**NOTIFICATION OF CLAIM –**

**CRITICAL COVER EXTRA**

|  |
| --- |
| **ALL SECTIONS MUST BE COMPLETELY FILLED OUT.** |

1. **PARTICULARS OF CLAIMANT**

|  |  |
| --- | --- |
| **First Name:** |       |
| **Middle Initial:** |       | **Last Name:** |       |
| **Date of Birth** (dd/mm/yyyy): |       | **The Patient is a** | [ ]  Principal Insured [ ]  Dependent |

|  |  |
| --- | --- |
| **Policy ID Number (of Principal Insured):** |       |

**CONTACT DETAILS:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Home Address:** |       | **Tel. No.:** |       |
| **Office Address:** |       | **Tel. No.:** |       |
| **Mobile No.:** |       | **Fax No.:** |       |
| **E-mail Address:** |       |

**If you are insured with another company for related or similar benefits to Pacific Cross Critical Cover Extra, please provide details below.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Insurer** | **Type of Benefit** | **Amount of Benefit** | **Has a claim been submitted?** |
|       |       |       | [ ]  Yes [ ]  No |
|       |       |       | [ ]  Yes [ ]  No |
|       |       |       | [ ]  Yes [ ]  No |
|       |       |       | [ ]  Yes [ ]  No |

1. **AUTHORITY, RELEASE, and DECLARATION STATEMENTS**

**Authority:** I hereby authorize the Company (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 and Subrogation:** 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 and 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.

**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 Insurance Policy.

|  |  |
| --- | --- |
| **Name of Patient or of Principal Insured, if Patient is a Minor**: |       |

|  |  |
| --- | --- |
| **Signature of Patient or of Principal Insured, if Patient is a Minor:** |  |

|  |  |
| --- | --- |
| **Date** (dd/mm/yyyy): |       |

**Note:** For Critical Illness claims resulting to death, the signatory of this form should be the Claimant’s Beneficiary or legal representative.

1. **PAYMENT OPTIONS**

(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 |
| **Bank and Branch of Account:** |       |
| **Account Name:** |       |
| **Account No.:** |       |
| **Account Type:** | [ ]  S/A [ ]  C/A |
| **SWIFT Code:** |       |
| **Account Holder’s Address:** |       |

|  |
| --- |
| **For Blue Royale Policies only, please indicate preferred currency of transfer:** |
| [ ]  Peso | [ ]  Dollar (for those with USD Bank accounts only) |
| **Bank Account Name:** |       |
| **Bank Account No.:** |       |
| **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.
 |

|  |  |
| --- | --- |
| [ ]  | **GCASH** |
|  | [ ]  If you already have a GCash Card registered to Pacific Cross, please provide the following details: |
| **Account Name:** |       |
| **Account No.:** |       |
|   | [ ]  If you do not have a GCash Card registered to Pacific Cross yet, please fill out a GCash Registration Form. You may request a copy from our Customer Service Team, or download it from our website. |

1. **CLAIMANT’S STATEMENT**

|  |
| --- |
| 1. Please provide details of any medical practitioners you have consulted and received medical treatment from in connection with your condition.
 |
|

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Consultation** | **Doctor’s Name** | **Hospital and Tel. No.** | **Regular Physician (Yes/No)** |
|       |       |       | [ ]  Yes [ ]  No |
|       |       |       | [ ]  Yes [ ]  No |
|       |       |       | [ ]  Yes [ ]  No |
|       |       |       | [ ]  Yes [ ]  No |

 |
| 1. Please state the name, address and, contact number of your regular physician (if not stated in no. 1 above).
 |
|

|  |  |
| --- | --- |
| Name of Physician: |       |
| Address: |       |
| Contact No.: |       |
| For how long has been your regular physician? |       |

 |
| 1. Please provide details of hospitals or institutions you were conﬁned in connection with your condition.
 |
|

|  |  |  |
| --- | --- | --- |
| **Admission Date** | **Discharge Date** | **Name of Hospital/Institution** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |

 |
| 1. Have you ever had any illness in the last ﬁve (5) years?
 | [ ]  Yes [ ]  No |
| If *Yes*, please provide details below. |
|

