COMPANY POLICIES AND PROCEDURE'S MANUAL

1. **Standard Name**
   Underwriting Manual

2. **Standard Purpose**
   To provide a common framework by which Underwriting staff shall provide services to clients and other departments in the office.

3. **Standard Owner**
   The MDCARE-underwriting-001 is owned by MedoCare, and nobody is allowed to generate and distribute copies without permission from the MedoCare Operations Department.

   All changes/modifications/deviations from this document shall be subject to approval of the Chairman & CEO.

   Dissemination of copies of this Manual should be carried out with prior authorization from the EVP-GM.

UNDERWRITING

Policies and Guidelines On Underwriting Undertakings

A. Duties and Responsibilities of an Underwriting Staff

Handling Membership of all Accounts

1. Receives all applications/deletions for/from membership.
2. Writes action memo for every transaction received from the account.
3. Underwrites the eligibility of submitted names for membership based on underwriting guidelines for membership eligibility and/or corporate contract.
4. Encoding/uploading of approved applications/deletions for/from membership.
5. Printing of membership ID cards.
6. Generation of billing list based on printed IDs for Credit and Collection.
7. Processing of Refunds for deletions/returned IDs
   Requirements:
   a. surrendered Medocare ID
   b. utilization print out

Prepared by: ACA Recommending approval: RAP NAS ELS JUJ LUY MANCOM CHAIRMAN ARS	Date :	Approved by : Col. Esteban B. Uy Chairman and CEO

8. Inventory of Membership Cards
   - keep record of Active and deleted/resigned members, returned ID cards, spoilages, replacements of cards

9. Packing of ID cards with Manual of Guidelines & List of Accredited Hospitals.

10. Filing of records & documents.

B. Guidelines For Underwriting Applications For Membership

1. The underwriting staff shall make sure that ALL listings submitted shall be in our recommended format. After the new account has submitted their Letter of Intent, the underwriting staff will give the prescribed format to facilitate underwriting and uploading of new members.

2. ALL transactions with existing accounts shall be coursed through the Marketing and Sales Department.

3. The underwriting process shall be time bound, from evaluation of applications to printing of IDs and generation of billing lists. **Turn around Time 3-5 days for accounts less than 300 new enrollees.**

4. Encoding and uploading of Abstracts into the system must be done before effectivity date.

5. ALL IDs delivered should have an accompanying transmittal form.

6. Regular inventory of all supplies eg. ID cards, plastic card holders, printer ribbons, manuals, guidelines, envelopes should be conducted to avoid depletion of stocks. Minimum stock level (3,000 ID cards, manuals, envelopes) should always be followed at all times.

7. Cut-off dates for addition of new members will be as follows:

	Date of Receipt	Effectivity Date
a.	1st to 10th of current month	16th of current month
b.	11th to 25th of current month	1st of following month
c.	26th to 31st of current month	16th of following month

8. Deletion should be done as soon as notice of cancellation has been received.

9. If ID card is not returned, the company should sign an Undertaking that if availment is done after cancellation date, the cost of availment shall be shouldered by the company.

10. Refunds of payments of deleted members will be done after a thorough review of the member's utilization has been conducted. If there is no utilization a pro rated computation of the refund will be done plus 2% withholding tax and 10% administrative cost (+ commission if applicable)

Prepared by: ACA Recommending approval: RAP NAS ELS JUJ LUY MANCOM CHAIRMAN ARS	Date :	Approved by : Col. Esteban B. Uy Chairman and CEO

CLAIMS DEPARTMENT
PROCESSING OF REIMBURSEMENT CLAIMS
(Head Office)

PROCEDURE	SECTION / RESPONSIBLE	REMARKS
1. Submit Reimbursement Claim		
1.1 Secure *Reimbursement Claim Form* from Medocare offices.	Member	see attached form
1.2 Accomplish supporting documents	Member	see Reimbursement Claim Form for supporting documents
1.3 Submit *Reimbursement Claim Form* to Medocare (Claims Dep't)	Member	Submitted Documents: - Reim. Claim Form - Professional Fee OR - Hospital Bill OR - Hospital SOA - charge slips - Medical certificate - Clinical Abstract - other documents
2. Receive Reimbursement Claim		
2.1 Receive claim documents from Member	Reimbursement Officer	
If claim was mailed by the member.		
2.1.1 Receive mailed claim documents	Receiving Clerk	
2.1.2 Forward claim documents to Reimbursement Officer	Receiving Clerk	
2.2 Check supporting documents for completeness.	Reimbursement Officer	
If claim is incomplete,		
2.2.1 Return claim documents to Member (identifying the necessary requirement). Action memo.	Reimbursement Officer	if personally delivered incomplete claims will be accepted if mailed
2.3 Encode received reimbursement claimsfor inventory report purposes	Reimbursement Officer	
3. Batch Claim Documents and Status Verification		
3.1 Arrange received claims documents into the standard order	Reimbursement Officer	standard arrangement: - Reim. Claim Form - Professional Fee OR - Hospital Bill OR - Hospital SOA - charge slips - other documents
3.2 Forward claims to Underwriting Department for Status Verification		
4. Evaluate claim		
4.1 Forward claim documents to Medical Evaluator	Reimbursement Officer	
4.2 Evaluate claim		
6.2.1 Determine if claim is ER or non-ER	Medical Evaluator	
6.2.2 Indicate RUV if procedures require	Medical Evaluator	
6.2.3 Evaluate if case is Dreaded / Pre-Existing / Congenital	Medical Evaluator	approved or denied
6.2.4 Write special notes/revisions at the top of the sheet		
6.2.5 Signify signature on the Reimbursement Claims Evaluation Sheet	Medical Evaluator	write special notes at the top of the sheet
4.3 Sign at the attached batch form	Medical Evaluator	
4.4 Process claim	Reimbursement Officer	
4.5 Create action Memo for Denied Claims		
5. Check Releasing		
5.1Release check to member or authorized representative		

1. **Standard Name**
   Billing and Collection Manual

2. **Standard Purpose**
   To provide a common framework by which Billing and Collection staff can efficiently generate billing and streamline collections.

3. **Standard Owner**
   The MDCARE-billingcollection-001 is owned by MedoCare, and nobody is allowed to generate and distribute copies without permission from the MedoCare Operations Department.

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BILLING AND COLLECTION

Policies and Guidelines On Billing and Collection Undertakings

A. Duties and Responsibilities of a Billing and Collection Staff (Finance Unit)

1. In-charge of Preparation of Billing Statement of All Active Accounts.
   - preparation of Statement of Accounts and necessary attachments.

2. Posting of Payments

3. Process Premium Refund
   - process all request for refunds for remaining amount paid by requesting client.

4. Helps maintain the good image of MEDOCARE at all times.

B. Guidelines for Billing and Collection

1. All listings (including addition and deletions) coming from existing accounts for billing shall be coursed through the Underwriting staff.

2. Cut-off dates for addition of new members will be as follows:

	Date of Receipt	Effectivity Date
a.	1st to 15th of current month	16th of current month
b.	16th to 31st of current month	1st of following month

3. The Underwriting staff shall balance the list with the latest Medocare listing for the same account. If there are discrepancies noted, the Underwriting Staff shall reconcile the listing with the designated representative of the said account.

4. The Underwriting Staff shall immediately start evaluating each additional member for eligibility for membership (underwriting). In case there are discrepancies or ineligible individuals, the Underwriting Staff will note this down and inform the representative of the said account.

5. The Underwriting staff shall immediately forward the Official List for Billing to the Billing Officer.

6. The Billing Officer prepares the Statement Of Account and attach a Routing Slip then forwards it to the duly assigned signatories.

7. Each signatory shall affix his/her signature to the space provided for and indicate date and time the SOA was received and released on the Routing Slip.
   i. The Billing Officer shall release the SOA to the appropriate account
   ii. The Collection Officer shall be furnished with a copy of the SOA for Entry to the Payments Ledger and Monitoring of Billings and Collections.

8. The above procedure shall be performed in conjunction with the assigned Auditor.

9. The Accounting Staff shall furnish the VP Operations and the VP-Finance a regular report of all premium payments and receivables. The Collection Officer shall also furnish all Officers a list of collectibles on a weekly basis.

10. The Collection Officer shall also complete entries in the Ledger after payment has been received.

Prepared by: ACA Recommending approval: VAV RAP NAS FGC MANCOM CHAIRMAN ELS	Date :	Approved by : Col. Esteban B. Uy Chairman and CEO

11. Total Turnaround Time for the whole Underwriting and Billing Process shall not exceed three (3) working days.

D. General Guidelines for Collection

1. Billing for a certain period, depending on the mode of payment, should be generated and sent to the different accounts 15-30 days before due date.
2. It shall be the primary responsibility of the Client to keep their Healthcare Program Agreement on active status by paying on or before due date.
3. If membership fees are not paid on due date, members enrolled by the Client cease to be entitled to any medical benefits under their Agreement.
4. The Client is given 30 days grace period from due date to settle all unpaid membership fees.
5. Benefits are reinstated on the day all unpaid dues are updated. However, any confinement the admission date of which precedes the date the payment is made shall not be covered.
6. The Collection Officer shall monitor payments made by the different accounts. Regular follow-ups should be conducted to ensure prompt payment.

E. Collection of "uncollected non covered charges" (UNCC)

1. Members who have incurred non-covered charges will be billed back by the Claims Department. (**All communications, especially billing for NCCs, must be countersigned by the Head of the Department before sending out to the concerned party.**)
2. The Collection Officer shall monitor payments made for non-covered charges. Regular follow-ups should be conducted to ensure prompt payment.
3. Payments for non-covered charges will be credited to the contract period from which the NCC was incurred.

Prepared by: ACA Recommending approval: VAV RAP NAS FGC MANCOM CHAIRMAN ELS	Date :	Approved by : Col. Esteban B. Uy Chairman and CEO

1. **Standard Name**
   Call Center Manual

2. **Standard Purpose**
   To provide a common framework by which Call Center staff shall provide services to clients and health care providers.

3. **Standard Owner**
   The MDCARE-call center-001 is owned by MedoCare, and nobody is allowed to generate and distribute copies without permission from the Medocare Operations Department.

