Intellicare
YOUR INTELLIGENT HEALTH CHOICE

Referral Control Sheet for Out-Patient Consultation (RCS 1)

Loa No.: 10165608201
VALID UNTIL: 8/23/2020

Name of Patient : **REYES, CASSANDRA AMARIS ANCHUELO**	ApCode : **BRK-082015-104**	RCS Date: **8/20/2020 2:44:18 PM**
Card Number: **1195000002582359** Account Number: **43-00-00128-00140-01/4** Company: **QUANTRICS ENTERPRISES, INC.** Validity: **12/31/2020 11:59:59 PM**	Hospital/Clinic: **THE MEDICAL CITY** Birth Date: **5/20/2016 12:00:00 AM** Age: **3** Sex: **FEMALE**	
Inclusion: Exclusion:	PEC Limit: **150,000.00** Max Limit: **150,000.00** Room and Board: **SEMI PRIVATE**	

Coordinator: _____

Diagnosis:	**Recommendation:**

REYES, CASSANDRA AMARIS ANCHUELO
Parent/Member Printed Name and Signature

DIAZ, CORAZON SERAFICA
Requesting Physician/Coordinator's Name and Signature

MEMBER UNDERTAKING AND CONSENT FORM

This Form allows you to provide your explicit and written authorization, consent, and grant of access to and/or collection, processing, and disclosure of your personal and sensitive personal information, such as your medical records including, but not limited to, your age, residence, past medical history, results of medical examinations, diagnosis, abstracts, treatments, utilization (collectively referred to as "Information") and to be furnished copies thereof for the specific purpose of evaluating your medical claim under your applicable Health Plan and to provide health managed care for your employer pursuant to the Health Service /Group Corporate Agreement (Purposes).

Should you have questions or concerns about this form or should you wish to lodge a complaint or correct any information, please email us at dpo@intellicare.net.ph For more information on how Intellicare protects its data and your information, you may visit our website at www.intellicare.net.ph .

By signing this Form, you agree to:

1. Allow the company, through its agents, representatives, personnel, subcontractors, and/or medical facilities connected with the Company including, but not limited to, physicians, nurses, and consultants, to collect, use and process your personal and sensitive personal information specific only for the purposes mentioned above.

2. Authorize the Company to disclose such Information to its agents and affiliates, including your registered employer, your employer's registered broker if any, and/or the principal member to which you are a dependent, if applicable.

3. Permit the Company to generate reports from the Information collected and share the same to the entities mentioned under item no. 2 above. For this purpose, your Information will be stored by the Company for a period of five (5) years, without prejudice to your rights as a data subject.

4. Give consent to the identified hospital or physician to release your Information and related documents, including a summary thereof derived from laboratory services and medical consultations, to the Company or its authorized representatives for the evaluation of your medical claim and for the Company to disclose such information to entities mentioned under item no. 2 above.

Kindly note that if you decide not to sign this document, INTELLICARE will not be able to process your requested transaction.

DATA PRIVACY CONSENT & WAIVER

I, the undersigned, have read the foregoing statement and hereby express my consent to the above. I further understand (a) the reasons for the collection, processing, and disclosure of my Information and the ways in which said Information may be used, and I agree to said usage and disclosure; and that (b) it is my choice as to what information I provide and that withholding or falsifying information might act against the best interests of my assessment. I also acknowledge that the Company has and will always take commercially reasonable steps to protect and maintain the confidential nature of my personal information in accordance with its applicable privacy policies. I hereby affirm my right to be informed, object to processing, access and rectify, suspend or withdraw my information, and be indemnified in case of damages pursuant to the provisions of Philippine Data Privacy Law, other applicable laws, rules and regulations.

OTHER UNDERTAKINGS

I, likewise, acknowledge that all of the procedures indicated in this document had been done. I promise to pay for any procedure and professional fees not explicitly covered by the provisions of the Health Service /Group Corporate Agreement. Furthermore, by virtue of this undertaking, I hereby render the Company free from any liability on the collection of the acquired non-coverable charges (i.e. excess in limits, exclusions, etc.). I fully understand that in instances wherein payables were not settled upon availment, I will be subjected to credit documentation and will be charged of administrative fees as applicable.