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Details/Medical Condition** | **Nature/Date of Treatment** | **Current Status** | **Doctor’s Name** | **Doctor’s Current Info.**(Address, Phone, Fax) |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |

 |
| 1. Do you smoke or have you smoked in the past?
 | [ ]  Yes [ ]  No |
| If *Yes*, please provide the number of cigarettes/cigars smoked per day: |       |
| 1. Have you been drinking alcohol?
 | [ ]  Yes [ ]  No |
| If *Yes*, a.) Please state type (spirits, wine, beer, etc.):  |       |
| b.) Please state quantity of intake (centiliter, units, glasses, bottles, etc.) per week: |       |
| 1. Have you ever used any habit-forming drugs or narcotics?
 | [ ]  Yes [ ]  No |
| If *Yes*, please provide details:  |       |

1. **ATTENDING PHYSICIAN’S STATEMENT**

|  |
| --- |
| 1. Critical Illness Condition (Tick the box on the Critical Illness patient is diagnosed of.)
 |
| [ ]  Cancer (Type:       )[ ]  Multiple Sclerosis[ ]  Myocardial Infarction[ ]  Benign Brain Tumor | [ ]  Cerebrovascular Accident (Stroke)[ ]  Coronary Artery By-pass Surgery[ ]  Kidney/Renal Failure[ ]  Major Organ Transplant |
| 1. Exact date when ﬁrst symptom appeared? *(dd/mm/yyyy):*
 |       |
| 1. Please state the symptoms of the Critical Illness Condition and date when it ﬁrst appeared.
 |
|

|  |  |
| --- | --- |
| **Date (mm/dd/yyyy)** | **Symptoms** |
|       |       |
|       |       |
|       |       |
|       |       |

 |
| 1. Date when patient was ﬁrst informed of the condition *(dd/mm/yyyy):*
 |       |
| 1. If the status of the Illness is already end stage, date when patient was ﬁrst informed *(dd/mm/yyyy):*
 |       |
| 1. Date you ﬁrst attended to the patient for the Critical Illness Condition *(dd/mm/yyyy):*
 |       |
| 1. Please provide dates with full and exact details of diagnosis of the Critical Illness Condition.
 |
|

|  |  |
| --- | --- |
| **Date (dd/mm/yyyy)** | **Diagnosis** |
|       |       |
|       |       |
|       |       |
|       |       |

 |
| 1. Please describe the underlying cause/s of the Illness.
 |
| 1.
 |
| 1.
 |
| 1.
 |
| 1. Please provide details of the laboratory/diagnostic procedures conducted.
 |
|

|  |  |
| --- | --- |
| **Laboratory/Diagnostic Procedures** | **Results** |
|       |       |
|       |       |
|       |       |
|       |       |

