

OFFICE OF THE VICE PRESIDENT

Medical Assistance Application Form

Processing of Applications and Interviews are done at
Ground Floor Ben-Lor Bldg., 1184 Quezon Ave., Quezon City
Contact # (02) 8-370-1714 or 8-370-1716 local 113 and 112
Email Address: pad@ovp.gov.ph



**OFFICE OF THE
VICE PRESIDENT
OF THE PHILIPPINES**

Pursuant to the Data Privacy Act of 2012 (Republic Act 10173), I hereby give my consent to the Office of the Vice President (OVP) to process my personal information and sensitive personal information for my application for medical assistance. I understand that the processing shall be limited to the purpose specified.

I understand that I can only avail of the medical assistance as provided under OVP guidelines such as the maximum amount of P20,000.00 and only once in one year and I will comply with these requirements.

Date of Interview

Record No.

Name of Patient	FIRST NAME	MIDDLE NAME	LAST NAME
Date of Birth	MONTH, DAY, YEAR	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Current Address			
Diagnosis			Educational Attainment
Dialysis Center/ DOH Hospital's Name			Occupation
Family Monthly Income		Signature	

Household Composition

Name	Age	Sex	Relationship to Patient	Civil Status	Educational Attainment	Occupation	Daily/Monthly Income

Details of Authorized Representative

Name of Authorized Representative	FIRST NAME	MIDDLE NAME	LAST NAME
Relationship to the Patient	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Signature
Contact Number	E-mail Address		

Evaluation _____ TO BE FILLED OUT BY OVP PERSONNEL

DENIED

Due to availment of the medical assistance within one (1) year from the date of this application
DATE OF LAST AVAILMENT: _____

Invalid/Non-compliant Documents

Blacklisted due to fraud

Others: _____

Recommending Approval

SIGNATURE OVER PRINTED NAME

FOR COMPLETION OF REQUIRED DOCUMENTS

Please return on: _____ Actual Date of Return: _____

Details/Instructions to be placed on the checklist at the back of this form.



RECOMMENDED FOR APPROVAL

For Credit Line Requested Amount: _____

For Fund Transfer For: _____

For issuance of Guarantee Letter Recommended Amount: _____

Remarks: _____

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PATIENT/REPRESENTATIVE WAIVER FORM

Ako si _____, (pasyente / representative), ay nangangako na ang lahat ng impormasyon at dokumentong aking isusumite ay tunay at totoo. Naiintindihan ko na ang aking ipinasang aplikasyon ay dadaan muna sa pagsusuri upang makumpirma ang katunayan ng mga dokumento.

Anumang mapatunayang kasinungalingan o pag gamit ng mga pekeng dokumento ay magdudulot ng disqualification o pagkansela ng aplikasyon para sa Medical Assistance Program at maaaring magresulta sa criminal o civil liability gaya ng pagkakulong at multa.

SIGNATURE OVER PRINTED NAME

DATE

Requirements for Chemotherapy, Radiation Therapy, Brachy Therapy, Hospital Bill, Dialysis, Implant, Surgery, and Transplant

<input type="checkbox"/> Referral Letter from Hospital or Dialysis Center (kung hindi partner service provider)	Nakasaad na sila ay tumatanggap ng Guarantee Letter, pati na rin ang bank account details ng ospital kung saan maaaring i-transfer ng OVP ang tulong medikal
<input type="checkbox"/> Application Form	na nasagutan ng maayos at pirmado ng pasyente at ng representative (if applicable)
<input type="checkbox"/> Medical Records	Clinical Abstract o Medical Certificate na may kumpletong pangalan, pirma at lisensya ng doktor. (Ang date ay di lalampas sa 6 months sa araw ng assessment)
<input type="checkbox"/> Social Case Study Report o Barangay Certificate of Indigency addressed to OVP o generic.	Dapat ito ay pirmado ng registered social worker o ng Barangay Captain, at ang petsa ay hindi lalampas ng 1 year sa araw ng assessment.
<input type="checkbox"/> Valid ID (front and back) ng pasyente at authorized representative	

Iba Pang Requirements

Chemotherapy, Radiation Therapy, Brachytherapy, and Radio-Iodinotherapy

- Treatment Protocol**
na may cost breakdown na may kumpletong pangalan, pirma at lisensya ng doktor. Ang date ay di lalampas sa 6 months sa araw ng assessment.