_____ _____
Signature over Printed Name Date

Intellicare
YOUR INTELLIGENT HEALTH CHOICE

Referral Control Sheet for Out-Patient Consultation (RCS 1)

Loa No.: 10165608201
VALID UNTIL: 8/23/2020

Name of Patient : **REYES, CASSANDRA AMARIS ANCHUELO**	ApCode : **BRK-082015-104**	RCS Date: **8/20/2020 2:44:18 PM**
Card Number: **1195000002582359** Account Number: **43-00-00128-00140-01/4** Company: **QUANTRICS ENTERPRISES, INC.** Validity: **12/31/2020 11:59:59 PM**	Hospital/Clinic: **THE MEDICAL CITY** Birth Date: **5/20/2016 12:00:00 AM** Age: **3** Sex: **FEMALE**	
Inclusion: Exclusion:	PEC Limit: **150,000.00** Max Limit: **150,000.00** Room and Board: **SEMI PRIVATE**	

Coordinator: _____

Diagnosis:	**Recommendation:**

REYES, CASSANDRA AMARIS ANCHUELO
Parent/Member Printed Name and Signature

DIAZ, CORAZON SERAFICA
Requesting Physician/Coordinator's Name and Signature

MEMBER UNDERTAKING AND CONSENT FORM

This Form allows you to provide your explicit and written authorization, consent, and grant of access to and/or collection, processing, and disclosure of your personal and sensitive personal information, such as your medical records including, but not limited to, your age, residence, past medical history, results of medical examinations, diagnosis, abstracts, treatments, utilization (collectively referred to as "Information") and to be furnished copies thereof for the specific purpose of evaluating your medical claim under your applicable Health Plan and to provide health managed care for your employer pursuant to the Health Service /Group Corporate Agreement (Purposes).

Should you have questions or concerns about this form or should you wish to lodge a complaint or correct any information, please email us at dpo@intellicare.net.ph . For more information on how Intellicare protects its data and your information, you may visit our website at www.intellicare.net.ph.

By signing this Form, you agree to:

1. Allow the company, through its agents, representatives, personnel, subcontractors, and/or medical facilities connected with the Company including, but not limited to, physicians, nurses, and consultants, to collect, use and process your personal and sensitive personal information specific only for the purposes mentioned above.

2. Authorize the Company to disclose such Information to its agents and affiliates, including your registered employer, your employer's registered broker if any, and/or the principal member to which you are a dependent, if applicable.

3. Permit the Company to generate reports from the Information collected and share the same to the entities mentioned under item no. 2 above. For this purpose, your Information will be stored by the Company for a period of five (5) years, without prejudice to your rights as a data subject.

4. Give consent to the identified hospital or physician to release your Information and related documents, including a summary thereof derived from laboratory services and medical consultations, to the Company or its authorized representatives for the evaluation of your medical claim and for the Company to disclose such information to entities mentioned under item no. 2 above.

Kindly note that if you decide not to sign this document, INTELLICARE will not be able to process your requested transaction.

DATA PRIVACY CONSENT & WAIVER

I, the undersigned, have read the foregoing statement and hereby express my consent to the above. I further understand (a) the reasons for the collection, processing, and disclosure of my Information and the ways in which said Information may be used, and I agree to said usage and disclosure; and that (b) it is my choice as to what information I provide and that withholding or falsifying information might act against the best interests of my assessment. I also acknowledge that the Company has and will always take commercially reasonable steps to protect and maintain the confidential nature of my personal information in accordance with its applicable privacy policies. I hereby affirm my right to be informed, object to processing, access and rectify, suspend or withdraw my information, and be indemnified in case of damages pursuant to the provisions of Philippine Data Privacy Law, other applicable laws, rules and regulations.

OTHER UNDERTAKINGS

I, likewise, acknowledge that all of the procedures indicated in this document had been done. I promise to pay for any procedure and professional fees not explicitly covered by the provisions of the Health Service /Group Corporate Agreement. Furthermore, by virtue of this undertaking, I hereby render the Company free from any liability on the collection of the acquired non-coverable charges (i.e. excess in limits, exclusions, etc.). I fully understand that in instances wherein payables were not settled upon availment, I will be subjected to credit documentation and will be charged of administrative fees as applicable.

_____ Signature over Printed Name

_____ Date