Pls. specify currency)
	TOTAL			

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

DIRECT CREDIT TO MY NOMINATED BANK ACCOUNT

❑ BDO ❑ Metrobank ❑ BPI ❑ Eastwest ❑ UnionBank

❑ Other Banks (except Rural Banks)

Bank and Branch of Account: ____________________

Bank Address: ____________________

Account Name: ____________________

Account No.: ____________________

Account Type: ❑ S/A ❑ C/A

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.

TO BE COMPLETED BY THE MAIN ATTENDING PHYSICIAN/SURGEON ONLY

NOTIFICATION OF IN-PATIENT CLAIM

1. Admitted FROM: _____ TO: _____
2.

Complete Diagnoses of medical conditions	Day, Month and Year when symptoms first appeared	Day, Month and Year when this condition was first diagnosed
a.		
b.		
c.		

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: _____

Physician's Address: _____

Physician's Tel. No.: _____

_____
Signature over Printed Name of the Main Attending Physician/Surgeon

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 hospital bill was partly covered by HMO Plan, Claims Adjustment Report or breakdown and details of coverage from HMO for the confinement being reimbursed.
- ❑ Proof of active 1st layer HMO Plan, Schedule of Benefit and Contract (Terms and Conditions).
- ❑ Certification of Exhausted Benefit from 1st layer HMO Provider specifying total utilization amount.

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)

For injury as a result of an accident:

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

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.

HEAD OFFICE

2nd Floor (Client & Partner Center),
8th Floor (Sales & Customer Service 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

PROVINCIAL OFFICES

CLARK

2nd Floor, The Medical City Clark, 100 Gatwick Gateway,
Clark Global City, Clark Freeport Zone, Pampanga, 2023, Philippines
Mobile Nos.: +63 917 174-0149, +63 956 759-6256, +63 928 348-1907
E-mail: markanthony_gabriel@pacificcross.com.ph, kevin_ilagan@pacificcross.com.ph

CEBU

Unit 201-202, Avagar Building,
No. 09, Escario corner Molave Street, Lahug, Cebu City, Philippines
Tel. Nos.: +63 32 233-5812, +63 32 233-5816,
+63 32 416-4468, +63 32 260-9101 (Customer Service Hotline)
Fax No.: +63 32 233-5814
E-mail: cebu@pacificcross.com.ph

DAVAO

2nd Floor, Left Wing, Door No. 6, Matina Town Square,
Mc Arthur Highway, Matina, Davao City, Philippines
Tel. Nos.: +63 82 297-7314, +63 83 285-5101 (Customer Service Hotline)
Telefax: +63 82 297-7151
E-mail: davao@pacificcross.com.ph