Dialysis

- Dialysis Quotation**
(Kung ang Dialysis Center ay hindi Partner Service Provider ng OVP) excluding the cost of dialyzer and PF na may kumpletong pangalan, pirma at lisensya ng doktor. Ang petsa ay di lalampas sa 6 months sa araw ng assessment.

Implant/Medical Device

- Supplier Quotation**
(Kung ang supplier ay hindi Partner Service Provider ng OVP) Ito ay dapat may kumpletong pangalan, pirma ng authorized representative at ang date ay hindi lalampas sa 6 months sa araw ng assessment.

Hospital Bill/Operation

- Estimated Cost ng Operation**
na may kumpletong pangalan, pirma at lisensya ng doktor. Ang petsa ay di lalampas sa 6 months sa araw ng assessment.

- HOSPITALIZATION, CONFINED**
Pinakabagong **Billing Statement of Account** na may pangalan at pirma ng billing or accounting officer.

- HOSPITALIZATION, DISCHARGED**
Pinakabagong **Billing Statement of Account at Promissory Note (Hospital Bill)**
Dapat ito ay pirmado ng representative ng pasyente, hospital accounting officer o credit & collection officer.

Requirements for Medicine, Laboratory, Diagnostic Procedure, Therapy

<input type="checkbox"/> Application Form	na nasagutan ng maayos at pirmado ng pasyente at ng representative (if applicable)
<input type="checkbox"/> Medical Records	Clinical Abstract o Medical Certificate na may kumpletong pangalan, pirma at lisensya ng doktor. (Ang date ay di lalampas sa 6 months sa araw ng assessment)
<input type="checkbox"/> Social Case Study Report o Barangay Certificate Of Indigency	na pirmado ng registered social worker o Barangay Captain, at ang petsa ay hindi lalampas ng 1 year at 3 months sa Barangay Indigency sa araw ng assessment, addressed to OVP o generic.
<input type="checkbox"/> Photocopy ng Valid ID (front and back) ng pasyente at representative	

Iba Pang Requirements

Medicines

- Pinakabagong Reseta** na may petsa, kumpletong pangalan, pirma at lisensya ng doktor

Laboratory, Diagnostic Procedure, and Therapy (Physical, Occupational, Speech, and Phototherapy)

- Laboratory Request** na pirmado ng doktor na ang petsa ay hindi lalampas ng 6 months sa araw ng assessment.
- Quotation** (Kung ang ospital o clinic ay hindi kabilang sa Partner Service Provider ng OVP) galing sa ospital o diagnostic center kung saan gagawin ang laboratory o procedure, dapat pirmado ng authorized staff ng ospital.

Listahan ng Valid IDs (Dapat hindi expired sa araw ng interview)

1. Driver's License	7. PWD ID	13. 4Ps ID	Kung ang pasyente ay menor de edad: 1. Registered Birth Certificate 2. School ID (kasalukuyang enrolled) 3. Barangay ID 4. Service Issue Card
2. NBI Clearance	8. Senior Citizen ID	14. Postal ID	
3. Passport	9. Solo Parent ID	15. Company ID	
4. PhilHealth ID	10. TIN ID	16. Barangay ID	
5. Police Clearance/ID	11. UMID/GSIS or SSS ID	17. National ID	
6. PRC ID	12. Voter's Certification/ID		

Mga Paalala

Ayon po sa aming Guidelines, maaari lamang pong makatanggap ng tulong medikal mula sa OVP **once every twelve (12) months**. Ito po ay upang mabigyan ng pagkakataon ang mas marami pang nangangailangang indibidwal na makatanggap ng tulong medikal.

Para din po sa inyong kaalaman, hindi po namin mapo-proseso ang request na may mga kulang na dokumento.

Humihingi po kami ng paumanhin kung hindi po agarang mapo-proseso ang inyong aplikasyon. Ito ay dahil sa dami ng bilang ng mga requests na natatanggap ng aming opisina. Huwag po kayong mag-alala at kayo po ay agad naming kokontakin tungkol sa status nito kapag ito po ay dumaan na sa aming pagsusuri.

Para sa nais mag follow-up, maaari po kayong tumawag sa **8370-1714** local **113** o mag e-mail sa **pad@ovp.gov.ph**

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