   All changes/modifications/deviations from this document shall be subject to approval of the Chairman & CEO.

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CALL CENTER

Policies and Guidelines On Call Center Undertakings

A. Duties and Responsibilities of a Customer Relations Officer (CRO)

1. Functions as the frontliner in providing EFFICIENT CLIENT SERVICES especially in attending to calls received from network providers and members through:
   - accurate information dissemination of members' benefits, availments, exclusions, and other matters pertaining to their contract including assignment of the required approval code for procedures/ laboratory examinations requested by MedoCare affiliated physicians.
   - proper coordination/channeling with the different departments regarding customers' concerns
   - ensures that the coverage for members are within the terms and conditions and extent of coverage as stipulated in the health care agreement.

2. Provides personalized customer services by efficient and prompt handling of inbound and outbound calls.

3. Monitors and ensures that resolution of transactions are done within the set turn around time.

4. Elevates unresolved matters to proper higher authorities for proper disposition as the need arises.

5. Participates in the formulation and ensures that all the standard operating procedures and guidelines set by the management are strictly observed and implemented.

6. Observes politeness, courteousness and client focus attitude at all times.

7. Provides regular monitoring reports and other significant data as scheduled or requested by management.

8. Encodes temporary estimated utilization for in- patient availments (LOA) and out-patient complex diagnostic procedures, surgical procedures and other treatment modalities, eg. Hemodialysis, chemotherapy.

9. Performs any other task or special assignment requested by the supervisor or any officer of the company.

B. Guidelines for Answering Calls for Approval of Out-Patient procedures and Laboratory Examinations: (TAT = 2-3 mins if Medical Officer is in the office, 2-4 mins for cell phone approvals)

Member goes to Hospital coordinator for consultation → member is referred to a specialist or laboratory examinations are requested → Coordinator's secretary calls for Approval (**For procedures/laboratory examinations whose total amount is < Php 500 in Metro Manila or < Php 1,000 in the provinces, no more need to seek approval from the Call Center**)

1. The Customer Relations Officer (CRO) receives the call from the Coordinator's secretary/industrial clinic of the accredited hospital.

2. The CRO asks for pertinent data ie. **ID number, diagnosis, procedures/laboratory examinations, doctor/specialist, hospital** and inputs the information into the Call Center Form -1.

3. The CRO verifies membership status of the patient.

4. If the patient's status is lapsed or cancelled, the CRO calls/proceeds to the Underwriting Department for further verification/clearance.

5. If the patient is an active member or has been cleared by the Underwriting Department, the CRO checks the member's benefits, exclusions and availments as well as the remaining balance from the Maximum Benefit Limit.

6. The CRO seeks approval for the requested procedures/laboratory examinations from the Medocare Approving Medical Officer.

7. The approving officer signs all approvals that were referred to him/her during the day. All approvals without the signature of the approving officer will not be processed by the Claims Department.

8. The CRO informs the Coordinator's secretary which procedures/laboratory examinations have been approved and gives the appropriate reason in case of disapproval.

9. The CRO reminds the Coordinator's secretary/Industrial Clinic staff to fill out the Out-Patient Procedures Authorization form completely indicating the approval number and limitations of procedures if any.

10. The CRO encodes the details of each transaction including the patient's name, age, ID number, diagnosis, procedures/laboratory examinations approved with limitations if any, approval number and account name.

11. If after verification the CRO notes that the patient is not eligible for coverage, whether due to non-payment of premiums, excess in their MBL or if the illness/procedure is under our Exclusions, the CRO informs the patient and explains why the procedure will not be covered and tells the patient what needs to be done for future availments to be covered in a polite manner.

12. If a call for approval is received by another department, it is imperative that an available CRO goes to the said department to receive the call.

C. Guidelines for Answering Calls for Approval of Emergency and Elective Admissions
(TAT = 2-3 mins if Medical Officer is in the office, 2-4 mins for cell phone approvals)

1. The Customer Relations Officer (CRO) receives the call from the Hospital's Admitting Section asking for approval of intended admission.

2. The CRO asks for pertinent data ie. **ID number, name of patient/member, diagnosis, room category, doctor/specialist, if ER case, chief complaint and reason for admission** and inputs the information into the Call Center In-Patient Monitoring form.

3. The CRO verifies membership status of the patient.

4. If the patient's status is lapsed or cancelled, the CRO calls/proceeds to the Underwriting Department for further verification/clearance.

5. If the patient is an active member or has been cleared by the Underwriting Department, the CRO checks the member's benefits, exclusions and availments as well as the remaining balance from the Maximum Benefit Limit. CRO reminds member of the requirements for confinement such as Medocare ID and Philhealth.

6. If after verification the CRO notes that the patient is not eligible for coverage, whether due to non-payment of premiums, excess in their MBL or if the illness/procedure is under our "Exclusions", the CRO informs the patient and explains why the procedure will not be covered and tells the patient what needs to be done for future availments to be covered.

7. For admissions to hospitals that are located in the provinces where there are no LOs, the CRO fills out completely, the Admission Review Form (ARF) which includes the: **name of patient/member, diagnosis, ID number, name, status, doctor/specialist, company, period covered, PhilHealth, dreaded disease limit, maximum benefit limit, remaining balance, chief complaint and reason for admission** then submits the ARF to the Medocare Medical officer for pre- approval.

8. For admissions to hospitals that are in Metro Manila and nearby areas where there are LOs, the CRO notifies the LO concerned of the said admission or when admissions are detected by the assigned LO.

9. In-Patients from provincial hospitals without LOs, ARF are filed by CROs and seek the approval of the medical officer on duty.

10. The CRO prepares the Letter of Authority (LOA) for signing of the Medocare Medical Officer and places the Maximum Benefit for the said admission as advised by the Medocare Medical Officer. The CRO then sends the LOA thru fax and verifies if the LOA was received by the hospital. The CRO also reminds the hospital to collect all non-covered charges from the patient and to advise the patient to file their PhilHealth if necessary. (**Turn around time - 10 minutes**).

D. Guidelines for Answering Queries/ Complaints from Members

Guidelines for Answering Queries Regarding Coverage

1. The Customer Relations Officer (CRO) receives the call from the member inquiring about benefits, exclusions and availments as well as the remaining balance from the Maximum Benefit Limit
2. The CRO asks for pertinent data ie. **ID number, name of patient/member, account name.**
3. The CRO verifies membership status of the patient.
4. The CRO checks the abstract of the contract from the system for the member's benefits, exclusions and availments as well as the remaining balance from the Maximum Benefit Limit.
5. The CRO gives appropriate response to the member's inquiry. (Turn Around Time 3 mins.)

Guidelines for Answering Queries Regarding Affiliated Providers and Doctors' Schedules

1. The Customer Relations Officer (CRO) receives the call from the member inquiring about affiliated hospitals, doctors and doctors' schedules.
2. The CRO asks for pertinent data ie. **ID number, name of patient/member, account name.**
3. The CRO verifies membership status of the patient.
4. The CRO checks the list of affiliated hospitals, doctors and schedules.
5. The CRO gives appropriate information to the inquiring member. Turn around Time 3 mins.

Guidelines for Answering Queries Regarding Filing of PhilHealth claims.

General Rule in answering Queries regarding filing of PhilHealth Claims:

> **ALL MEMBERS WHO ARE CONFINED IN THE HOSPITAL OR WHO WILL UNDERGO SURGICAL PROCEDURES SHOULD FILE THEIR PHILHEALTH CLAIMS.**

Guidelines for Answering Other Queries From Members and Providers

1. The Customer Relations Officer (CRO) receives the call from the member or provider with an inquiry.
2. The CRO asks for pertinent data ie. **ID number, name of patient/member, account name, doctor's name or hospital name.**
3. The CRO searches for information needed by the caller.
4. The CRO gives appropriate response. Turn around Time 3 mins.

Guidelines for Handling Telephone Complaints

1. Accept the telephone complaint, get the details of the complaint and logs the complaint into a complaint form.
2. Assign a Control Number for the particular complaint.

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3. Use an incident report form/form for monitoring this complaint and assign the same Control Number indicated in the complaint form.

4. If the complaint cannot be readily addressed by the CRO, refer the complaint to the Medical Officer on duty or present at the time of complaint.

5. Get the telephone number of the Patient.

6. Advise the Patient/Client that the department concerned will call back once the complaint has been reviewed and an action has been taken regarding his/her complaint. **Turn around Time 10 minutes.**

7. Advise the client of the resolution to his/her complaint.

CORPORATE MANUAL

MEDOCare
Health Systems Inc.

Document Code: MDCARE-checkpaymentmonitoring-001	
Document Type: Policies and Guidelines	
Division-Department: Medical – Claims/Accounting	Print Date: 08/13/21
Effectivity Date: February 15,2010	Page: Page1 of 2

Subject/Title/Description:
Policies and Guidelines in monitoring release and receipt of checks payments to providers

Filename:
MDCARcheckpaymentmonitoring

1. **Standard Name**
Release and Receipt of Checks Payment Monitoring Manual

2. **Standard Purpose**
To provide a common framework by which Claims and Accounting staff shall provide services to health care providers through to timely payments, proper monitoring and receipt of checks released.

3. **Standard Owner**
The MDCARE-checkpaymentmonitoring-001 is owned by MedoCare, and nobody is allowed to generate and distribute copies without permission from the Medocare Operations Department.

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CLAIMS FLOW

Policies and Guidelines On Claims Flow, Check Payment and Receipt Monitoring

A. Guidelines for Receiving Hospital Bills, Professional fees up to Monitoring of Released Checks

1. Bills are received in the information through courier service or messenger, bills are entered into a logbook then forwarded to the receiving claims staff.
2. Receiving Claim's staff will then place a control number/batch number on the upper right hand corner of the covering letter for easy identification and tracking. He/she shall indicate date received, due date, hospital name, patient name and discharge date (for in-patient claims), inclusive dates of out-patient availments and amount claimed to the **Claims Monitoring Matrix**. The receiving staff then forwards the claims to the corresponding claims personnel for processing and encoding.
3. The claims processor shall process the bills according to the above information and Medocare Claims processing guidelines.
4. The processors will then encode the batch/claim number, amount processed, date processed and place their initial.

