

HOSPITALIZATION BENEFIT APPLICATION FOR REIMBURSEMENT

To be accomplished by employee in one copy only

Revised 12-04-2006

Name (Last) (First) (MI)		ID No.	Post/Unit	
Hospital confinement was notified <i>(must be within 24 hours) --</i> <input type="checkbox"/> to operations manager <input type="checkbox"/> area supervisor <input type="checkbox"/> by employee <input type="checkbox"/> by family member <i>(specify)</i> _____ <input type="checkbox"/> thru landline <input type="checkbox"/> thru voice call <input type="checkbox"/> thru text message			Reason/s for Confinement <i>(specify illness per record)</i>	
Date of Notification: _____ Time of Notification: _____				
Name & Address of Hospital		Date of Admission Time of Admission Date of Discharge		Inclusive No. of Day/s
Total Hospital Bill ₱ _____ Less: Philhealth Room _____ Net Amount ₱ _____ Doctor's Fee + _____ Net <u>₱ _____</u>		Cost of Related Medicines	Total Amount of Reimbursement	_____ Employee's Name & Signature

To be accomplished at the office

Application is acceptable <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Amount of disallowed expenses ₱ _____	Reason/s for disallowed expenses		
Total amount to be recommended for approval				
Total Hospital Bill ₱ _____ Less: Philhealth Room _____ Net Amount ₱ _____ Doctor's Fee + _____ Net <u>₱ _____</u>	Cost of Related Medicines	Total Amount of Reimbursement	Processed/Checked _____ Office Staff's Signature	
Endorsed for Approval: _____ Operations Manager	Approved: _____ Authorized Signatory		Payment Processed/Credited: _____ Finance Department	

Attached the following documents: (original)

- Medical certificate
- Billing Statement
- Original OR ng pinagbayaran sa hospital
- Reseta ng mga gamot
- Original OR ng mga gamot aside sa covered ng hospital
- Admission Record
- Discharge Summary