WellCare
Health Maintenance

2nd Floor, 551 Cabildo St.
Casa Marinero II Building, Intramuros, Manila

WELLCARE HEALTH MAINTENANCE REIMBURSEMENT FORM

INSTRUCTIONS: Please fill out this form and attach **all original documents**. This form should be submitted to **WellCare Health Maintenance within 30 days from the date of availment** or as agreed in the Service agreement, otherwise, reimbursement of claim(s) declared in this form will be forfeited. Please ensure that all pertinent information are completely accomplished.

Please attach the applicable 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 & Incident Report
- **[ ]** **Medical Certificate with Final Diagnosis or Medical/Clinical Diagnosis Only**

CLAIMANT'S DECLARATION

COMPANY NAME :		PLAN:
NAME OF PATIENT: Last	First	M.I.
CLINIC / HOSPITAL :	Checking Account Number/Branch	Birth date:
TREATMENT DONE:		Age:
FINAL DIAGNOSIS:		

THIS AUTHORIZES AND HOLDS HARMLESS WELLCARE HEALTH MAINTENANCE AND THE CLIENT COMPANY FOR ACCESS AND DISCLOSURES OF INFORMATION RELATED TO THIS CLAIM.

_____
SIGNATURE OVER PRINTED NAME OF EMPLOYEE
Contact Number_____
Email Address_____

_____
DATE