REIMBURSEMENT FORM

Tel: 04-2367575 Fax: 04-2367979

Provider Name:	Patient Name:	Policy No.:
Insurance Company:	Contact No.:	Policy Expiry Date:
Hospital File No:	MaxCare ID No.:	Company Name:
Year of Birth: / /	Gender: M ☐ F ☐	

Please Complete Clearly (All Fields Mandatory)

ADMINISTRATIVE

Healthcare Provider:	Patient's Name:		
Date of Service:______/_____/______ (dd mm year) Card No.	Patient Tel:	DOB:_____/_____/_____ (dd mm year) Patient Employer:	Sex: ☐ F ☐ M
(Mandatory) ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐		*(Mandatory)*	

SUBJECTIVE (*To be completed by Physician*)

Symptom(s) As Described by the Patient (CHIEF COMPLAINT)

Date of Present Symptom Onset: _______/_______/_______ (dd mm year)

What date did the Patient first feel same / similar Symptom(s):_____/_____/_______ (dd mm year)

Is the Patient under any type of Treatment? ☐ Yes ☐ No If yes, indicate what Assesment and since when:

OBJECTIVE/ASSESSMENT (*To be completed by Physician*)

Clinical Findings: Vital Signs: B/P: __________ T: __________ HR: __________ RR: __________

Cause: ☐ Physical Illness ☐ Accident ☐ Maternity ☐ Preventive ☐ Psychiatric ☐ Dental ☐ Work Related ☐ Other

Assesment/Diagnosis: ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected *INDICATE DIAGNOSIS NOT SYMPTOM*	*DIAGNOSIS CODE*
1.	
2.	
3.	

Is Assessment/Diagnosis related to another Assessment? ☐ Yes ☐ No If yes, specify: (i.e. Retinopathy related to Diabetes)

MEDICAL PLAN

Itemized Orignal Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim.

☐ Consultation	*Cost*	☐ Physiotherapy	*Cost*
☐ Pharmacy	*Cost*	☐ Laboratory / Radialogy / Other	*Cost*
TOTAL CHARGES			

Was In-patient Required? Length of Stay ____________ Indicate Provider ___________ Cost __________

* Discharge Summary, Itemized Invoices, Reports & Receipts Attached?

Treating Physician Name:

Tel / Fax:

Signature & Stamp:

I hereby authorize any Healthcare Provider, Insurer, Employer or other Organization to release any information regarding my medical condition & history to MaxCare ME for the purpose of determining insurance benefits.

Patient's Signature (Parent if minor) *Date*