Prepared by:	Date :	Approved by :
ACA Recommending approval: RAP NAS ELS JUJ LUY MANCOM CHAIRMAN ARS		Col. Esteban B. Uy Chairman and CEO

5. After undergoing claims processing, bills are then forwarded to accounting for vouchering. The vouchering staff encodes the voucher number, voucher date, voucher amount and his/her initials into the Monitoring Matrix.

6. Bills then go to Audit for evaluation and are forwarded to the Checking officer for Check preparation and signing by the Chairman.

7. Signed checks together with their attachments are forwarded to the Checks Releasing Officer. The checks releasing Officer prepares a transmittal and covering letter for the checks about to be released and inputs the date he/she received the checks, check number, check date, check amount and the date he/she released the checks to the
   a) liaison officers for professional fees (PF),
   b) courier,
   c) messenger/collector

8. All checks released shall have their corresponding receipts and shall be submitted to the releasing officer for safe keeping.

9. The releasing officer then encodes the date the checks were received, the Original Receipt number and OR date into the Monitoring Matrix. He/she also files a copy of the covering letter or transmittal and a copy of the receipt issued.

NOTE: THE CLAIMS FLOW MONITORING MATRIX MUST ALWAYS BE UPDATED EVERYTIME THERE IS A TRANSACTION THAT HAS TRANSPIRED.

Prepared by: ACA Recommending approval: RAP NAS ELS JUJ LUY MANCOM CHAIRMAN ARS	Date :	Approved by : Col. Esteban B. Uy Chairman and CEO

1. Standard Name

Claims Operations Manual

2. Standard Purpose

To provide a common framework by which Claims staff shall undertake timely and appropriate claims processing

3. Standard Owner

The MEDOCARE-claims-001 is owned by MedoCare, and nobody is allowed to generate and distribute copies without permission from the Medocare Operations Department.

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CLAIMS PROCESSING

Guide to Medical Words and Abbreviations

a. MEDOCARE
The organization that has been contracted for the delivery of Emergency, outpatient & inpatient medical services.

b. MEMBERS
An enrollee who has complied with all the requirements of membership under the MEDOCARE HMO program and is hereby entitled to its medical benefits. Unless otherwise specified the persons specified under Article III are the one's who may qualify as MEDOCARE MEMBERS.

c. MEDICAL BENEFITS
The medical, surgical and dental services available as out-patient and or in-patient benefits to MEMBERS as specified in the contract whenever the need for them arises, and when rendered by and in MEDOCARE accredited doctors, hospitals and clinics.

d. MEDICAL SERVICE TEAM (MST)
A group of MEDOCARE accredited physicians and other allied health professionals, who will carry-out the delivery of MEDOCARE medical and hospital services to MEDOCARE members in the hospital/clinic where it is accredited. Accreditation is by institution.

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e. PRIMARY PHYSICIAN/COORDINATOR
The Officer-in-charge physician who shall initially see the MEMBER in a MEDOCARE accredited hospital. He may direct the MEMBERS' medical care; examine, treat and/or refer Members to

Specialists, order x-rays and other laboratory tests; prescribe medications and arrange for the MEMBERS confinement, if needed.

f. MEDOCARE ACCREDITED HOSPITALS/CLINICS
Hospitals or clinics accredited by MEDOCARE where MEMBERS may go for consultation, diagnosis, treatment or hospitalization to avail of their benefits under this healthcare program.

g. MEDOCARE CORPORATE HEALTH PROGRAM AGREEMENT
Refers to this Agreement. It contains the provisions of enrollment eligibility and effectivity date; benefits and coverage; claims and member satisfaction provisions; exclusions and limitations of benefits; payment of membership fees; termination of coverage, etc.

h. MEDOCARE IDENTIFICATION CARD
Issued by MEDOCARE to MEMBERS for their identification. It contains the MEMBERS' name and signature; account number, effectivity date, validating signature, date of birth, type and room rate.

i. EMERGENCY CARE PATIENT
A member who is suffering from severe pain or when a member is injured and when his physical condition indicates imminent danger of loss of life and limb and other bodily function if treatment is not provided within 6-8 hours from occurrence of the emergency condition. The Attending ER physician will decide whether the case is an emergency or not.

j. IN-PATIENT
A MEMBER who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a MEDOCARE physician.

k. OUT-PATIENT
A person receiving medical services under the direction of a MEDOCARE physician, not as an in-patient and includes emergency room (ER) services.

l. CONVALESCENT CARE OR REHABILITATION CARE
The restoration of a person's ability to function as normally as possible after a disabling illness or injury.

m. DOMICILIARY CARE
Care provided because care in the patient's home is not available or is inadequate.

n. MAXIMUM BENEFIT LIMIT (MBL)
The total amount of benefits a member may avail per illness per year of membership.

o. ANNUAL BENEFIT LIMIT (ABL)
The total aggregate availment a member is entitled to per contract year. In this case 200% of the MBL

p. EFFECTIVITY DATE
The start of a one's Membership with MEDOCARE and the time from which the counting of the MEMBERS' coverage period shall start to run; and the time when MEMBERS may start to avail of his benefits under this Health Care Program.

q. DUE Dates
The date/s agreed when the Membership fee is to be paid in accordance with the chosen mode of payment.

Policies and Guidelines On Claims Undertakings

A. Guidelines for Determining Payable Claims (Reception)

1. All claims documents are complete.
   - Letter Of Authorization (LOA)/ Out Patient Procedure Authorization (OPPA)
   - Hospital Statement of Account (SOA) / Charge Slips
   - Operative Record / Technique if applicable
   - Histopath Results (if with biopsy) if applicable
   - Admission Review Form (ARF) : *for In-Patient claims only*
2. There is no termination in member's coverage.
3. All premiums covering the period when claims was incurred are paid.
4. Illness is not pre-existing in nature, a complication or a result of a pre-existing condition.
5. Claim is incurred after the contestability period has been satisfied for certain medical conditions.
6. Claim is for an illness not excluded from coverage.
7. Total covered expenses does not exceed the Maximum Benefit per Illness stated in the schedule.

IMPORTANT: Always check if the hospital for processing of bills has given Medocare a discount.

B. Guidelines for Determining Covered Hospitalization Benefits

1. The hospitalization must be arranged and/or approved by a Medocare Affiliated Physician and MedoCare Medical Officer before admission to the hospital.
2. Claims will be covered only if a Letter of Authorization (LOA) or Referral Letter is issued upon the request of a Medocare Authorized Physician.
3. The confinement should be in an Affiliated Hospital.
4. The Room & Board accommodation must be in accordance with the member's purchased plan.

Prepared by: ACA Recommending approval: VAV RAP NAS FGC MANCOM CHAIRMAN ELS	Date :	Approved by : Col. Esteban B. Uy Chairman and CEO

5. The professional service must only be rendered by a Medocare Physician or a Medocare Affiliated Physician.
6. The date of discharge from the hospital must be as advised/authorized by the Medocare Physician.

C. Guidelines for Determining Covered Out-Patient Benefits

1. Out-Patient services were done at the Medocare affiliated medical facility.

   1.1 Out-Patient services include Laboratory and X-rays and other diagnostic procedures.

2. Out-Patient treatments rendered by an Affiliated Physician was recommended by a Medocare Authorized Physician using an Out Patient Authorization Form (OPAF) or a Referral Letter.

3. Out-Patient treatment done in an Affiliated Medical facility was recommended by a Medocare Authorized Physician using an Out Patient Authorization Form (OPAF) or a Referral Letter.

4. Validate/authenticate approval number

5. Reconcile laboratory examinations submitted against the copy of CRO

6. Do not pay laboratory examinations not found in the CRO's copy

7. Execute accounting for difference for record purposes

8. Check for the application of limits for Complex Diagnostic Procedures

D. Guidelines on Room And Board Payment

* Always refer to the Schedule of Benefit of the Member to determine PLAN and ROOM accommodation.
* Any excess in Room&Board charges will be charged to the member once it exceeds the Maximum Daily Room&Board limit under the member's plan

E. Guidelines on Ancillary Services and Pharmacy Payment

Ancillary Services refer to the following:

Laboratory	Dietary	Nuclear Medicine (Scans/Ultrasounds)
X-Ray	Nursing Service	Heart Station (ECG, Holter Monitoring)
Operating Room	Delivery Room	

**** Medications that were used during the hospital stay will be paid as charged. However,**

medications that have been prescribed during confinement but will be used on an out-patient basis will not be covered.

Incremental: **Should a member avail of a Room accommodation which is not in accordance with his/her plan, the member will be charged an additional 20% for every upgrade in room category to cover for the difference in Ancillary services consequent to the room upgrade.**

F. Guidelines in Computing for Philhealth Benefits

Source: The Revised Implementing Rules and Regulations of the National Health Insurance Act of 1995". (Republic Act 7875) 1st Edition, July 2000.

1. Included Benefits
   - 1.1 Inpatient Hospital Care
     - Room and Board
     - Services of Health Care Professional
     - Diagnostic, laboratory, and other medical examination services
     - Use of surgical or medical equipment and facilities
     - Prescription drugs and biologicals
     - Inpatient education packages
   - 1.2 Outpatient Care
     - Services of Health Care Professional
     - Diagnostic, laboratory, and other medical services
     - Personal Preventive Services
     - Prescription drugs and biologicals
   - 1.3 Emergency and Transfer Services
   - 1.4 Such other health care services that the Corporation determines to be appropriate and cost-effective

2. Benefit Package (please see Attachment 1)

3. Case Type Classification
   - 3.1 **D** - rare and severe illnesses usually contracted by Overseas Workers during their stint outside the country.
   - 3.2 **C** - refers to illness or injury such as but not limited to cancer cases with metastasis and/or requiring chemotherapy or radiation therapy, meningitis, encephalitis, cirrhosis of the liver, myocardial infarction, cerebrovascular attack, rheumatic heart disease (grade III), renal failure, other conditions requiring

dialysis or transplant, other conditions with massive hemorrhage, shock of any cause;

- refers to surgical procedure or multiple surgical procedures done in one sitting with a total Relative Unit Value of 20 and above such as but not limited to coronary bypass, open heart surgery, or neurosurgery.

