



**MEDICAL INFORMATION CENTER (MIC)**  
Number: 02-8895-3308  
PLDT Toll Free: 1-800-10-8895-3308  
Email: mic@etiqua.com.ph

**OUTPATIENT DIAGNOSTIC & PROCEDURE FORM  
LETTER OF GUARANTEE (LOG)**

DATE ISSUED:		CONTROL NO.:	
HOSPITAL/CLINIC NAME:		APPROVAL CODE:	APPROVED BY:
PATIENT NAME:		AGE:	GENDER:
COMPANY NAME:	ID NO.:	EXPIRY DATE:	PLAN TYPE:
REMARKS & OTHER ENDORSEMENTS ON BENEFIT:		APPROVED BENEFIT LIMIT: IN EXCESS C/O PATIENT	

DIAGNOSIS:	
DIAGNOSTIC/PROCEDURE REQUEST/RUV/RVS:	PHILHEALTH: _____ REQUIRED TO FILE _____ OPTIONAL
TYPE OF ILLNESS: <input type="checkbox"/> CONGENITAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> ACQUIRED <input type="checkbox"/> ACCIDENT	

**PLAN MEMBER'S PRIVACY POLICY & CONSENT:** I, for myself and on behalf of my dependents, authorize Etiqa Philippines to process my personal data, such as, but not limited to, my medical diagnosis/utilization data and to disclose the said personal data to necessary third parties such as, but not limited to, my employer, accredited network providers, headquarter, reinsurers, group policy holders and auditors. I understand that the processing of my personal data shall be used in servicing my account which includes, but is not limited, to the following benefits administration, medical treatment, and management of the plan. I agree to receive marketing updates and offers. I agree to obtain a copy of my records relative to my hospitalization, consultation and treatment or any other medical advice in connection with the benefit/claim availed.

**PLAN MEMBER'S UNDERTAKING & REMINDER:** Plan Member must sign AFTER availment. Unused LOG should immediately be reported to Etiqa Philippines Account Reconciliation Exit Clearance. Final computation of your coverage will be made once Etiqa Philippines Medical Claims Payables Department adjudicates your claims considering any of the following: (a) any call-less availment; (b) reimbursement claims; and (c) unprocessed claims that are yet to be billed by the accredited network providers. I agree that any availment may be denied under circumstances such as concealment and procedures not related to the illness. I agree to settle for billback any incurred ineligible excess charges on benefits. I render Etiqa Philippines free from any liability on the collection of the acquired excess charges on benefits.

**ACCREDITED PROVIDER'S UNDERTAKING & REMINDER:**

Accredited Network Provider must sign AFTER COMPLETION OF SERVICE. All procedures/tests must have prior approval from Etiqa Philippines MIC. For immediate payment, please submit all bills within 30 calendar days. Accredited Network Provider shall notify Etiqa Philippines if payment is not received within 30 calendar days from receipt of submitted bills.

Member's Signature Over Printed Name/Date Signed

Physician's Signature Over Printed Name/Date Signed

White - Etiqa Philippines' Copy

Green - Hospital/Clinic's Copy

**Etiqa Life and General Assurance Philippines, Inc.**

(Formerly: AsianLife and General Assurance Corporation)

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