Rayomar Insurance Business, Inc.

CLAIMS FACILITATION N
Unit 26 3rd Floor Legaspi Tower 300, 2600
Roxas Blvd. Cor. P. Ocampo St. Malate Manil

SUBMIT CLAIMS WITH COMPLETE REQUIRMENTS TO:
Ventis Maritime Corp. - c/o Teta Bacolod - Welfare Ofcr.
"K" Line Bldg. Coral Way Drive
Central Business Park I, Island A, Pasay City
Tel No. (02)514-5486/0917-5630979
ALL OFFICIAL RECEIPTS (OR) SHOULD BE ORIGINAL
Please paste OR in a bond paper

Ventis Maritime Corporation

# NOTICE OF CLAIM

| Name of Patient | Name of Principal Member ( If patient is dependent) | | Cert. No/Client No. |
|---|---|---|---|
| Present Address | | Employer (Principal) | Principal Employment Status<br>O On Board O On vacation |
| Patient Relationship to Principal<br>O Spouse O Child<br>O Parents O Others | Patient date of Birth | Date of Confinement | Date Received Claim / Phone Number |
| Sex<br>O Male O Female | Is Patient Employed?<br>O Yes O No | If Yes, Occupation | Claim Settlement Pay to<br>O Claimant O Provider O Employer<br>Payees Name/Check Payable to: |
| Type of Claim<br>O Accident O Surgery O Sickness/ Illness | | Is this Hospital/ Clinic/ Provider registered with the Department of Health<br>O Yes O No | |
| Hospital/ Clinic/ Provider | | If not, does it have permit to operate as Hospital Clinic and to admit In-Patient<br>O Yes O No | |

## Claimant

*For Data Protection Purposes I/We acknowledge that any personal data secured from me/us a result of this claim will be held and processed for insurance administration and claims investigation. For this purpose, the information may also be passed to select third parties and insurer.*

*I/We consent to you processing sensitive data about me/us and other person who may be insured under the contract.*

*I/We understand that all personal data I/We supply must be accurate and I/We have the specific consent of those other person insured to disclose their personal data.*

*I/We consent to seeking of information from other insurers, Credit and other Information Agencies to check the answer we have provided and will authorize the giving of such information.*

*I/We declare that on settlement I/We transfer all rights of subrogation and recovery to the Insurer and or/their Loss Adjuster. Please note that we have rights to salvage and we will exercise these rights where applicable.*

*I/We declare that to the best of our knowledge and belief the information given in this form is correct and complete.*

*Claimant Name :* _____ *Date:* _____
*( Incase claimant is minor, name of person applying for claim)*

*Signature:* _____

## Employer (Principal)

*I HEREBY Certify that the forgoing statement are true and correct and complete to the best of my knowledge and belief. I certify further that the employee named above is a regular full time employee of our Company in accordance with our records and insured under our Group Hospitalization Policy issued by the Insurer. In the event of underpayment or overpayment of claim due to changes in the benefits or wrong computation of claim, our Company and the Insurer mutually agree to pay to the amount involved.*

CRISTETA T. BACOLOD
Welfare Officer
Ventis Maritime Corporation

| Printed Name | Signature | Position/Title | Date |
|---|---|---|---|
| Employer/ Company Representative/Welfare Office | | | |

## Documentary Requirements for Claims

- *Duly Accomplished Notice of Claim (NOC)*
- *Medical Certificate from attending physician*
- *Original OR of all payments made*
- *Drug prescription from attending physician*
- *Statement of account Itemized and summarized (SOA)*
- *Supporting charge slip of statement of statement of account incase where hospital has no itemized SOA*
- *If surgical procedure is done: Copy of Operative Report/Histopathology Report/Admitting History/ Discharge Summary Report.*
- *If private duty nurse was deemed necessary: Referral Letter Slip from attending physician requiring patient to have nurse.*
- *For Injury result of an accident: Basic requirement for patient Claims and copy of the police report.*
- *In event of death of the insured: Copy of the Registered Death Certificate*
  - *If applicable: Basic requirements for In Patient Claim and*
  - *Copy of Police Report.*
- *For dependent, proof of dependency, Birth certificate, Marriage certificate*

*Note: All original copy of the documents are required in filing for reimbursement/claim.*
*Please answer all the question herein in order to expedite settlement of the claim*

## To be Accomplished by the Attending Physician

| | |
|---|---|
| Name of patient:<br>Date of Birth: | Date of confinement:<br>From: _____ To: _____ |
| Name of Hospital/Clinic | Is the Hospital/Clinic registered with the Bureau of Medical Services? O Yes O No |

Complete and Final Diagnosis ( If Injured, please give date and place of accident)

Short history of illness or disability

Did Disability or Illness arise out of and in a course of the patient employment? O Yes O No

If so, Please explain briefly.

| | |
|---|---|
| Is Disability due to Pregnancy? O Yes O No | If yes, please give approximate date of first day of last menstruation |

Complete if X-Ray or Laboratory services were performed prior to this confinement

| Place/ Hospital/Laboratory | Type of examination | Date | Fee Charged | Findings |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

If Surgery was performed: Nature of Surgical Operation/ Obstetrical procedure performed: Please attaché Operative report.

ICD Code: _____

| Date Performed | Place Performed | Type of Confinement |
|---|---|---|
| | | |

Name of Surgeon/Anesthesiologist/Other Doctors who attend to claimant

| Name | Specialty | Procedure | Fee | Date of Attendance |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Remarks

I Hereby Certify that the forgoing answers have been taken from the medical/hospital records of the above-named patient. They are full, complete, correct and true.

| Name of Attending Physician | Signature of Attending Physician | Date |
|---|---|---|

Address_____ Tel. No._____ License No._____