3.3 **B** - refers to all confinements requiring services in an intensive case unit such as respiratory and monitoring support, cardiac/hemodynamic monitoring and maintenance

- refers to other similar serious illnesses or injuries such as but not limited to cancer, pneumonia, moderately or far advanced pulmonary tuberculosis including its complications, cardiovascular attack, disease of the heart, chronic obstructive pulmonary disease, liver disease, typhoid fever, fever grade III, H-fever, kidney disease, septicemia, diarrhea with severe dehydration, hepatitis B, dengue hemorrhagic, or severe injuries.

- refers to surgical procedure or multiple surgical procedures done in one sitting with a total Relative Unit Value of 8 but not exceeding 19.99.

3.4 **A** - refers to illnesses or injuries other than those included in the above enumeration.

4. Requirements for the availment of Benefits - to avail of the NHIP Benefits, a member must present the PhilHealth Identification Card or any other proof of identification and contribution in its absence.

5.Single Period Confinement - The series of confinement / procedures for the same illness with the interval between such confinements not exceeding ninety (90) calendar days within the calendar year shall be considered as a single period of confinement. Hence, the member shall only be entitled for the remainder of the benefit ceilings set by the Corporation for that period for drugs and medicines, x-rays, laboratories, and others.

G. Professional Fee Guidelines

1. Surgeons Fee

1.1 Minor Surgery

1.1.1 Simple

Surgeons Fee = per benefit schedule (RUV rate 110 if PCS member)

1.2 Major Surgery

Surgeon's Fee = per schedule
Pre-Operative visits = for one day visits
Post-Operative visits = only if there are complications in the patient's condition
Follow-Up visits:
Surgical Case = Surgeon's PF for surgical procedures done include one pre-operative visit and three post-operative visit unless there are complications
Non-Surgical case = allowed one visit

1.3 If two Surgical Procedures were done:
1.3.1 For two different organs under one incision / one setting with **two different surgeons** = pay 100% each surgical procedure
1.3.2 For two different organs under one incision / one setting with **only one surgeon** = pay 100% of the Surgical procedure with the higher rate pay 50% of the other surgical procedure

2. Assistant Surgeon's Fee
- Assistant Surgeon's Fee is not payable unless specified in the accreditation agreement.

3. Anesthesiologist's Fee
- Payable at 50% of Standard Fee or Surgeon's bill

Anything in excess of the Standard Fee will be charged to the member.
- Anesthesiologist's Fee is at Php1,000 minimum.

Note: For hospitals with special agreement/arrangement refer to the hospital accreditation agreement for the schedule of the professional fees.

4. Internal Medicine

1. For Surgical cases and Pediatrics

- Payable if the Internist is the Attending Physician. In this case, we pay for the Pre-Operative and Post-Operative visits.

2. For non-surgical cases – payable as daily visits at P450.00/visit for Ward, P550.00 for Semi private, P650.00 for Private
- P600.00 if the doctor is a Neurologist
- ICU visits are P1200.00

Special Rate for Neuro: P 1200.00 ICU
P 600.00 Private room
P 500.00 Semi Private

P 400.00 Ward

3. For maternity cases
   - payable if member has Maternity Benefits.

5. Clearance Fee
   - Php 600.00 for out patient and Php 800.00 for in-patient
   - includes Cardiology/FM (CP), OB-Gyne (OB clearance,) and (EENT)

6. Special Procedures
   - payable as follows:
     per schedule, PLUS
     daily visits per plan
     e.g. Gastroscopy, Laryngoscopy, etc...

- If with Co-Management, payable as daily visits per plan

7. Others

7.1 Pathologists - payable as charged
7.2 Radiologists - payable as charged
7.3 Reader's Fee - payable as charged
7.4 Cardiac Monitoring - payable at P1200

7.5 Out-Patient Consultations
7.5.1 Metro Manila Affiliated Clinics - payable at 300 per head for consultation
7.5.2 Provincial Clinics/Coordinators - payable at 300 per head for consultation
7.5.3 If consultation is done by a GP, FM, Derma and REhab - payable at 250 per head

7.6 Out-Patient (minor) Surgery
7.6.1 Metro Manila Affiliated Clinics - payable at 300 per head
7.6.2 Provincial clinics/coordinators - payable at 250 per head

H. General Exclusions Applicable to Health Care Coverage
EXCLUSIONS

1. Services a member receives from a non-MEDOCARE Physician, non-MEDOCARE Accredited Hospital or other provider of care, except as described in the emergency care in non-MEDOCARE hospitals including adverse medical conditions arising from previous treatment by them as provided in this Agreement.
2. Hereditary and/or congenital defects of whatever form including congenital heart surgeries.

3. Plastic/reconstructive surgery for cosmetic purposes and for physical congenital deformities and abnormalities including dermatological care for aesthetic purposes
4. Developmental disorders, hereditary or congenital metabolic diseases, sleep (non-obstructive) and eating disorders.
5. AV malformation and aneurysms which are considered congenital except only those unequivocably proven to be acquired secondarily.
6. Autoimmune neurological diseases.
7. Epilepsy, seizure disorder except Benign Febrile Convulsion (BFC).
8. Herniation, scoliosis, and spondylosis.
9. Corrective eye surgery for error of refraction.
10. Experimental medical procedures, acupuncture, acupressure, reflexology and chiropractics, iridology.
11. Any organ transplantation surgery.
12. Diagnostics for hypersensitivity and desensitization treatment.
13. Purchase or lease of durable medical equipment, oxygen dispensing equipment and oxygen except during hospital confinement under the Hospital Confinement Benefit.
14. Corrective appliances and artificial aids and prosthetic devices.
15. Screening tests for blood donors.
16. Psychiatric and psychological illnesses including neurotic and psychotic behavioral disorders.
17. Treatment for alcoholic intoxication and drug addiction or overdose reaction to use of prohibited drugs including illnesses directly related to it and other injuries attributed as a result of it.
18. Cardiac rehabilitation treatment, speech and occupational therapies
19. Sexually transmitted diseases and their complications.
20. Services to diagnose and/or reverse infertility or fertility and virility/potency
21. Maternity care and other conditions as a result of pregnancy unless specifically provided
22. Hormonal disorders and therapy
23. Transfusion related diseases
24. Hazardous job-related illnesses and/or injuries
25. Physical examinations required for obtaining or continuing employment, insurance or government licensing
26. Injuries or illnesses resulting for participation in war-like or combat operations, riots, insurrections, rebellions, strikes and other civil disturbances.
27. Treatment of self-inflicted injuries or injuries attributable to the Member's own misconduct, gross negligence, use of alcohol and/or drugs, vicious or immoral habits, participation in acts of crime, violation of a law or ordinance, unnecessary exposure to imminent danger or hazard to health, and hazardous sports-related injuries.
28. Custodial, domiciliary care, convalescent, and intermediate care
29. Oral surgery for purposes of beautification, temporomandibular joint disease (TMJ) disease surgery done by a Dental Practitioner.
30. Circumcision, except for correction of phimosis
31. Treatment of injuries sustained in a motor vehicle accident if the member or his guardian fails or refuses to execute the deed of Subrogation.
32. Professional fees of medico-legal officers
33. Diagnosis of unknown etiology or the absence of any organic dysfunction
34. Cost of vaccines for active and passive immunization

Prepared by:	Date :	Approved by :
ACA Recommending approval: VAV RAP NAS FGC MANCOM CHAIRMAN ELS		Col. Esteban B. Uy Chairman and CEO

35. Any condition or illness waived upon membership except as otherwise provided for in this Agreement.

I. Guidelines on Pre-Existing Conditions

Any illness, injury or any adverse medical condition shall be considered PRE-EXISTING if during the entire period prior and within the first twelve months from the effectivity date of this Agreement:

1. Any professional advise or consultation and/or treatment was made given as a result of such illness, injury or adverse medical condition; or

2. The Member was aware or should reasonably have been aware of the signs or symptoms of such illness, injury or adverse medical condition; or

3. The pathogenesis or onset of such illness, injury or adverse medical condition started during the contestability period for membership in this Corporate Health Program as determined by MEDOCARE's Medical Director or Accredited Physicians.

Without necessarily limiting the following enumeration, the following are automatically considered as **PRE-EXISTING CONDITIONS** if consultation or treatment is sought within the first twelve (12) months of coverage:

1. Any DREADED diseases as defined in this Agreement except numbers 12 and 16.
2. Hypertension
3. Goiter (nodular, hypo/hyperthyroidism)
4. Cataracts/Glaucoma
5. ENT conditions requiring surgery
6. Bronchial Asthma and other systemic allergies
7. Primary Complex/Tuberculosis/Leprosy/Sarcoidosis
8. Chronic cholecystitis, acalculo/cholelithiasis, polyps and other GB diseases
9. Chronic pancreatitis
10. Acquired hernias
11. Benign Prostatic Hypertrophy and other prostatic disorders
12. Hemorrhoids and anal fistulae
13. Benign tumors
14. Endometriosis and other causes of dysfunctional uterine bleeding
15. Buerger's disease and other forms of vasculitis
16. Varicosities
17. Arthritis/Osteoporosis
18. Migraine headache
19. Dyspepsia/gastritis/duodenal or gastric ulcer
20. Ascites and other edematous states

J. Guidelines on Dreaded Diseases

"DREADED DISEASES" are potentially or actually life threatening conditions. They may also be illnesses that may require unusually or uncustomary prolonged or repeated hospitalization and may likewise require intensive care management. These are enumerated but not limited to the illnesses/conditions in Section 2 of this Article.

