



**REIMBURSEMENT CLAIM
INFORMATION SHEET**

Claim No.:
Date Filed:
Date Completed:

PARTICULARS OF CLAIMANT

Name of Patient:	Account Name:	HMI ID No.:
Name of Sponsor:	Relationship:	Tel. No.:
Address:		

REASON / S FOR CHARGING

IF MEMBER IS A MINOR OR DECEASED, PLEASE INDICATE TO WHOM CHECK WILL BE PAYABLE

Name: _____ Pls. Print	Relationship: _____
_____ Signature of Member/Representative	_____ Date

FOR HMI USE ONLY

<p>REQUIRED DOCUMENTS:</p> <p><input type="checkbox"/> OUT-PATIENT</p> <ol style="list-style-type: none"> Original Official Receipts of payment(s) Charge Slips Referral Form/Medical Certificate (clinic case) Result of Laboratory/Diagnostic test(s) Operative Report (if surgical case) Police Report for Medico-Legal cases 	<p><input type="checkbox"/> IN-PATIENT</p> <ol style="list-style-type: none"> Original Official Receipt(s) for hospital bills & professional fees Statement of Account Itemized breakdown of hospital charges/Charge Slips Clinical Abstract/Discharge Summary Report Operative Report for surgical cases Hispathological Report for surgical cases Police Report for Medico-Legal cases 	<p><input type="checkbox"/> EMERGENCY ROOM CASE</p> <ol style="list-style-type: none"> Original Official Receipt(s) of payment(s) Charge Slips Emergency Room Treatment Certificate Result(s) of Diagnostic Examination(s) (if any) Police Report for Medico-Legal cases
<p>ADDITIONAL REQUIRED DOCUMENTS IF CLAIM FOR REIMBURSEMENT IS FOR:</p> <p><input type="checkbox"/> MATERNITY BENEFIT : Certificate of Live Birth</p> <p><input type="checkbox"/> VEHICULAR ACCIDENT: • LTO latest Official Receipt and Certificate of Registration of the vehicle involved in the accident (photo copy only) • Valid Driver's License and Official Receipt (photo copy only)</p>		<p>NOTE: In claiming checks thru a representative, the following documents must be submitted:</p> <ol style="list-style-type: none"> Letter signed by the member duly authorizing the representative to claim the check. Photocopy of valid ID with picture bearing the signature of the member. Valid ID with picture & signature of the representative.

CLAIMS INFORMATION

MSU:	IP/OP:	Util. Date:	
Diagnosis:			
Diagnosis Code:			
Service/s Rendered:	<p>RECOMMENDATION/APPROVAL</p> <p>Approved Amt.:</p> <p>Less: A/R :</p> <p>Net :</p>		
Others:			
Prepared	A/R Clearance	Claims Approval	Medical Approval
By/Date:	By/Date:	By/Date:	By/Date:

NOTE: To file complete documents within thirty (30) days after avilment



Reminder:

To follow-up status of your reimbursement, please call HMI Reimbursement Section on _____ at 811-1313 or 752-0552 local 13 or text/call cell phone numbers: 0917-8111313 • 0917-8128806 • 0917-8111653.