



**INSULAR LIFE HEALTH CARE INC.**  
A Subsidiary of the Insular Life Assurance Co., Ltd.

**GUIDELINES ON FILING OF CLAIMS**

Claims for reimbursement will be governed by the following guidelines:

**VALIDITY PERIOD:**

1. A claim for reimbursement must be filed and received by I-Care within sixty (60) days from the date of availment for out-patient benefits and sixty (60) days from the date of discharge in case of in-patient benefits
2. Processing period shall be thirty (30) days from the date of receipt by I-Care of the said claim provided that the member has submitted (together with the claim) all the necessary documents required. In case an additional requirement is needed, the 30-day period shall be reckoned against (he date when said additional requirement is submitted

**REQUIREMENTS:**

All claims for reimbursement must be submitted together with the original copy of the following documents:

❖ **OUT PATIENT**

- Medical Certificate from the attending physician
- Official Receipts of payments to physician &/or hospital
- Charge slips with breakdown of charges

❖ **IN PATIENT**

- Medical Certificate from the attending physician
- Official Receipts of payments to physician &/or hospital
- Statement of Account
- Charge Slips with breakdown of charges
- Operative Record/Surgical Procedure including histopathological report when applicable
- Police Report &/or Subrogation Report if Medico-legal case

❖ **PRESCRIPTION BENEFIT/DENTAL BENEFIT**

- Medical Certificate from the attending physician / dentist
- Prescription
- Official Receipts indicating medicines purchased

It is understood that other requirements may be imposed as deemed necessary.

For inquiries and follow-up, you may call the Medical Claims Section at Tel. No. 8130131-36 local 8301-8302.

**CLAIM FOR REIMBURSEMENT FORM**

**A. CLAIMANT'S GENERAL DATA**

Name: \_\_\_\_\_ I.D. No. \_\_\_\_\_  
 Address: \_\_\_\_\_ Age/Sex: \_\_\_\_\_  
 Tel. No. \_\_\_\_\_ Inclusive Dale of Availment: \_\_\_\_\_  
 Plan Type: \_\_\_\_\_ Hospital Availed At: \_\_\_\_\_  
 Payee/Cheque payable to: \_\_\_\_\_

**B. NATURE OF CLAIM**

- In-Patient
- Out-Patient
- Prescription Benefit
- Dental Benefit
- Others: (pls. specify) \_\_\_\_\_

**C.** Please cite reason(s) for reimbursement (You may use a separate sheet if necessary which must be signed and dated by the claimant:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**D. Declaration**

I, the undersigned, declare that all the foregoing information are true, and that I have submitted all the required documents relevant to this claim, and the amount claimed herein are lawfully due to me under the terms, conditions and exceptions of my health care agreement.

Amount in Words

Amount in Figures

Signature Above Printed Name

Date