The following are considered **DREADED DISEASES**:

1. Cerebrovascular Accident and its complications
2. Central Nervous System Diseases EXCEPT neurological autoimmune diseases
3. Cardiovascular Disease
4. Chronic Obstructive and Restrictive Pulmonary Disease
5. Liver Parenchymal Disease EXCEPT Hepatitis A
6. End Stage Renal Disease and other conditions that may require dialysis
7. Urological Disease
8. Inflammatory Bowel/Chronic Gastrointestinal Tract Disease requiring bowel resection and/or anastomosis
9. Collagen Diseases
10. Diabetes Mellitus and its complications
11. Malignancies and Blood Dyscracias
12. Injuries from accidents or assaults, frustrated homicide or murder (subject to police report)
13. Complications of an apparent ordinary illness including Multiple Organ Dysfunction (MOD) and SIRS (Systemic Inflammatory Response Syndrome)
14. Single or multiple organ dysfunction and failure
15. Chronic pain syndrome (greater than six weeks)
16. Near drowning and drowning
17. Any illness other than the above which would require Intensive Care Unit confinement

MEDOCARE shall pay for the hospitalization services, as herein defined, of a member for "DREADED DISEASE" up to the maximum amount or limit as specified per illness per year.

K. List of Out Patient Complex and Common Diagnostic Procedures

The following **COMPLEX DIAGNOSTIC EXAMINATIONS** and therapeutic procedures shall be covered up to P10,000.00 (depends on individual account) each per member per year subject to the pre-existing conditions Coverage subject to the approval of the **MEDOCARE** Head Office (inclusive of operating room charges, professional fees and other incidental expenses relative to the procedure):

a. Angiography
b. Pulmonary perfusion and ventilation scan
c. Tests involving use of Nuclear technologies/imaging and radioimmunodiagnosis and therapy

d. Electromyography, Nerve Conduction Velocity (EMG-NCV) Studies, Electroencephalogram (EEG)
e. 24-hour holter monitoring, 2-D echo/transesophageal echocardiography, venous/arterial duplex/doppler studies, etc
f. Treadmill stress test
g. Myelogram
h. Video gastroscopy and other endoscopic procedures
i. Connective tissue disease examinations
j. All tumor markers
k. Imaging studies
l. ENT procedures
m. X-rays requiring the use of contrast media
n. Procedures requiring use of the operating room
o. Perfusion scan

Note: Complex Diagnostic Examinations done during confinement will be fully covered as part of Maximum Benefit Limit (MBL)

The following procedures are described as **NON-COMPLEX DIAGNOSTIC EXAMINATIONS** (Ordinary medical examinations/procedures requested by a physician to confirm medical diagnosis):

a. Complete Blood Count (CBC)
b. Fecalysis/stool exam with occult blood/amoeba concentrate
c. Urinalysis
d. Electrocardiogram (ECG)
e. Plain X-ray
f. Blood examinations not found under complex diagnostic exams
g. Sputum examinations
h. Arterial blood gas and pulmonary function tests
i. Pap smear
j. Other procedures not found under Complex Diagnostic Examinations.

L. List of Special Out Patient Diagnostic Procedures

1. Special Out-Patient Diagnostic Procedures
The Member shall be entitled to a specialized out-patient laboratory examinations and diagnostic procedures, provided this is requested by the MEDOCARE Physician or Specialist handling the case of a Member, except in emergency cases as determined by the hospital ER Physician.

These procedures shall be covered up to P10,000 per availment and shall include but are not limited to the following:

a. CT scan
b. Treadmill Stress Test
c. Nuclear Medicine Scans
d. Magnetic Resonance Imaging (MRI)
e. Holter monitoring

f. Endoscopic Diagnostic Procedures
g. Thallium Scan

2. <u>New Modalities of Treatment and Other Diagnostic Procedures</u>

New Modalities of Treatment are defined as operations/diagnostic procedures for conditions with established etiologies and its use is only as an ALTERNATIVE to the conventional method. These treatment/ procedures will be covered provided that it was recommended by a MEDOCARE Affiliated Physician or Specialist handling the case and approved by the MEDOCARE Utilization Management Committee.
These special surgical treatment shall be covered with a limit of P40,000 and shall include but are not limited to the following:

a. Laser surgery and treatment except eye treatment to correct error of refraction
b. Lithotripsy
c. Arthroscopic knee surgery
d. Laparoscopic Cholecystectomy
e. Endoscopic Sinus Surgery
f. Laparoscopic Pelvic Operations
g. Trans-urethral Microwave Therapy of the Prostate
h. Cryosurgery
i. Stereotactic Brain biopsy

Note: Limit shall apply both for In-Patient and Out Patient.

1. **Standard Name**
   Duties and Responsibilities of the Hospital Medical Coordinator

2. **Standard Purpose**
   To provide a common framework by which the Hospital Medical Coordinator shall provide services to Medocare clients as health care provider.

3. **Standard Owner**
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   Dissemination of copies of this Manual should be carried out with prior authorization from the COO-Medical Director.

IN-PATIENT DUTIES AND RESPONSIBILITIES OF THE HOSPITAL COORDINATOR

1. The Medocare Hospital Coordinator shall preferably be a diplomate of Internal Medicine or Family Medicine, or in the absence of one, a diplomate of Pediatrics.

2. The Medocare Hospital Coordinator makes arrangements for the admission of all Medocare clients referred to his/her hospital in accommodations commensurate to their particular plans.

3. He shall answer referrals from the ER, and decide on the admissibility of these cases based on the following:

   1.1 emergency nature of the admission
   1.2 admissibility of the case
   1.3 room accommodations in accordance to plan

   Consequently, all ER admissions must have prior approval from the COORDINATOR. If his physical presence is necessary to arrive at the medical decisions, then such will be made available.

4. The Medocare Hospital Coordinator shall ensure that the patients admitted in Room and Board Accommodations outside of the health plan due to non-availability of rooms are subsequently transferred to the specified Room and Board Accommodation as soon as the latter becomes available unless otherwise specified by the patient. In which case, the provisions on excess charge will apply.

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5. As soon as the admissibility of an ER case is determined, the Medocare Hospital Coordinator shall act as the attending physician and refer to a specialist if a legitimate need for one arises.

6. The Medocare Hospital Coordinator shall ensure that confinements are promptly discharged from the hospital after the necessary medical services and treatment have been provided

7. The Medocare Hospital Coordinator shall ensure that referrals to other specialists, as necessary, will be in net-work. In the absence of an affiliated specialist needed for a referral, he shall find one outside of the network and negotiate for an acceptable fee after clearance from the Medocare.

8. No referrals should be made to non-affiliated specialist without the prior coordination with Medocare to avoid possible problems with patients regarding such as non-standard professional fees which the non-affiliated physician may charge.

9. The Medocare Hospital Coordinator shall conduct case management review of confinement cases together with the attending physician and the Liaison Officers..

10. The Medocare Hospital Coordinator shall coordinate with Medocare through the Liaison Officers and other officers, as the case maybe, for any problems concerning patient care which cannot be resolved at his level.

11. The Medocare Hospital Coordinator shall ensure that a core group of specialists across all fields of specializations is identified as organized. These specialists will be responsible for providing the basic medical need of our members. Additional specialist may be accredited as the needs arise.

12. The Medocare Hospital Coordinator shall recommend placements for accredited specialists who decide to terminate their contracts as providers of Medocare. Likewise, he shall inform Medocare of relievers assigned by accredited physicians to take care of their patients if they go on leave / go on out of town trips.

13. The Medocare Hospital Coordinator shall ensure that all professional fees charged by our affiliated doctors are in accordance with our schedule of fees. The Coordinator shall also call the attention of affiliated physicians in his hospital who are charging additional professional fees other than those covered by Medocare and recommend to Medocare any appropriate action thereof.

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14. The Medocare Hospital Coordinator shall relay to Medocare any problems with his hospital, including problems with the affiliated physicians if any. For such problems, the Coordinator shall mediate between parties concerned in order to arrive at an arrangement amenable to both.

15. The Medocare Hospital Coordinator shall make daily rounds on Medocare confined clients to show them the concern of Medocare management.

16. The Medocare Hospital Coordinator shall assign a reliever in his place in case of his/her non availability and inform Medocare of such assignment at least a week prior to effectivity.

OUT-PATIENT DUTIES AND RESPONSIBILITIES

1. The Medocare Out-patient Hospital Coordinator shall require from the patients their active Medocare I.D. (issued by Medocare to its members containing the clients' name and other necessary informations) or a Letter of Authority (LOA) from Medocare indicating the clients' name, limitation of coverage, the type of medical service required, as well as other relevant information.

2. The Medocare Hospital Out-patient Coordinator shall not, in any way, receive two (2) kinds of payments for the same patient on the same date. The MOHC should determine forthwith patient's need for primary care or specialist consult and refer the patient immediately if specialist availment is necessary.

3. The Medocare Hospital Coordinator shall refer Medocare patients only to specialists/sub- specialists affiliated with Medocare and when it is deemed necessary.

4. When requesting for laboratory/diagnostic procedures, the Medocare Hospital Coordinator must exercise prudence without sacrificing the well-being of the patient by prioritizing only procedures that are necessary for the illness being consulted for.

5. The Medocare Hospital Coordinator must not give in to personal requests for referrals, diagnostic procedures and only inform the patient what tests will be done after approval from the head office has been sought.

6. For procedures/ examinations whose total amount is more than Php 500.00, approval must be sought from the Medocare Medical Department (MMD).

7. Approval of Special Diagnostic Procedures shall be made by the Utilization Management Committee (UMC).

Special

Diagnostic Procedures are the following but not limited to:

a. 2D Echo and the like, 24 hour Holter Monitoring
b. Duplex Scan
c. CT Scan
d. Nuclear Imaging Studies
e. Radio Isotope Studies
f. Bone Densitometry Scan
g. Endoscopic Procedures
h. Angiography
i. Arteriography
j. Laboratory/ancillary services for conditions whose pathogenesis or subsequent clinical improvement is not yet fully established in Medical Science
k. New modalities and/or diagnostic and treatment procedures for conditions with established etiologies and its use is only as alternative to the conventional methods.
l. Electromyelography and Nerve Conduction Velocity Studies
m. Treadmill Stress Test
n. Myelogram
o. Orthopedic Arthroscopy
p. Adrenocortical Function
q. Plasma/urinary Cortisol
r. Mammography
s. Anti-Nuclear Antibody (ANA)Test, C- Reactive Protein, Lupus Cell Exam
t. Genetic/ Immunological Studies
u. Radioactive Iodine Therapy
v. Prostate Treatment

8. All elective procedures/ surgeries must be approved by the Medocare Medical Department (MMD).

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1. **Standard Name**
Hospital/ Liaison Service Manual

2. **Standard Purpose**
To provide a common framework by which Hospital Liaison Service staff shall provide services to clients and health care providers.

