PUBLIC SAFETY MUTUAL BENEFIT FUND, INC.

Medical Assistance Reimbursement Application (MARA)

Important Instructions: (1) Please fill out this form and attach all original documents and submit PSMBFI **within 30 days from date of availment**, otherwise reimbursement of claim(s) declared in this form will be forfeited. (2) Please ensure that **all pertinent information is completely accomplished**. (3) Any amounts exceeding the Maximum Benefit Limit will be charged against the member's equity value.

MEMBER GENERAL INFORMATION
(To be accomplished by the patient/ member/ representative

Patient Name:	**Partner Agency:**	**Mobile Number**
Hospital/ Clinic/ Provider where the member availed:		**Email Address**

Preferred Disbursement Media

☐ Instacredit* ☐ Bank Transfer ☐ Cheque
☐ Others _____
Bank: _____
Reference / Account Number:_____
*more than ₱ 5,000 claim reimbursement

How did you learn about the IMAP?

☐ Text Message ☐ Flyers ☐ PSMBFI Personnel
☐ Facebook ☐ Posters ☐ PSMBFI Website
☐ co-worker ☐ Others _____

To be evaluated by PSMBFI:

1. Is member patronage between 20 to 24 years? ☐ Yes ☐ No
2. Is member **NOT** covered under Medicare Plus? ☐ Yes ☐ No
3. Is date of filing of reimbursement within the patronage period? ☐ Yes ☐ No
4. Has Member **NOT** filed for a voluntary termination during evaluation period? ☐ Yes ☐ No
5. Member has submitted **ORIGINAL** required documents:
   a. Charge slips/ of detailed itemized breakdown of charged (charges per item paid) ☐ Yes ☐ No
   b. BIR-registered sales/service invoice or cash invoice with TIN ☐ Yes ☐ No
   c. Medical certificate indicating diagnosis & procedure done ☐ Yes ☐ No
   d. Statement of account ☐ Yes ☐ No
   e. Police report (for causes of assault and vehicular accidents) ☐ Yes ☐ No
6. Is the sales/ service invoice submitted within 30 days from the date of file? ☐ Yes ☐ No
7. Is the claim **NOT** duplicitous (i.e. No AHB, No IHB filed, not filed with Medicare Plus)? ☐ Yes ☐ No
8. Is Medical Assistance Reimbursement within the remaining outstanding balance of Medical Assistance Coverage? Amount for Reimbursement _____ ☐ Yes ☐ No
9. Is member cleared of past due issues? Amount of Past Due: _____ ☐ Yes ☐ No
10. Is request for reimbursement an included incident? ☐ Yes ☐ No
11. Has Philhealth been deducted? ☐ Yes ☐ No
12. Is the treatment within medical guidelines/ scope of diagnosis? ☐ Yes ☐ No

IMPORTANT

To ensure the accuracy of the details provided to PSMBFI for purposes of evaluating this reimbursement claim, I hereby irrevocable authorize PSMBFI as my attorney-in-fact to examine and obtain, collect, examine, process and store copies of my medical records as well as any information relating to my hospitalization, consultation, treatment or any other medical advice; and (b) disclose such information to PSMBFI an/ or its duly authorized representative/s and my employer and/or its authorized representatives, upon request. In lieu of the original record, a certified photocopy will be honored as the original. I understand my rights and obligations pursuant to the Data Privacy Act and its implementing rules and regulations, as the same may be amended. I further agree to hold PSMBFI and its Representatives free and harmless from and against any and all suits or claims, actions, or proceedings, damages, costs, and expenses, including attorney's fees, which may be filed, charged, or adjudged against PSMBFI or any of its directors, officers, employees, agents, or representatives in connection with or arising from the use, processing and disclosure by PSMBFI or its Representatives of the aforementioned information.

In signing this form, Member assures the (1) truthfulness of submitted documents and if found fraudulent will be denied; and (2) reimbursed claims in excess of the Maximum Benefit Limit of ₱ 40,000 will be charged against member's equity value.

_____ _____
Signature over Printed Name of Member Date Signed