6/F, Makati Executive Center, L.P. Leviste cor. V.A Rufino Sts., Salcedo Village, Makati City
Trunkline: (02) 8817-3333

REIMBURSEMENT FORM

TO : **EASTWEST HEALTHCARE INC.**

FROM : _____

DATE : _____

REQUIREMENTS FOR REIMBURSEMENT

1. In lieu of physician declaration, The Claimant and Attending Physician should accomplish fully this form duly signed by authorized representative of The Company.

2. Please attach the following documents:

[ ] All Original Official Receipts of the Clinic/Hospital
[ ] Clinic/Hospital Statement of Account(Summary &Itemized)
[ ] All Original Official Receipts for the Physician's Professional Fees
[ ] Operative Report for Surgical Cases
[ ] Diagnostic Request Form from Physician
[ ] Result of Diagnostic Laboratories & Procedure
[ ] Police Report for Medico-Legal Cases
[ ] Medical Certificate with Final Diagnosis
[ ] Bank Accounts Details: **BDO Account Name:** _____
Account Number: _____
METROBANK Account Name: _____
Account Number: _____

CLAIMANT'S DECLARATION AND WAIVER

COMPANY NAME:		BRANCH / AFFILIATE:
NAME OF EMPLOYEE: Last	First	M.I.

I/We hereby authorize any representative of Eastwest Healthcare, Inc., whenever reasonably necessary, to secure any relevant medical information from the hospital, physician and other reliable sources, including but not limited to documents, records, reports and data, including the medical records, names, addresses, telephone numbers, identification numbers, dates of birth and all other personal information, subject to the rules and requirements of confidentiality under the agreement between Eastwest Healthcare and the Subscriber Company and other relevant laws and regulations in the Philippines, including but not limited to Republic Act No. 10173 or the Data Privacy Act of 2012. A photocopy of this authorization shall be effective and valid as the original.

This holds harmless Eastwest Healthcare, Inc. and the client company for access and disclosure of information related to this claim.

_____
SIGNATURE OVER PRINTED NAME OF EMPLOYEE
Contact Number: _____

_____
DATE

PHYSICIAN'S STATEMENT

NAME OF PATIENT: Last	First	M.I.
CLINIC / HOSPITAL:	Relationship to Employee:	Birth date:
TREATMENT DONE:		Inclusive Dates:
FINAL DIAGNOSIS:		
ATTENDING PHYSICIAN:		Date:
CLINIC ADDRESS:	Telephone:	License No:

ATTENDING PHYSICIAN: _____ _____
Printed Name and Signature Date