3. **Standard Owner**
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HOSPITAL LIAISON SERVICE

Policies and Guidelines On Hospital Liaison Service Undertakings

A. Duties and Responsibilities of a Liaison Officer

1. Attends to all the needs of the admitted member in terms of requirements, benefit availments and ensures that the services provided are within the terms and conditions as stipulated in the health care agreement.
2. Represents MEDOCARE in meetings with the hospital management and physicians and provides corresponding reports to the management.
3. Coordinates with the Claims Department in matters related to providing network servicing such as but not limited to claims payment.
4. Distributes correspondence, cheques and professional fees to the hospital and specialists.
5. Improves customer service through constant communication with the service providers in coordination with the Medical Department.
6. Coordinates with the call center representatives regarding customer's complaints/inquiries.
7. Attends meetings/conferences (M-W-F) at the Head Office for field reports.
8. Helps maintain the good image of MEDOCARE at all times.

B. Guidelines for Attending to the Admitted Member

1. The Liaison officer (LO) checks admissions of Medocare members at assigned hospital/s or;
2. The LO coordinates with the Call Canter for any endorsements of confinements.
3. The LO calls the admitting office/ HMO office for details of admission ie. patient's name, room and board category, chief complaint, initial impression.
4. The LO verifies ID number, account name, membership status, principal/ relationship to principal, coverage, Maximum Benefit Limit and remaining balance of admitted patients with 24-hour call center or underwriting.
5. The LO goes to the Billing Section to check the patient's current utilization.

6. The LO proceeds to the Nurses' Station and reads patient's charts and gathers pertinent data such as history, procedures done, diagnosis, and attending physician.
7. The LO prepares an Admission Review Form or calls the Medocare Medical Officer for approval of the present admission.
8. The LO goes to the patient's room, establishes rapport and then explains benefits, exclusions, requirements eg; philhealth filing, affidavit of support and other concerns. (Patient-members must be visited **AT LEAST** twice during his/her confinement. One right after admission and one before discharge.)
9. The LO makes arrangements for any request in relation to confinement such as room transfer, guarantee letters, etc.
10. The LO issues Letter of Authorization (LOA) for covered cases to the hospital's Billing or Credit and Collection Department within 24 hours if possible.
11. The LO informs the hospital's Credit and Collection, attending physician and patients of non-coverage of cases.
12. The LO coordinates billing and coverage of patients with hospital's Credit and Collection.
13. The LO coordinates with attending physicians for diagnosis and significant findings on patients.
14. The LO monitors and evaluates patients' progress through follow up visits.
15. The LO assists patients for discharge in securing Statement of Account.
16. The LO computes for and collects excess charges from patients
17. The LO submits a weekly report to LO supervisor for collation and submission to the COO-Medical Director.

C. Other Duties of the Liaison Officer

1. Collects hospital bills (in-patient and out-patient) and out-patient LOAs from affiliated physicians.
2. Distributes checks to affiliated physicians.
3. Performs other duties that may be assigned by the superior from time to time.

1. **Standard Name**

   Provider Relations Manual

2. **Standard Purpose**

   To provide a common framework by which Provider Relations Staff shall render appropriate and timely services to clients and health care providers.

3. **Standard Owner**

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   All changes/modifications/deviations from this document shall be subject to approval of the Chairman & CEO.

   Dissemination of copies of this Manual should be carried out with prior authorization from the COO/ Medical Director.

PROVIDER RELATIONS

Policies and Guidelines On Provider Relations Undertakings

A. Duties and Responsibilities of a Provider Relations Officer

1. **Responsible for the accreditation of hospitals, clinics, and laboratories nationwide;**
2. **Responsible for the accreditation of Physicians/ Specialists in the different hospitals and clinics nationwide;**
3. Conducts orientations of medical service procedures for corporate accounts, clinics and Hospitals
4. Provides front line support and handles inquiries and/or complaints of service providers.
5. Effectively measure service level against standards and provides solutions to any variances noted.
6. Provides continuous assessment of providers' needs and expectations through regular meetings with the different hospitals, clinics and doctors.

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7. **Maintains and regularly updates the database of all the medical service teams nationwide and disseminates information to all concerned**.
8. Prepares and sends official internal files and documents;
9. Files complete documentation of all Attending Physicians/ Specialists/ Coordinators Terms of Agreement including Memorandum of Agreement of Hospitals and Medical Clinics
10. Calls accredited hospitals regularly to establish rapport and gather information regarding the company's servicing and payments
11. Helps maintain the good image of Medocare at all times
12. Performs any other tasks or special assignment as the need arises

B. Guidelines for Handling Inquiries from Members Regarding Provider Information

1. The Provider Relations Officer (PRO) receives the direct call or call center transferred call from a member inquiring about accredited hospitals, clinics, physicians and schedules of physicians.
2. The PRO asks for pertinent data ie. **ID number, name of patient/member, account name.**
3. The PRO verifies membership status of the patient.
4. The PRO searches the provider database for the required information.
5. The PRO gives appropriate response to the member's inquiry. Turn around time 2-3 minutes.

C. Guidelines for Handling Physician Affiliation

There are three (3) ways by which a physician can be affiliated with Medocare:

a) member's request
b) completion of an affiliated hospital's medical service team
c) physician applies for affiliation

Requirements for affiliation of Physicians

a) Letter of intent **with hospital coordinator's endorsement**
b) Curriculum vitae
c) Supporting documents (ie. training certificates, specialty/subspecialty certificates)

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d) Hospital Affiliation and Clinic schedule

Steps In Affiliating A Physician Who Is Requested By A Member

1. Member requests for affiliation of a certain physician
2. The PRO calls or sends a letter of invitation to the said physician to know if he/she is interested in affiliating with Medocare. If so, the PRO requests for the required documents.
3. The PRO receives and reviews the required documents then forwards them to the Medical Director for approval.
4. Once the application for affiliation has been approved by the Medical Director, the PRO sends Medocare's standard Affiliation Agreement to the physician
5. The physician signs the Affiliation Agreement and sends it back to Medocare or the LO gets the signed agreement from the doctor's clinic
6. The PRO receives the signed Affiliation Agreement and adds the physician's credentials to the Provider database.
7. The PRO forwards the Affiliation Agreement to Legal Department for notarization. The PRO then sends a copy of the notarized agreement to the newly affiliated physician and files the original.
8. The PRO then disseminates the information to the clients

Steps In Affiliating A Physician Needed to Complete The Medical Service Team

1. The coordinator sees the need for affiliation of a certain physician/specialty/subspecialty
2. The PRO calls or sends a letter of invitation to the said physician to know if he/she is interested in affiliating with Medocare. If so, the PRO requests for the required documents.
3. The PRO receives and reviews the required documents and forwards them to the Medical Director for approval.
4. Once the application for affiliation has been approved by the Medical Director, the PRO sends Medocare's standard Affiliation Agreement to the physician
5. The physician signs the Affiliation Agreement and sends it back to Medocare or the LO gets the signed agreement from the doctor's clinic
6. The PRO receives the signed Affiliation Agreement and adds the physician's credentials to the Provider database.

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7. The PRO forwards the Affiliation Agreement to Legal Department for notarization. The PRO then sends a copy of the notarized agreement to the newly affiliated physician and files the original.

Steps In Affiliating A Physician Who Applied For Affiliation

1. Physician sends an application letter complete with Letter of intent and Hospital Coordinator's endorsement, credentials and resume.
2. The PRO reviews application and refers to the Medical Director for Approval
3. Once the application for affiliation has been approved by the Medical Director, the PRO sends Medocare's standard Affiliation Agreement to the physician
4. The physician signs the Affiliation Agreement and sends it back to Medocare or the LO gets the signed agreement from the doctor's clinic
5. The PRO receives the signed Affiliation Agreement and adds the physician's credentials to the Provider database.
6. The PRO forwards the Affiliation Agreement to Legal Department for notarization. The PRO then sends a copy of the notarized agreement to the newly affiliated physician and files the original

D. Guidelines for Handling Hospital/Clinic Affiliation

There are three (3) ways by which a Hospital/Clinic can be affiliated with Medocare:

a) member's request
b) if there is no other provider in the area or if provider can not handle the volume of members in the area or for bidding purposes
c) the hospital/Clinic applies for affiliation

Steps In Affiliating A Hospital/Clinic That Is Requested By A Member

1. Member requests for affiliation of a certain hospital or clinic
2. The PRO sends a proposal to the prospective hospital/clinic. The proposal will include:

a) company profile
b) financial statement
c) SEC registration
d) Forms – Letter of Authorization (LOA), Out- Patient Procedures Authorization (OPPA), Referral forms, Emergency Treatment form
e) Sample of member ID

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f) Vicinity map of the Provider
g) Memorandum of Agreement (MOA)
h) Schedule of fees
i) List of clients
j) Specimen signatures of Officers

3. The PRO follows – up with the Hospital/Clinic Administrator or Medical Director and requests for a copy of the current hospital rates including laboratory/diagnostic procedures, OR fees and Room and Board.

4. The PRO forwards the rates to the VP – Benefits Development and Actuary for review. If there is a need to ask for discounted rates, the PRO with the help of the MedoCare Medical Director will negotiate for discounted rates after the rates have been agreed upon.

5. If there are revisions in the standard MOA, the hospital administrator sends the MOA back with the revisions via mail or fax.

6. The PRO receives the MOA with revisions and refers to the Medocare Medical Director and EVP-GM for approval of the revisions.

7. The Medical Director and EVP-GM initials all pages of the MOA and the PRO sends it to the Office of the Chairman and CEO for signing.

