**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 NameDate: 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 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  |