Life & Health HMP, Inc.
2/F Cocomall Building, Osmeña Boulevard, Capitol Site, Cebu City, Philippines
Telephone no. (032) 255 0035
Email: info@lifeandhealthhmp.com

GUIDELINES FOR FILING OF CLAIMS

1. The validity period for filing of requirements is thirty (30) days from the date of availment for Out- Patient and thirty (30) days from the date of discharge for In-Patient; otherwise, eligibility for reimbursement will be forfeited.
2. Reimbursement will be processed thirty (30) working days (excluding weekends & holidays) from the date of receipt of Life & Health provided that complete documents has been submitted by the member.
3. Life & Health reserves the right to impose additional requirements to justify payment of claim or deny even upon completion of requirements. Reimbursement is subject to plan coverage only.
4. For inquiries and follow-up, you may call our Claims Section at the hotline: **419-4777**.
   Cebu: 0917 153 7833; 0932 143 7139
   Davao: 0917 702 4499; 0917 659 6854
   NCR: 0917 133 3915; 0917 727 8357
   General Santos: 0917 779 6931; 0917 167 7998
   Butuan: 0954 276 2951; 0954 255 6402

REQUIREMENTS

OUT-PATIENT	IN-PATIENT
1. Filled out Reimbursement Request Form	1. Filled out Reimbursement Request Form
2. Medical Certificate from the attending physician	2. Medical Certificate from the attending physician
3. Original Official Receipt/ Sales Invoice with TIN	3. Original Official Receipt/ Sales Invoice with TIN
4. Doctor's Request with Diagnosis	4. Statement of Account (Summary of Hospital Bill)
5. Laboratory Result	5. Charge slips with detailed breakdown of charges per item
6. Charge slips with 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. Filled out Reimbursement Request Form	1. Filled out Reimbursement Request Form
	2. Claim Form (signed by attending physician)
2. Medical Certificate from attending physician	3. Police Report/ 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 claimant with the insured
4. Delivery Room Record/ Operative Record	7. Medical Expenses Incurred (Official Receipts)
	8. Medical Certificate

REIMBURSEMENT REQUEST FORM

PATIENT NAME	PATIENT CONTACT NUMBER	LIFE & HEALTH I.D. NO.	RELEASE ☐ PICK-UP
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