8. The PRO sends the signed MOA back to the hospital administrator.

9. The hospital signs the MOA.

10. The PRO conducts an orientation regarding MedoCare's policies and procedures

11. The PRO updates the Provider database.

Steps In Affiliating A Hospital If There Is No Other Provider In The Area

1. The PRO identifies areas where there is a need to affiliate new providers/ hospital.

2. The PRO sends a proposal to the prospective hospital. The proposal includes:
   a) company profile
   b) financial statement
   c) SEC registration
   d) Forms – Letter of Authorization (LOA), Out- Patient Procedures Authorization (OPPA), Referral forms, Emergency Treatment form
   e) Sample of member ID
   f) Vicinity map of Provider
   g) Memorandum of Agreement (MOA)
   h) Schedule of fees
   i) List of clients

j) Specimen signatures of Officers

3. The PRO follows – up with the Hospital Administrator or Medical Director and requests for a copy of the current hospital rates including laboratory/diagnostic procedures, OR fees and Room and Board.

4. The PRO forwards the rates to the VP – Benefits Development and Actuary for review. If there is a need to ask for discounted rates, the PRO with the help of the Medical Director will negotiate for discounted rates after the rates have been agreed upon.

5. If there are revisions in the standard MOA, the hospital administrator sends the MOA back with the revisions via mail or fax.

6. The PRO receives the MOA with revisions and refers to the Medocare Medical Director and EVP-GM for approval of the revisions.

7. The Medical Director and EVP-GM initials all pages of the MOA and the PRO sends it to the Office of the Chairman and CEO for signing.

8. The PRO sends the signed MOA back to the hospital administrator

9. The hospital signs the MOA.

10. The PRO conducts an orientation regarding MedoCare's policies and procedures

11. The PRO updates the Provider database.

Steps in Affiliating A Hospital Who Is Applying For Affiliation

1. The hospital signifies its intention to affiliate with MedoCare.

2. The PRO requests for the following requirements:
   - Vicinity Map
   - Hospital/Clinic Profile
   - Services Available
   - Current Rates/Facilities being offered
   - List of Active Physicians
   - DOH License
   - Clinic Schedule (for clinics only)
   - Contact Person
   - Contact number/s
   - PHA Affiliation (for hospitals only)
   - PHIC Accreditation
   - Classification : Tertiary
     Secondary
     Primary
   - Financial Documents – Photocopy of BIR and SEC registration

3. The PRO forwards the rates to the VP – Benefits Development and Actuary for review. If there is a need to ask for lower rates, the PRO with the help of the Medical Director will negotiate for discounted rates.

   After the rates have been agreed upon,

   a. If there are revisions in the standard MOA, the hospital administrator sends the MOA back with the revisions via mail or fax.

   b. The PRO receives the MOA with revisions and refers to the Medocare Medical Director and EVP-GM for approval of the revisions.

   c. The Medical Director and EVP-GM initials all pages of the MOA and the PRO sends it to the Office of the Chairman and CEO for signing.

   d. The PRO sends the signed MOA back to the hospital administrator.

   e. The hospital signs the MOA.

   f. The PRO conducts an orientation regarding Medocare's policies and procedures.

   g. The PRO updates the Provider database.

E. Guidelines in Handling Provider Inquiries, Concerns

1. The PRO receives the inquiry/ concern from the hospital/physician
2. The PRO endorses the inquiry/ concern to the department concerned
3. Once a resolution to the concern has been made, the PRO informs the hospital/physician that a resolution has been reached.

CORPORATE MANUAL

MEDOCare Health Systems Inc.

Document Code: MDCARE-marketing-001	
Document Type: Policies and Guidelines	
Division-Department: Marketing	Print Date: 08/13/21
Effectivity Date: November 3, 2013	Page: Page1 of 7

Subject/Title/Description:
Policies and Guidelines for new business acquisition

Filename:
MDCAREmarketingnewbusiness

1. Standard Name
Reservation Policies and Procedures

2. Standard Purpose
To provide MEDOCare with a common framework on the policies and procedures for reserving an account

3. Standard Owner
The Reservation Policies and Procedures are owned by MEDOCARE, and nobody is allowed to generate and distribute copies without permission from the OIC COO, SVP, VP- Sales and Marketing and VP Business Development. The said officers have the ultimate responsibility for approving changes to and allowing deviations from this document.

4. Document History
This is the original issue, version 2, with 7 pages. This version is fully effective by **JULY 8, 2013** unless superseded by revision or withdrawn.

5. Distribution of Copies
Client Affairs
Finance
Operations
Business Development
Sales and Marketing
SVP
OIC COO

Revision is controlled by MANCOM with the concurrence of the Chairman. It is the responsibility of the Sales and Marketing to distribute copies to the division/department heads.

POLICY:

This Reservation Policy is granted to sales intermediaries who wants to work on an account for economic gain. Upon approval of Reservation application, the sales intermediary is given exclusive right over a period of time. This policy is on a "First Come First Serve" basis. The provisions/procedures stated herein shall serve as Medocare's guide in resolving issues that may come up in the course of implementing this policy.

1. There are two (2) types of Reservation:

1.1 TEMPORARY RESERVATION

Prepared by:	Date :	Approved by :
ACA Recommending approval: VAV RAP NAS FGC MANCOM CHAIRMAN ELS		Col. Esteban B. Uy Chairman and CEO

Initial Franchise/Reservation for five (5) days is given to an applicant upon submission of Franchise/Reservation Form. However, if a broker on record (BOR) is presented upon submission of Reservation Form, a PERMANENT RESERVATION is immediately granted.

1.2 PERMANENT RESERVATION

Valid for sixty (60) days is awarded to intermediaries who will be able to submit the following vital documents: together with Reservation Form

a. List of employees with the date of birth, gender and marital status
b. Latest detailed or summarized utilization report
c. Contract or Terms of Reference (TOR)
d. Renewal advise/ Notice
e. Broker on record (BOR)

2. Extension of Reservation

Please refer to III

3. Turn around time (TAT) is one (1) hour within which awarding of Temporary/Permanent Reservation must be made.

4. Exclusivity of Reservation

All accounts for bidding whether government or private entities as well as the Bataan Export Processing Zone, Subic Freeport or companies within the Clark Special Economic Zone are reserved for MEDOCARE.

I. APPROVING AUTHORITY

For other reserving issues not covered in the procedures enumerated below that require approval, the following approving authority shall apply:

Person Responsible	Responsibilities
ANNALYN AVILA	1. Receives, awards and screens reservation form, list of employees, extension request, BOR and other documents. 2. Administer, reserve & update an account in reservation system/excel monitoring worksheet.

Prepared by: ACA Recommending approval: VAV RAP NAS FGC MANCOM CHAIRMAN ELS	Date :	Approved by : Col. Esteban B. Uy Chairman and CEO

	3. Handles BOR/Appointment Letter request without existing reservation
VP BUSINESS DEVT / VP SALES & MKTG	1. Handles BOR/Appointment Letter request, if with existing reservation assignment.
ANNALYN AVILA/JEAN SANTOS	1. Validates extension request from distribution channel. (agent/broker)
VP Business Development/VP Sales & Marketing	1. Approves extension request from distribution channel (agent/broker)
Reservation Committee	1. Reservation Committee includes OIC COO, SVP, VP Business Development, VP Operations, VP Sales & Marketing. 2. Resolves and decides on conflicts in reservation.

Procedure:

II. Reservation:

	Procedure	Person Responsible
	Receives and screens completely filled up Reservation Form (RF) in hard or soft copy and awards Temporary Reservation* valid initially for Five (5) working days to applicant (agent/broker) thru email or in writing via the RF. ***PERIOD WITHIN WHICH VITAL DOCUMENTS MUST BE COMPLIED WITH**	ANNALYN AVILA
	Temporary reservation of five (5) working days becomes permanent for sixty (60) days upon submission of the following vital documents necessary to come up with a competitive package and price. a. List of Employees in hard or soft copies (Name of Employee (optional) or employee number, Birth date, Gender, Marital Status) Position must also be indicated if the coverage is based on position or Broker on Record (BOR) b. Utilization Report or latest renewal notice/advise if the account has an existing HMO coverage with another company. c. Terms of reference (TOR) or CONTRACT d. Other documents that are being submitted by the agent/broker (or distribution channel)	ANNALYN AVILA

	NOTE: TEMPORARY RESERVATION IS CANCELLED IF THE ABOVE MENTIONED DOCUMENTS ARE NOT SUBMITTED WITHIN THREE (3) WORKING DAYS.	
	Check from reservation system/excel monitoring worksheet if the account has an existing reservation. A. If the account has an existing active reservation, deny request for reservation and return the documents to the distribution channel thru Sales & Marketing personnel. B. If the account for reservation has an existing coverage with MEDOCARE and claimed to be a different company, subsidiary, class of members (i.e. Company A and Company A Employee Union, Company B employees and Company B dependents) refers to Sales and Marketing B.1 Fill up Reservation Clearance Slip B.2 Forward Reservation Clearance Slip to Sales and Marketing. B.3 Log the name of the account in excel monitoring worksheet. B.4 TAT shall be within 2 days.	ANNALYN AVILA
	C. If the account has no existing active reservation, the distribution channel is granted a reservation of five (5) working days within which he/she must submit pertinent documents (see D.1 and D.2) Failure to submit the above documents within five (5) working days will automatically cancel the reservation and the account shall be declared open for reservation by other distribution channel D. Reservation of sixty (60) days shall be awarded to agent/broker who provided the required documents to facilitate preparation of proposal. The documents that must be provided are the following: D.1 With existing account 1.1 Existing contract 1.2 Latest detailed or summary utilization report 1.3 Renewal notice/proposal (if any) 1.4 Complete census list if a "BOR" was submitted for	ANNALYN AVILA

	Reservation D.2 Virgin Account 2.1 Complete census list 2.2 Terms of Reference (TOR)	
	Check from person/unit in charge of accrediting agent/brokers if the intermediary is an existing distribution channel of MEDOCare. a. If the agent/broker is not an accredited one, inform the distribution channel that we cannot franchise/reserve the account with him/her until he/she/ undergoes process of accreditation DISCUSS POSSIBLE REQUIREMENTS/PROCESS b. If the distribution channel is a former employee of MEDOCare • Check from HR Officer the date of resignation of the employee. • Secure clearance from HR/Management c. If the distribution channel exists proceed to #5.	ANNALYN AVILA
	Issue acknowledgement receipt to the distribution channel and inform them to follow up the proposal directly from Sales and Marketing after 3 days.	ANNALYN AVILA
	Reserve the account in the reservation system/excel monitoring worksheet	ANNALYN AVILA
	Log in excel monitoring worksheet	ANNALYN AVILA
	Forward the RF and other documents of approved accounts reserved to Sales and Marketing or Business Development within 4 hours. Cut Off time is 3:00 PM. RF received after the cut-off time shall be considered to have been received the next day.	ANNALYN AVILA
	Release letter to the account's contact person informing them that their company was franchised/reserved to their appointed distribution channel.	ANNALYN AVILA / JEAN SANTOS

Prepared by:	Date :	Approved by :
ACA Recommending approval: VAV RAP NAS FGC MANCOM CHAIRMAN ELS		Col. Esteban B. Uy Chairman and CEO

III. Extension of Reservation:

An agent is given 60 days to work on the account. If the business is not closed within 60 days from the date of the proposal, the reservation automatically expires. However, an agent may request for an extension of reservation. Extension of reservations after the initial 60 day period may be granted once a written request (submit a duly accomplished Request for Reservation Extension Form – countersigned by the contact person) is made before the expiration date of the reservation, and if it can be established that negotiations are on-going. Regardless, reservation extensions are not automatic and are subject to the evaluation and approval of VP - Sales and Marketing.

