Republic of the Philippines

SOCIAL SECURITY SYSTEM

EC MEDICAL REIMBURSEMENT APPLICATION

FORM 2

MED - 01190 (08-2014)

THIS FORM MAY BE REPRODUCED AND IS NOT FOR SALE. THIS CAN ALSO BE DOWNLOADED THRU THE SSS WEBSITE AT www.sss.gov.ph.

PLEASE READ THE INSTRUCTIONS AND REMINDERS AT THE BACK OF FORM 1 BEFORE FILLING OUT THIS FORM. PRINT ALL INFORMATION IN CAPITAL LETTERS AND **USE BLACK INK ONLY**.

PART I - TO BE FILLED OUT BY PAYEE/CLAIMANT

TYPE OF CLAIM ☐ Initial ☐ Subsequent ☐ Reconsideration

TYPE OF PAYEE/CLAIMANT ☐ Member ☐ Company ☐ Hospital ☐ Doctor

SS NUMBER OF MEMBER | COMMON REFERENCE NO. OF MEMBER (IF ANY) | DATE OF BIRTH (MMDDYYYY) | TAX IDENTIFICATION NUMBER (IF ANY)

NAME OF MEMBER (LAST NAME) (FIRST NAME) (MIDDLE NAME) (SUFFIX)

PAYEE/CLAIMANT 1 (LAST NAME) (FIRST NAME) (MIDDLE NAME) (SUFFIX) | PRC NUMBER (IF DOCTOR) | TAX IDENTIFICATION NUMBER (IF ANY)

ADDRESS (RM/FLR/UNIT NO. & BLDG. NAME) (HOUSE/LOT & BLK NO.) (STREET NAME)

(SUBDIVISION) (BARANGAY/DISTRICT/LOCALITY) (CITY/MUNICIPALITY) (PROVINCE) ZIP CODE

PAYEE/CLAIMANT 2 (LAST NAME) (FIRST NAME) (MIDDLE NAME) (SUFFIX) | PRC NUMBER (IF DOCTOR) | TAX IDENTIFICATION NUMBER (IF ANY)

ADDRESS (RM/FLR/UNIT NO. & BLDG. NAME) (HOUSE/LOT & BLK NO.) (STREET NAME)

(SUBDIVISION) (BARANGAY/DISTRICT/LOCALITY) (CITY/MUNICIPALITY) (PROVINCE) ZIP CODE

PAYEE/CLAIMANT 3 (LAST NAME) (FIRST NAME) (MIDDLE NAME) (SUFFIX) | PRC NUMBER (IF DOCTOR) | TAX IDENTIFICATION NUMBER (IF ANY)

ADDRESS (RM/FLR/UNIT NO. & BLDG. NAME) (HOUSE/LOT & BLK NO.) (STREET NAME)

(SUBDIVISION) (BARANGAY/DISTRICT/LOCALITY) (CITY/MUNICIPALITY) (PROVINCE) ZIP CODE

CHARGES

	ITEM	AMOUNT CLAIMED
1)	Medicine	₱
2)	Laboratory	
3)	X-ray/Ultrasound	
4)	Physical Therapy	
5)	Hospital Room	
6)	Emergency Room	
7)	Intensive Care Unit (ICU)	
8)	Operating Room	
9)	Central Supplies	
10)	Miscellaneous/Others	
	SUB TOTAL	₱
Less:	Philhealth	
	HMO	
	PCSO	
	Hospital Discount	
	Others	
	SUB TOTAL	₱
	NET TOTAL	₱

PART II - TO BE FILLED OUT BY HOSPITAL

EMPLOYER NUMBER | TAX IDENTIFICATION NUMBER (IF ANY) | PHIC ACCREDITATION NUMBER

NAME OF HOSPITAL

ADDRESS (RM./FLR./UNIT NO. & BLDG. NAME) (HOUSE/LOT & BLK. NO.) (STREET NAME)

(SUBDIVISION) (BARANGAY/DISTRICT/LOCALITY) (CITY/MUNICIPALITY) (PROVINCE) ZIP CODE

TELEPHONE NUMBER (AREA CODE + TEL. NO.) | E-MAIL ADDRESS | WEBSITE (IF ANY)

HOSPITALIZATION ☐ Out-patient ☐ Confined | DATE ADMITTED (MMDDYYYY) | DATE DISCHARGED (MMDDYYYY)

CERTIFICATION

I certify that the services claimed are duly recorded in the patient's chart and the information provided in this form, including the attached copy of the patient's statement of actual charges are true and correct.

PRINTED NAME OF AUTHORIZED SIGNATORY | SIGNATURE OF AUTHORIZED SIGNATORY | POSITION TITLE | DATE

PART III - TO BE FILLED OUT BY MEMBER OR EMPLOYER (WAIVER)

I hereby waive my right to the reimbursement of this claim in favor of the herein-named Payee/Claimant.

PRINTED NAME OF MEMBER	SIGNATURE OF MEMBER	DATE

PRINTED NAME OF EMPLOYER REPRESENTATIVE	SIGNATURE OF EMPLOYER REPRESENTATIVE	DATE

PART IV - TO BE FILLED OUT BY ATTENDING DOCTOR/S

NAME OF ATTENDING DOCTOR 1	PRC NUMBER	TAX IDENTIFICATION NUMBER	PROFESSIONAL FEE ₱	NO. OF VISIT/S

SERVICES RENDERED

SIGNATURE OF ATTENDING DOCTOR _____ DATE _____

NAME OF ATTENDING DOCTOR 2	PRC NUMBER	TAX IDENTIFICATION NUMBER	PROFESSIONAL FEE ₱	NO. OF VISIT/S

SERVICES RENDERED

SIGNATURE OF ATTENDING DOCTOR _____ DATE _____

NAME OF ATTENDING DOCTOR 3	PRC NUMBER	TAX IDENTIFICATION NUMBER	PROFESSIONAL FEE ₱	NO. OF VISIT/S

SERVICES RENDERED

SIGNATURE OF ATTENDING DOCTOR _____ DATE _____

NAME OF ATTENDING DOCTOR 4	PRC NUMBER	TAX IDENTIFICATION NUMBER	PROFESSIONAL FEE ₱	NO. OF VISIT/S

SERVICES RENDERED

SIGNATURE OF ATTENDING DOCTOR _____ DATE _____

PART V -TO BE FILLED OUT BY MEMBER (AUTHORIZATION)

I authorize the herein-named hospital/employer/doctor/provider who provided/paid the medical services, appliances and supplies to file an Employee's Compensation (EC) medical expense claim under P.D. 626 for payment of services rendered to me during my treatment and the release to the SSS/EC of any information needed for this or a related EC claim. I agree to pay reasonable expenses incurred in excess of what are reimbursable under EC medical service and any portion of the claim subsequently disallowed by SSS.

PRINTED NAME	SIGNATURE	DATE

If member cannot sign, affix fingerprints. Please read Instruction No. 4 of Form 1.

Below are the witnesses to fingerprinting:

1) _____ _____ _____
PRINTED NAME SIGNATURE DATE

ADDRESS & CONTACT NUMBER _____

2) _____ _____ _____
PRINTED NAME SIGNATURE DATE

ADDRESS & CONTACT NUMBER _____

RIGHT THUMB	RIGHT INDEX