Republic of the Philippines

SOCIAL SECURITY SYSTEM

EC MEDICAL REIMBURSEMENT BENEFIT APPLICATION

FORM B301
(Rev. 02/97)

PLEASE READ INSTRUCTIONS AT THE BACK BEFORE FILLING UP

PART I - EMPLOYER TO FILL IN ALL ITEMS

ACCIDENT/SICKNESS REPORT

NAME OF EMPLOYEE		SS NUMBER	
HOME ADDRESS	ZIP CODE	AGE	SEX M ☐ F ☐

OCCUPATION (State brief description of duties/Specify name of chemicals or substances to which the employee is exposed)

NAME OF EMPLOYER AT THE TIME OF ACCIDENT/SICKNESS	ID NUMBER
ADDRESS	ZIP CODE

PERIOD OF EMPLOYMENT	REGULAR WORKING HOURS	OVERTIME SCHEDULE
From _____ To _____	☐ AM ☐ AM From _____ ☐ PM To _____ ☐ PM	☐ AM ☐ AM From _____ ☐ PM To _____ ☐ PM
DATE OF ACCIDENT/ONSET OF SICKNESS	TIME OF ACCIDENT/SICKNESS ☐ AM _____ ☐ PM	PLACE OF ACCIDENT/SICKNESS

BRIEF DESCRIPTION OF ACCIDENT/SICKNESS (Specify where employee was going at the time of accident or the purpose of the trip and describe the circumstances of the accident)

PART II - JOINT CERTIFICATION

We hereby certify that all the above information are true and correct.

PRINTED NAME AND SIGNATURE OF IMMEDIATE SUPERVISOR

PRINTED NAME AND SIGNATURE OF AUTHORIZED COMPANY REPRESENTATIVE

PRINTED NAME AND SIGNATURE OF EMPLOYEE	RIGHT THUMBPRINT (in lieu of signature)	(If member cannot sign/deceased) PRINTED NAME AND SIGNATURE OF WITNESS

NOTE: ANY MISREPRESENTATION OR FALSIFICATION SHALL BE SUBJECT TO FINE AND IMPRISONMENT UNDER THE LAW (P.D. 626, ARTICLE 207)

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SOCIAL SECURITY SYSTEM
EC MEDICAL REIMBURSEMENT

ACKNOWLEDGEMENT STUB
TO BE FILLED UP BY EMPLOYER/EMPLOYEE
FORM B301 (Rev. 02/97)

PLEASE PRESENT THIS RECEIPT WHEN INQUIRING ABOUT THE STATUS OF YOUR APPLICATION. VERIFICATION WILL BE ENTERTAINED AFTER _____ DAYS FROM THE DATE OF RECEIPT.

NAME OF PAYEE		FOR SSS USE ONLY DATE RECEIVED
NAME OF EMPLOYEE (SURNAME) (FIRST NAME) (MIDDLE NAME)	SS NUMBER	RECEIVED BY

INSTRUCTIONS

1. Fill in all items properly. Please type or print legibly.

2. Attach the following in cases of:

    a) ***vehicular accident***

        • police report
        • specify employee's destination and purpose of the trip

    b) ***medico-legal incident***

        • police report
        • specify motive of the aggressor in inflicting the injuries

    c) ***work-related illness***

        • pre-employment physical examination report/ chest x-ray/ ECG reports.
        • pertinent clinical records/laboratory and other diagnostic procedures.

Note: Employee's Compensation claims should be filed within 3 years from date of work-related accident or illness.

Republic of the Philippines

SOCIAL SECURITY SYSTEM

EC MEDICAL REIMBURSEMENT BENEFIT APPLICATION

FORM B301
(Rev. 12/95)

PLEASE READ INSTRUCTIONS AT THE BACK BEFORE FILLING UP

PART I - PAYEE/CLAIMANT TO FILL IN ALL ITEMS

PAYEE/CLAIMANT	☐ Initial Claim ☐ Related/Subsequent	
ADDRESS OF PAYEE	ECC ID NO.	ZIP CODE
PAYEE/CLAIMANT		
ADDRESS OF PAYEE	ECC ID NO.	ZIP CODE
PAYEE/CLAIMANT		
ADDRESS OF PAYEE	ECC ID NO.	ZIP CODE

PART II - HOSPITAL TO FILL IN ALL ITEMS

NAME OF HOSPITAL	ECC NUMBER	☐ Out-patient ☐ Confined
ADDRESS:	DATE ADMITTED	DATE DISCHARGED

CHARGES	AMOUNT CLAIMED	AMOUNT ALLOWED
A. MEDICINES		
B. LABORATORY		
C. X-RAY/ULTRASOUND		
D. PHYSICAL THERAPY		
E. HOSPITAL ROOM/ER		
F. OPERATING ROOM		
G. CENTRAL SUPPLIES		
H. MISCELLANEOUS/OTHERS		
T O T A L		

I CERTIFY THAT THE SERVICES CLAIMED ARE DULY RECORDED IN THE PATIENT'S CHART AND THE INFORMATION GIVEN IN THIS FORM, INCLUDING THE ATTACHED COPY OF THE PATIENT'S STATEMENT OF ACTUAL CHARGES, IS CORRECT.

PRINTED NAME AND SIGNATURE OF AUTHORIZED REPRESENTATIVE	POSITION

PART III - DOCTOR TO FILL IN ALL ITEMS

DIAGNOSIS			PARTS OF THE BODY AFFECTED	
			PROFESSIONAL FEE	**APPROVED**
PRINTED NAME AND SIGNATURE OF ATTENDING PHYSICIAN	ECC NUMBER	TIN		(For SSS use only)
SERVICES RENDERED		NUMBER OF VISITS		
PRINTED NAME AND SIGNATURE OF SURGEON	ECC NUMBER	TIN		
SERVICES RENDERED		NUMBER OF VISITS		
PRINTED NAME AND SIGNATURE OF ANESTHESIOLOGIST	ECC NUMBER	TIN		
SERVICES RENDERED		NUMBER OF VISITS		

PART IV - AUTHORIZATION

I AUTHORIZE THE HEREIN-NAMED HOSPITAL/EMPLOYER/PHYSICIAN/PROVIDER WHO PROVIDED/PAID THE MEDICAL SERVICES, APPLIANCES AND SUPPLIES TO FILE AN EMPLOYEES' COMPENSATION MEDICAL EXPENSE CLAIM UNDER P.D. NO. 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 SERVICES AND ANY PORTION OF THE CLAIM SUBSEQUENTLY DISALLOWED BY SSS.

		(If member cannot sign/deceased)
PRINTED NAME AND SIGNATURE OF EMPLOYEE	RIGHT THUMBPRINT (In lieu of signature)	PRINTED NAME AND SIGNATURE OF WITNESS

INSTRUCTIONS

1. Fill in properly all blank spaces.

2. Indicate complete diagnosis including body parts affected:

- head/neck	- upper extremities	- lower extremities
- eyes	- arms	- legs
- trunk	- head	- foot
- spine		- others

3. ***If claimant is employee or employer***, attach the following:

   a. original official receipt with BIR permit number

   b. charge slips or statement of account with itemized list or breakdown of expenses

4. ***If claimant is hospital***, attach charge slips or statement of account with itemized list or breakdown of expenses.

5. ***If member is unable to sign***, affix thumbprint, with printed name and signature of witness to thumbprint.

6. ***If member is deceased***, indicate the relationship on the employee portion, with printed name and signature of witness.

7. Use another sheet if there are more than three payees.