	Procedure	Person Responsible
	Receives Request for Reservation Extension Form with countersign from contact person.	ANNALYN AVILA / JEAN SANTOS
	Check reservation and expiration date of an account in the reservation system/excel monitoring worksheet	ANNALYN AVILA / JEAN SANTOS
	Issue acknowledgement receipt	ANNALYN AVILA / JEAN SANTOS
	Forward Extension Request Form to Sales and Marketing to validate reason for extension and approval of request.	ANNALYN AVILA / JEAN SANTOS
	Check for reason of extension, and validate the status of negotiation	ANNALYN AVILA / JEAN SANTOS
	Approve/Disapprove request of extension	VP-Sales & Marketing/VP Business Development
	Return approved request to sales & marketing / business development	ANNALYN AVILA / JEAN SANTOS
	Encode approval/disapproval of request in franchising/reservation system/excel worksheet	ANNALYN AVILA
	After 60 days – 30 day extension – The agent/broker will be given another 60 days to work on the account should his request for reservation extension be approved. Thereafter, extension of another thirty (30) days may be granted once a written request with Request for Reservation Extension Form (RF/REF) is made before the expiry date of previous extension and if it can justify that negotiations are on-going.	ANNALYN AVILA / JEAN SANTOS

IV. Handling of BROKER OF RECORD (BOR) / APPOINTMENT LETTER

Accredited/recognized/licensed Agents, in-house brokers, or brokers who are officially appointed by a company through an exclusive "Broker of Record" (BOR) appointment are

automatically given reservation of the account. In the event that the account is already reserved with an agent/broker, the following procedure should be followed:

	Procedure	Person Responsible
	Receives completely filled up Reservation Form, Broker of Record Appointment letter, list of employees with birthday and position	ANNALYN AVILA
	MEDOCare (MHSI) shall confirm with the signatory the appointment letter issued thru phone call or email whichever is applicable (preferably email)	ANNALYN AVILA / JEAN SANTOS
	Reserve the account to the appointed agent/broker.	ANNALYN AVILA
	Forward to Sales and Marketing / Business Development for proposal preparation	ANNALYN AVILA / JEAN SANTOS
	Issue letter to the existing agent/broker informing the transfer of franchise.	ANNALYN AVILA / JEAN SANTOS

V. Closing an Account:

In case of successful negotiation with the account Sales and Marketing Staff/Officer ask for client code and tag the same as "CLOSED ACCOUNT".

	Procedure	Person Responsible
	Receipt of confirmation letter from Sales and Marketing / Business Development indicating the name of agent/broker who closed the account.	ANNALYN AVILA / JEAN SANTOS
	Update reservation system or excel worksheet status to "CLOSED ACCOUNT"	ANNALYN AVILA
	Update excel monitoring worksheet	ANNALYN AVILA
	E-mail Sales & Marketing / Business Development of the assigned client code for the account.	ANNALYN AVILA / JEAN SANTOS

Prepared by: ACA Recommending approval: VAV RAP NAS FGC MANCOM CHAIRMAN ELS	Date :	Approved by : Col. Esteban B. Uy Chairman and CEO

1. **Standard Name**
New Business

2. **Standard Purpose**
To provide a common framework by which Marketing staff shall provide services to to prospective clients.

3. **Standard Owner**
The MDCARE-marketing-001 is owned by MedoCare, and nobody is allowed to generate and distribute copies without permission from the Medocare Operations Department.

All changes/modifications/deviations from this document shall be subject to approval of the Chairman & CEO.

Dissemination of copies of this Manual should be carried out with prior authorization from the COO-Medical Director.

MARKETING AND SALES GUIDELINES

Policies and Guidelines On Handling Prospective Clients

A. Guidelines On Handling Prospective Clients with Agents

1. The agent secures a franchise (please see guideline for Franchising) for the prospective account.

2. The Marketing Staff checks if the prospective account has not been franchised by other agents first.

3. After Franchise has been granted, the Actuary computes for premium rates to be proposed to the client and an Abstract for New Accounts shall be prepared. This shall then be routed to the different Officers for evaluation.

4. After all officers have signed, the Abstract shall then be submitted to the Chairman and CEO for final approval.

5. A proposal shall then be prepared by the Marketing Staff which shall then be submitted to the prospective client.

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6. A presentation shall be conducted by a team in case it is required.

Marketing in coordination with actuary shall handle the negotiations. Any changes in the package of benefits shall always be in coordination of Actuary.

Generation of Contract :

a) Upon verbal agreement that the client has chosen Medocare to be its Healthcare Provider, Marketing shall request for the Letter of Intent (LOI) from the client.

b) The Marketing Officer shall issue a Notice to all Departments with regard to a new account.

c) After receipt of the approved proposal and LOI, Marketing shall request Operations for the preparation and printing of the draft contract.

d) The draft contract will then be forwarded to the new account for review and confirmation.

e) If confirmed , the draft contract shall be returned to Marketing with the corresponding initial by the Account's authorized representative.

f) Four copies of the final contract shall then be printed and schedule of signing will be arranged by Marketing.

g) Upon retrieval of signed contract, Marketing will have the signed contract notarized and one original copy shall be sent to the Account and one copy for Operations for guidelines preparation.

B. **Guidelines On Handling Prospective Direct Accounts**

1. The Marketing Officer shall request for a standard proposal from Benefits Development. This shall then be sent to the prospective agent to serve as jump off point for negotiations.

2. The Marketing Staff checks if the prospective account has not been franchised by other agents first.

3. After ensuring that the account is not franchised, the Actuary computes for premium rates to be proposed to the client and an Abstract for New Accounts shall be prepared. This shall then be routed to the different Officers for evaluation.

4. After all officers have signed, the Abstract shall then be submitted to the Chairman and CEO for final approval.

5. A proposal shall then be prepared by the Marketing Staff which shall then be submitted to the prospective client.

Generation of Contract :

a) Upon verbal agreement that the client has chosen Medocare to be its Healthcare Provider, Marketing shall request for the Letter of Intent (LOI) from the client.

b) The Marketing Officer shall issue a Notice to all Departments with regard to a new account.

c) After receipt of the approved proposal and LOI, Marketing shall request Operations for the preparation and printing of the draft contract.

d) The draft contract will then be forwarded to the new account for review and confirmation.

e) If confirmed , the draft contract shall be returned to Marketing with the corresponding initial by the Account's authorized representative.

f) Four copies of the final contract shall then be printed and schedule of signing will be arranged by Marketing.

g) Upon retrieval of signed contract, Marketing will have the signed contract notarized and one original copy shall be sent to the Account and one copy for Operations for guidelines preparation.

1. **Standard Name**
Renewal and Contract Preparation

2. **Standard Purpose**
To provide a common framework by which Marketing staff shall provide services to renewing accounts through timely processing and costing.

3. **Standard Owner**
The MDCARE-marketing-001 is owned by MedoCare, and nobody is allowed to generate and distribute copies without permission from the Medocare Operations Department.

All changes/modifications/deviations from this document shall be subject to approval of the Chairman & CEO.

Dissemination of copies of this Manual should be carried out with prior authorization from the COO-Medical Director.

MARKETING AND SALES GUIDELINES

Policies and Guidelines On Processing of Renewing Accounts

A. Guidelines for Processing of Renewing Accounts

1. Every first working day of the month, Underwriting shall provide Marketing a list of accounts whose contracts are due to expire within 3 months.

2. 3 months (90days) before expiration of corporate contract, the Marketing Assistant shall request for the summary of utilization from MIS of the said account.

3. Together with the utilization summary the marketing assistant will then compute for the renewal rate based on the formula given by actuary. Finished product would be the "Abstract of Renewing Account" to be accomplished within forty five (45) days before contract expiry of the renewing account

4. The Abstract of Renewing Accounts shall then be routed to the approving officers namely: VP Business Development, VP Operations, Vice Chairman-Sales and Marketing, VP-Claims, COO/Medical Director, AVP Finance Lockheed Group before signing by the Chairman and CEO.

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5. Marketing in turn shall forward the renewal advise to the account at least 45 days prior to expiration.

Marketing in coordination with actuary shall handle the renewal negotiations. Any changes in the package of benefits shall always be in coordination with Actuary.

Generation of Contract :

a) Upon agreement of the renewal package, Marketing shall request for the Letter of Intent (LOI) from the client.

b) The Marketing Officer shall issue a Notice to all Departments with regard to renewal or non-renewal of a certain account.

c) Together with the renewal proposal and LOI, Marketing shall request Operations for the printing of the draft contract.

d) The draft contract will then be forwarded to the renewing account for review and confirmation.

e) If confirmed , the draft contract shall be returned to Marketing with the corresponding initial by the Account's authorized representative.

f) Four copies of the final contract shall then be printed and schedule of signing will be arranged by Marketing.

g) Upon retrieval of signed contract, Marketing will have the signed contract notarized and one original copy shall be sent to the Account and one copy for Operations for guidelines preparation.