COOPERATIVE HEALTH MANAGEMENT FEDERATION

Unit 102 Malakas Suite, #88 Malakas St., Brgy. Pinyahan, Central District, Diliman, Quezon City
Tel. No. 02-89310387 / 02-82832321Email: 1coophealth@chmf.coop

REIMBURSEMENT REQUEST FORM

(IMPORTANT: Kindly fill-up this form and attach the required documents)

Date Submitted: _____

PATIENT'S NAME: _____
CARD/ID NUMBER: _____
COOPERATIVE NAME: _____
CONTACT NUMBER: _____
EMAIL ADDRESS: _____
PLEASE SEND MY CLAIMS TO: _____
(Name & Address)

REIMBURSEMENT REQUIREMENTS CHECK LIST

(To be filled up by the COOP Representative or COOP Member)

Please check the box to the corresponding documents submitted.

CONSULTATION
- ☐ Original copies of the Official Receipts
- ☐ Original copy of Medical Certificate
- ☐ Letter of explanation if the consultation was done in an accredited provider
- ☐ Photocopy of Valid ID

LABORATORY / OPD PROCEDURES
- ☐ Original copies of the Official Receipts
- ☐ Original copy of Medical Certificate
- ☐ Breakdown of the Laboratory test/procedures
- ☐ Letter of explanation if the laboratory test was done in an accredited provider
- ☐ Photocopy of Valid ID

DENTAL CASES
- ☐ Original copies of the Official Receipts
- ☐ Tooth Number *(for extraction/filling)*
  Note: *Php 250.00 total reimbursable per procedure*
  Limitation: 2 procedures per day
- ☐ Photocopy of Valid ID

CONFINEMENT / IN-PATIENT
- ☐ Original copies of the Official Receipts
- ☐ Original copy of Medical Certificate
- ☐ Statement of Account (summary of fees)
- ☐ Itemized Billing Statement (breakdown of fees)
- ☐ Operative Records w/ Histopath Result (if applicable)
- ☐ Incident Reports: (if applicable)
  * Police Report – for vehicular accidents; include driver's license, OR/CR No. of vehicle, helmet sticker
  * Medico-Legal Report – for assaults
  * Operative Record (if applicable)
  * Written Report – for minor accidents
- ☐ Photocopy of Valid ID

EMERGENCY CASES
- ☐ Original copies of the Official Receipts
- ☐ Original copy of Medical Certificate
- ☐ Statement of Account (summary of fees)
- ☐ Itemized Billing Statement (breakdown of fees)
- ☐ Incident Reports:
  * Police Report – for vehicular accidents; include driver's license, OR/CR No. of vehicle, helmet sticker
  * Medico-Legal Report – for assaults
  * Written Report – for minor accidents
- ☐ Photocopy of Valid ID

NOTE:

1. Members requesting for reimbursement are given ***THIRTY (30) WORKING DAYS*** from the date of availment to complete **ALL** the requirements stated above.
2. 100% reimbursable up to limit for all availment to none accredited provider for areas **WITH NO ACCREDITED PROVIDERS.**
3. 80% reimbursable up to limit for all availment to none accredited provider for areas **WITH ACCREDITED PROVIDERS**.
4. For dependents (18 years old below) please provide a valid ID of the beneficiary/parent/legal guardian.
5. For those who wish to deposit their claims in their personal bank account, kindly provide an Authorization Letter complete with the bank details (bank name, account name, account number).
6. For those who wish to deposit their claims in their cooperative's bank account, kindly provide an Authorization Letter (from the member) and an Acknowledgement Letter from the cooperative/branch representative that they are aware of the member's request.
7. Incomplete requirements will not be processed.

For inquiries, questions and concerns, you may contact the **Medical Department** thru Mobile: 0917-8048837 / Landline: 02-82832321 or thru email: claims@chmf.coop.

Submitted by:	**Checked by:**	**Received by:**
(Signature over printed name)	**(Signature over printed name)**	**(Signature over printed name)**
Member	*Cooperative In-charge*	*CHMF Staff*