**CLAIM FORM**

**MOSQUITRONELLA INSURANCE**

PART I

DOCTOR’S MEDICAL EVALUATION REPORT

(To be accomplished by the attending physician)

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| Patient’s Name: Sex: Age: |
| Address: |
| Nature of Illness: |
| a. Chief Complaint |
| b. Final Diagnosis |
| c. Brief History of Present Illness |
| Date symptoms first appeared: |
| Date Patient first consulted you for this condition: |
| Laboratory tests / ancillary procedures done and the results: |
| **DECLARATION:**  I hereby certify that the statements and facts presented above are true and that I have not withheld any  material information in relation to the above condition.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physician’s Signature Over Printed Name  Date: License No.:  Contact No.: |
| **PART II**  **(To be accomplished by the Assured)** |
| **If the Patient Was Confined:**  Name of Hospital \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Assured’s Signature Over Printed Name  Date Filed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **PART III**  **How To File a Claim:**   * Consult a licensed Doctor and take all the necessary medical procedures. * Ask your attending physician to fill up and sign the Doctor’s Medical Evaluation Report which can be downloaded from our website. * All documentary requirements can be sent via e-mail to [mjcorral@fgic.com.ph](mailto:mjcorral@fgic.com.ph) or via Viber to 09209131558.   1. Duly accomplished Form   2. Laboratory tests results   3. If the claimant is a minor, photocopies of the Insured’s and legal guardian’s valid IDs and proof of affiliation to the Insured.   4. For Death Claims - Death Certificate, proof of affiliation to the Insured, and valid government ID of the beneficiary.   5. Duly accomplished Electronic Funds Transfer Authorization Form (EFTAF) (once the claim has been approved)   **Claim shall be Made Payable to:**   * + 1. For Medical Assistance Benefit- the Insured or insured’s legal guardian if the Insured is a minor.     2. In the event of the Insured’s demise, claim shall be made payable to the beneficiary named in your registration.   If you have any inquiry, please call FGIC – HO Claims Department at 8706-39-59 local 431, 432 and 434 or alternatively, send an e-mail to [mjcorral@fgic.com.ph](mailto:mjcorral@fgic.com.ph) |