 |
| 1. Please provide details of treatment/medications given.
 |
| 1.
 |
| 1.
 |
| 1.
 |
| 1. Please provide details on the contributory/risk factors in relation to this Critical Illness Condition (if there is any).
 |
| 1.
 |
| 1.
 |
| 1.
 |
| 1. If the Critical Illness Condition is MYOCARDIAL INFARCTION or CEREBROVASCULAR ACCIDENT, please answer or provide details for the following:
 |
| 1. Was there a history of chest pains?
 | [ ]  Yes [ ]  No |
| If *Yes*, when was the onset? *(dd/mm/yyyy)* |       |
| 1. Please provide the results of the cardiac enzymes:
 |
|       |
| 1. ECG/Echocardiogram ﬁndings:
 |
|       |
| 1. Is the condition directly or indirectly aggravated by (if applicable):
 |
| 1. pregnancy or childbirth?
 | [ ]  Yes [ ]  No |
| 1. drug or alcohol abuse?
 | [ ]  Yes [ ]  No |
| 1. If the Critical Illness condition is CEREBROVASCULAR ACCIDENT, is there evidence of a permanent neurological deﬁcit?
 | [ ]  Yes [ ]  No |
| If **Yes**, please provide details:  |       |
| 1. If the Critical Illness condition is KIDNEY/RENAL FAILURE, please answer or provide details for the following:
 |
| 1. In your opinion, is the condition chronic or acute?
 |       |
| 1. What is the underlying cause?
 |       |
| 1. Did the patient undergo
 |
| 1. Peritoneal Dialysis?
 | [ ]  Yes [ ]  No | If Yes, since when? *(dd/mm/yyyy)* |       |
| 1. Hemodialysis?
 | [ ]  Yes [ ]  No | If Yes, since when? *(dd/mm/yyyy)* |       |
| 1. Renal Transplantation?
 | [ ]  Yes [ ]  No | If Yes, since when? *(dd/mm/yyyy)* |       |
| 1. Please provide any additional information which, in your opinion, will assist us in evaluating the claim.
 |
|       |

|  |  |
| --- | --- |
| **Name of Physician:** |       |
| **PTR No.:** |       | **License No.:** |       |
| **Hospital/Clinic:** |       |
| **Hospital/Clinic Address:** |       |
| **Clinic Hours:** |       | **Clinic Tel. No.:** |       |
| **Mobile No.:** |       | **E-mail Address:** |       |

|  |  |
| --- | --- |
| **Signature of Physician:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Signing** (dd/mm/yyyy): |       | **Place of Signing:** |       |

|  |
| --- |
| **CLAIMS REIMBURSEMENT CHECKLIST (Must be original or Certified True Copy)** |
| [ ]  Duly-accomplishment Notification of Claim (NOC) form |
| [ ]  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 test requested and medications given) |
| **Additional Requirements:****If the diagnosis is Heart Attack/Myocardial Infarction (*must be diagnosed by Internist or Cardiologist*):**[ ]  Serial electrocardiography (ECG)[ ]  Blood test[ ]  Complete clinical history**If the diagnosis is Stroke (*must be conﬁrmed by a Neurologist*):**[ ]  CT Scan/MRI/MRA of the brain**If the diagnosis is Cancer:**[ ]  Surgical Pathology/Histopathology Report [ ]  Radiologic (CT Scan/MRI) results**If the diagnosis is Kidney Failure:**[ ]  Laboratory Tests/Procedures (i.e., blood test, ultrasound, etc.)**If Insured underwent Major Organ Transplant:**[ ]  Record of Operation**If diagnosis is Multiple Sclerosis (*must be conﬁrmed by a Neurologist*):**[ ]  Nerve Biopsy or Neural Biopsy or Electrophysiology[ ]  Medical Records indicating the following:1. Two (2) episodes of well-deﬁned neurological abnormalities
2. Evidence of demyelinating lesions at more than one (1) site within the central nervous system
3. Multiple neurological deﬁcits which occurred over a continuous period of at least six (6) months
4. Medical records showing multiple neurological deﬁcits which occurred over a continuous period of at least six (6) months
5. Well documented history of exacerbations and remissions of said symptoms or neurological deﬁcits

[ ]  CT Scan result**If diagnosis is Benign Brain Tumour:**[ ]  CT Scan or MRI[ ]  Surgical Pathology Report**If Insured underwent Coronary Artery Bypass Surgery *(must be diagnosed by a Cardiologist or Cardiovascular Surgeon)*:**[ ]  Coronary Angiography [ ]  Record of Operation |

|  |
| --- |
| **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 the available documents submitted and subject to the limits and the terms and conditions of your existing Insurance Policy.Paciﬁc Cross reserves the right to request for additional documents as deemed necessary. |

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