Life & Health HMP, Inc.
2/F Cocomall Building, Osmeña Boulevard, Capitol Site, Cebu City, Philippines
Telephone no. (032) 419 4777
Email: refund@lifeandhealthhmp.com

GUIDELINES FOR FILING OF CLAIMS

1. The validity period for filing requirements is thirty (30) days from the date of availment for Out-Patient cases and thirty (30) days from the date of discharge for In-Patient cases. Failure to comply within the prescribed period shall result in the forfeiture of eligibility for reimbursement.
2. Reimbursement will be processed within thirty (30) working days, excluding weekends and holidays, from the date of receipt by Life & Health, provided that the member has submitted complete documents.
3. Life & Health reserves the right to require additional documentation to justify the payment of a claim or to deny it, even if all initial requirements have been submitted. Reimbursement is subject strictly to the limits and conditions of the member's plan coverage.
4. For any inquiries or follow-ups, you may reach out to our Claims Section for assistance.
   Cebu: 0932 143 7139; 0917 153 7833
   NCR: 0917 133 3915; 0917 727 8357
   Butuan: 0954 276 2951; 0954 255 6402
   Davao: 0917 702 4499; 0917 659 6854
   General Santos: 0917 779 6931

REQUIREMENTS

OUT-PATIENT	IN-PATIENT
1. Duly accomplished Reimbursement Request Form	1. Duly accomplished Reimbursement Request Form
2. Medical Certificate issued by the attending physician	2. Medical Certificate issued by the attending physician
3. Original Official Receipt/Sales Invoice indicating TIN	3. Original Official Receipt/Sales Invoice indicating TIN
4. Doctor's request with diagnosis	4. Statement of Account (Summary of Hospital Bill)
5. Laboratory results	5. Charge slips with a detailed breakdown of charges per item
6. Charge slips with a detailed breakdown of charges per item	6. Operative Record (if applicable)
7. Police Report (for cases of motor vehicular accident or assault)	7. Police Report (for cases of motor vehicular accident or assault)
	8. Emergency Room Discharge Summary

MATERNITY	ACCIDENTAL DEATH & DISMEMBERMENT
1. Duly accomplished Reimbursement Request Form	1. Duly accomplished Reimbursement Request Form
	2. Claim Form signed by the attending physician
2. Medical Certificate from the attending physician	3. Police Report or Affidavit of Accident
	4. PSA-authenticated Death Certificate 4.a. PSA-authenticated Birth Certificate
3. Birth Certificate	5. Post-Mortem Report
	6. Proof of relationship of the claimant with the insured
4. Delivery Room Record / Operative Record (for Cesarean Section cases)	7. Official receipts for medical expenses incurred
	8. Medical Certificate

REIMBURSEMENT REQUEST FORM

PATIENT NAME	PATIENT CONTACT NUMBER	LIFE & HEALTH I.D. NO.	RELEASE ☐ PICK-UP TO L&H OFFICE
PRINCIPAL MEMBER NAME	PRINCIPAL MEMBER CONTACT NO.	DATE OF AVAILMENT/ DISCHARGE	☐ DELIVER TO COMPANY
PAYEE / PAYABLE TO	COMPANY / ACCOUNT NAME	TYPE OF CLAIM ☐ OP ☐ IP ☐ MATERNITY ☐ AD&D	

MEMBER'S CONFORME AND CONSENT

The member, his/her authorized relative or guardian (whichever is applicable), whose name and signature appears below gives consent to Life & Health HMP, Inc. to release personal information and related documents to the attending physician and/or authorized hospital representative. The Member holds Life & Health HMP, Inc., and its officers, stockholders, employees, consultants, and doctors free and harmless from all claims, suits, charges, fees, damages or liabilities arising from or connected with the collection, processing, release and disclosure of information including but not limited to, membership and medical records. Provided that the processing of member's information is made in accordance with the Data Privacy Act, its implementing Rules and Regulations, Memorandum Circulars, and such other issuances of the National Privacy Commission.

SIGNATURE OVER PRINTED NAME OF CLAIMANT

DATE FILED & SIGNED