



I-Heal

INSTRUCTIONS TO CLAIMANT:

1. This form (I-Heal Claim Form II) must be completed by the AUTHORIZED OFFICER of the hospital.
(If not applicable, please write N/A in the space provided for.)
2. The following must be submitted, along with this form:
 - 2.1. Hospital's Statement of Account and Receipt of Payment;
 - 2.2. Insured's Hospital records such as Admitting History, Clinical History and Physical Examination, Discharge Clinical Summary, Results of any Medical Examination/Laboratory Tests, or their equivalent;
 - 2.3. Insured's Statement of Claim (I-Heal - Accident or Sickness Form I, as applicable);
 - 2.4. Physician's Statement (I-Heal Claim - Accident or Sickness Form III, as applicable);
 - 2.5. Surgeon's Certification (I-Heal Claim form IV), if surgery was performed; and
 - 2.6. All required documents indicated in the above-listed forms.
3. Submit to the Customer Care Unit of The Insular Life Assurance Company, Ltd. located at the above address or to any Insular Life Office.

**HOSPITAL'S CERTIFICATION
(I-HEAL CLAIM FORM II)**

Name of Patient:			

Surname		Given Name	
Suffix (Sr., Jr., etc.)			
Date of Birth:	Age:	Gender:	Marital Status
Complete Name/s of Attending Physician/s:			
Dates of Confinement:			
Admitted on _____		Discharged on : _____	
(Month)	(Day)	(Year)	(Year)

TO BE COMPLETED BY THE HOSPITAL'S AUTHORIZED REPRESENTATIVE
 ONLY IF THE HOSPITAL STATEMENT OF ACCOUNT CANNOT PROVIDE THE DATA HEREIN.

Room & Board:	
Regular Rooms: _____ days	ICU : _____ days
From _____ / _____ / _____ To _____ / _____ / _____	From _____ / _____ / _____ To _____ / _____ / _____
(Month) (Day) (Year)	(Month) (Day) (Year)
Other Hospital Charges:	
Operating Room	P _____
Anesthesia	P _____
Laboratory	P _____
EKG, BMR, etc	P _____
X-Ray	P _____
Drugs, medicines, etc.	P _____
Dressings	P _____
Oxygen/blood transfusions	P _____
Diathermy, Physical Therapy, etc.	P _____
Others	P _____
TOTAL	P _____
Has this bill been paid? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach Official Receipt.	
Name of Hospital:	
Address of Hospital:	
No.	Name of Street/ Highway
Town/Municipality	City/Province
Country	Zip Code
Contact Nos.:	Email address:
Bureau of Health Facilities and Services, DOH Registration/Permit No. _____	
Date Issued: _____	Issued By: _____

I HEREBY CERTIFY that the foregoing answers have been taken from the hospital records of the above-named patient. They are true, correct and complete.

 Printed Name & Signature of Hospital's Authorized Representative

Official Title: _____

Date Signed: _____