



# Reimbursement Claim Form

Please complete the form and send it to: Marine Benefits Assistance Services, Inc  
Suite 1903, The Peak Tower, 107 Leviste St.  
Salcedo Village, Makati City, 1227 Philippines

## REMINDERS:

1. Member should fill-up Part I of this Reimbursement Claim Form and affix signature.
2. Request Attending Physician to fill-up Part II (at the back) of this form or just 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)
  - Original Official Receipt(s) of Hospital Bill
  - 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)
  - Other : \_\_\_\_\_
4. Submit the accomplished Reimbursement Claim Form with the supporting documents to Marine Benefits Assistance Services, Inc.

## Part I – TO BE ACCOMPLISHED BY MEMBER/SUBSCRIBER

Name of Patient (Last, First Name, Middle Name)	Agreement No./Member I.D.	Name of Company
Address	Contact Nos.	If Claims Approved: <input type="checkbox"/> for pick up <input type="checkbox"/> mail to member <input type="checkbox"/> others
Patient is <input type="checkbox"/> Principal Member <input type="checkbox"/> Dependent of _____ (name of principal)	Are you covered by medicare or workmen's compensation plan? <input type="checkbox"/> yes <input type="checkbox"/> no	Are you covered by any other health/insurance plan? <input type="checkbox"/> yes _____ (company) <input type="checkbox"/> no
<b>If claims is due to accident</b> Date & Time of accident _____ Place of Accident _____	Was member at work when the accident happened? <input type="checkbox"/> yes <input type="checkbox"/> no Give brief description of the accident.	
<b>Name and location of hospital where confined/treated.</b> _____ Was MBAS notified? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, date and time _____ Who was notified _____	Was this confinement/outpatient availment facilitated by MBAS with LOA? <input type="checkbox"/> yes <input type="checkbox"/> no  If so, what is the expense being claimed for?	
Were you previously confined in a hospital for this ailment? <input type="checkbox"/> yes <input type="checkbox"/> no If "yes", Name of hospital _____ Date admitted _____		



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**Payment Method** – Please provide the following if you want to receive a bank wire/ transfer:  
**Subscriber name as it appears on bank account:**

**Bank name:** \_\_\_\_\_ **Bank's Physical Address:** \_\_\_\_\_

**Bank's Contact Number:** \_\_\_\_\_ **Account #:** \_\_\_\_\_

**Bank Identifier Code (BIC/SWIFT):** \_\_\_\_\_

## DECLARATION

I acknowledge that Marine Benefits Assistance Services, Inc. liability is limited only to that provided for in the Agreement and that this claim may be denied by Marine Benefits Assistance Services, Inc. under the following circumstances:

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

I also acknowledge that Marine Benefits Assistance Services, Inc. is not responsible, among other things specified in the Agreement, for the payment of additional charges resulting from: (a) having availed such room accommodation different from that specified in the schedule; (b) incurring additional charges/items that are not from part of the specified room accommodation; (c) availing without Marine Benefits Assistance Services, Inc. authority of hospital services after discharge or after the number of days authorized; (d) refusing to transfer to an affiliated hospital as recommended by Marine Benefits Assistance Services, Inc. or affiliated physician.

I certify that on the commencement date of the hospitalization for which the benefit is being claimed, the person hospitalized was member of good standing of the OMB.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name & Signature of Claimant



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## Part II – To be accomplished by attending Physician

Name of Patient (Last, First Name, MI)	Was patient hospitalized? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, Date & Time Admitted _____ Date & Time Discharged _____		
Nature of illness or injury (admitting diagnosis)	Date of onset of illness prior to consultation/admission		
Final diagnosis			
Nature of procedure done, if any (please describe fully)			
Has patient been previously confined to a hospital or treated as an outpatient for this condition or for a condition for a related cause or causes? <input type="checkbox"/> yes <input type="checkbox"/> 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 of Attending Physician	Signature	Date	Contact Number