PACIFIC CROSS

NOTIFICATION OF CLAIM - SELECT GOHEALTH

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

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

_____

_____

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 accidental death claims, or 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

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.

❑ **GCASH**

❑ If you already have a GCash Card registered to Pacific Cross, please provide the following details:

Account Name: _____

Account Number: _____

❑ If you do not have a GCash Card registered to Pacific Cross yet, please fill out GCash Registration Form. You may request a copy from our Customer Service Team, or download it from our website.

TO BE COMPLETED BY THE MAIN ATTENDING PHYSICIAN/SURGEON ONLY

NOTIFICATION OF IN-PATIENT CLAIM

1. Details of the Injury or Illness:
   Is the injury or illness related to ❑ Accident ❑ Illness ❑ Work-related?

Medical Diagnosis	Describe the symptom/s	Date Symptons First Started (mm/dd/yy)	Date Diagnosis Was First Made (mm/dd/yy)
1.			
2.			
3.			

2. Reason for admission: _____
3. When did the patient first consult you on his/her condition? _____
4. If it is a complication, when did the symptoms of its cause start? _____
5. 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? _____
6. Is the illness or injury related to the patient's employment? ❑ Yes ❑ No
7. Maintenance medication prior to first consult: _____

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

Hospital Name/Address: _____
Physician's Tel. No.: _____

NOTIFICATION OF OUT-PATIENT CLAIM

Date of consultation/Treatment: _____

1. Details of the Injury or Illness:
   Is the injury or illness related to ❑ Accident ❑ Illness ❑ Work-related?

Medical Diagnosis	Describe the symptom/s	Date Symptons First Started (mm/dd/yy)	Date Diagnosis Was First Made (mm/dd/yy)
1.			
2.			
3.			

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: _____

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

Hospital Name/Address: _____
Physician's Tel. No.: _____

REMINDER TO PATIENT:

Please refer to back portion (Claims Reimbursement Checklist) for other documents required in filing a claim.

CLAIMS REIMBURSEMENT CHECKLIST

I. FOR EMERGENCY OUT-PATIENT TREATMENT DUE TO ACCIDENT

BASIC REQUIREMENTS:

- ❑ Duly accomplished Notification of Claim (NOC) form
- ❑ Emergency Medical Certification from a licensed medical facility where you had your emergency treatment
- ❑ Original official receipt(s) of all payments made (with itemized summary of charges)
- ❑ Copy of results of laboratory, X-ray, other diagnostic exams in which the diagnostic test was prescribed by the attending physician and done within the Period of Insurance
- ❑ Incident report or Police Report (if any)

II. FOR MEDICALLY DIAGNOSED IN-PATIENT COVID-19

BASIC REQUIREMENTS:

- ❑ Duly accomplished Notification of Claim (NOC) form
- ❑ Admitting Medical History
- ❑ Discharge Summary Report or Clinical Abstract stating the final diagnosis and confinement date
- ❑ Statement of Account reflecting room and board charges
- ❑ Copy of Positive (+) SARS-CoV-2 (COVID-19) RT-PCR test results in which the diagnostic test was prescribed by the attending physician and done within the Period of Insurance

III. EMERGENCY IN-PATIENT TREATMENT DUE TO ACCIDENT | EMERGENCY IN-PATIENT TREATMENT | IN-PATIENT TREATMENT DUE TO CANCER | EMERGENCY IN-PATIENT TREATMENT | IN-PATIENT TREATMENT DUE TO COVERED SPECIFIC ILLNESSES

BASIC REQUIREMENTS:

- ❑ Duly accomplished Notification of Claim (NOC) form
- ❑ Certified True Copy (CTC) of Admitting Medical History/ Discharge Summary Report or Clinical Abstract stating the final diagnosis and confinement date
- ❑ Statement of Account reflecting room and board charges
- ❑ Incident Report or Police Report (If any)
- ❑ Copy of valid I.D.

IV. FOR MEDICALLY DIAGNOSED DENGUE OR LEPTOSPIROSIS

BASIC REQUIREMENTS:

- ❑ Duly accomplished Notification of Claim (NOC) form
- ❑ Medical Certification with date symptoms first appeared and diagnosis of confirmed condition from a licensed physician in a licensed medical facility where you had your consultation/treatment or Admitting Medical History and Discharge Summary Report or Clinical Abstract stating the final diagnosis and confinement date
- ❑ Statement of Account room and board charges
- ❑ For Dengue copy of (+) NS-1 or Dengue Duo test (Immunoglobulin G and Immunoglobulin M) tests result in which the diagnostic test was prescribed by the attending physician and done within the Period of Insurance is required
- ❑ For Leptospirosis copy of (+), Leptospira IgG/IgM or Leptospira (+) Microscopic agglutination test (MAT) test result in which the diagnostic test was prescribed by the attending physician and done within the Period of Insurance is required

V. FOR POST-HOSPITALIZATION MEDICINES

BASIC REQUIREMENTS:

- ❑ Duly accomplished Notification of Claim (NOC) form
- ❑ Certified True Copy (CTC) of Admitting Medical History/ Discharge Summary Report or Clinical Abstract stating the final diagnosis and confinement date
- ❑ Statement of Account reflecting room and board charges as well as the use of a mechanical ventilator, if applicable.
- ❑ Discharge Instruction with list of prescribed take home medicines
- ❑ Drug prescription/s from the Attending Physician
- ❑ Original / Copy of Official Receipt for the purchased medicines
- ❑ Incident report or Police Report (if any)

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.

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