Reimbursement Claim Form

Marine Benefits Assistance Services, Inc.
Unit 802, 8th Floor, Pacific Star Building,
Sen. Gil Puyat Ave. Cor. Makati Ave.,
Makati City, 1209 Philippines

Tel. No.: +632 7534442
Mobile No.: +63 917 8636127
Skype: mbasmanila

REMINDERS:

1. Member should fill-out the part *to be accomplished by member* of this Form and affix signature.
2. Request Attending Physician to fill-out the part *to be accomplished by the attending physician* of this form and attach the Attending Physician's Report.
3. Prepare the following supporting documents needed to process or evaluate your claim for reimbursement:
   - Original Official Receipt(s) of Professional Fee(s), Hospital Bill, Medicine(s), Laboratory, Etc.
   - Statement of Account from the hospital where member/patient was confined or treated
   - Individual charge slips or itemized breakdown of charges to support the Statement of Account
   - For Inpatient Claims, Admitting History Report (to be obtained from the Medical Records Section of the Hospital where patient was confined)
   - Laboratory work-up(s) done and result(s).
4. Scan the accomplished Reimbursement Claim Form with the supporting documents and email to claims@marinebenefitsas.com or mbasmanila@marinebenefitsas.com preferably within 60 days from Date of Discharge/Hospital Visit.
5. The entire reimbursement process will take a maximum of 5 working days from the date MBAS received the complete documents.

TO BE ACCOMPLISHED BY MEMBER

Name of Patient:	MBAS ID No:	Date of Birth:
Complete Home Address:		Email Address: Contact Nos.:
What is/are the expense(s) being claimed for?		

PAYMENT METHOD – Please provide the following, payment is thru bank wire/transfer:

Account Holder Name:	Account Number & Account Type (e.g. USD):
Bank Name & Branch:	Bank Contact Number:
Bank Address:	
BIC/SWIFT Code:	RTGS Code/IFSC Code:
IBAN (for European Countries Only):	

Note: 1. Payable only to the employee or declared dependent spouse.
2. Please fill-out completely the above bank details to avoid delay in processing.

DECLARATION

I acknowledge that Marine Benefits liability is limited only to that provided for in the Policy and that this claim may be denied by Marine Benefits under the following circumstances:

1. Material mispresentation or concealment of relevant medical information in the application.
2. Illness, which is the reason for concealment, is determined by Marine Benefits to be pre-existing or is among the general specific exclusion stated in the agreement.
3. Treatment or procedure recommended by the Marine Benefits Affiliated Physician has not been followed.

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I also acknowledge that Marine Benefits is not responsible, among other things specified in the Policy, for the payment of additional charges resulting from: (a) having availed such room accommodation different from that specified in the schedule; (b) incurred additional charges/items that are not from part of the specified room accommodation.

I certify that the foregoing answers are true and correct to the best of knowledge and hereby authorize all doctors/persons who treated me and all the medical facility/ institutions to furnish full information including copies of their record(s) regarding this claim.

____________________ Date

______________________________________ Name & Signature of Member

To be accomplished by attending Physician

Name of Patient (Last, First Name, MI)	Was patient hospitalized? □ yes □ no If yes, Date & Time Admitted ______________________________ Date & Time Discharged ______________________________
*Date of onset of illness prior to consultation/admission:	Nature of illness or injury (admitting diagnosis)
	***Final Diagnosis**:
Nature of procedure done, if any (please describe fully)	
Has patient been previously confined to a medical facility or treated as an outpatient for this condition or for a condition for a related cause or causes? □ yes □ no if yes, please indicate details below :	

Name of hospital	Treatment Dates	Attending Physicians	Diagnosis

I HEREBY CERTIFY THAT THE INFORMATION PROVIDED ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Name/Signature of Attending Physician	License #	Date	Contact Number

Required Field