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

HIB REIMBURSEMENT REQUEST FORM

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

Date Submitted: _____

PATIENT'S NAME: _____
(Surname) **(First Name)** (Middle Name) (Ext.)

POLICY NUMBER: _____

COOPERATIVE NAME: _____

CONTACT NUMBER: _____

EMAIL ADDRESS: _____

HOSPITAL INCOME BENEFIT (HIB) REIMBURSEMENT REQUIREMENTS CHECKLIST

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

Please check the box to the corresponding documents submitted.

HOSPITAL INCOME BENEFIT (HIB) PHP 200.00/DAY (MAX OF 30DAYS)

- ☐ Statement of Account (SOA)
- ☐ Dishcarge Summary
- ☐ Photocopy of ID

MEDICINE SUBSCIDY – PHP 4,500.00 / YEAR

- ☐ Original copy of the Official Receipts
- ☐ Original copy of Specialist Prescription with signature & License No.

AMBULANCE – PHP 2,500.00 / YEAR

- ☐ Original copy of the Official Receipt

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. Applicable for in-patient / confinement only
3. For dependents (18 years old below) please provide photocopy of birth certificate and letter of the primary member to whom the check will be paid.
4. 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*