Republic of the Philippines
SOCIAL SECURITY SYSTEM
EC MEDICAL REIMBURSEMENT APPLICATION
FORM 1

MED - 01189 (08-2014)

TO BE FILLED OUT BY SSS
CONTROL NUMBER

CLAIM NUMBER

THIS FORM MAY BE REPRODUCED AND IS NOT FOR SALE. THIS CAN ALSO BE DOWNLOADED THRU THE SSS WEBSITE AT www.sss.gov.ph.

PLEASE READ THE INSTRUCTIONS AND REMINDERS AT THE BACK BEFORE FILLING OUT THIS FORM. PRINT ALL INFORMATION IN CAPITAL LETTERS AND **USE BLACK INK ONLY**.

PART I - TO BE FILLED OUT BY EMPLOYED MEMBER

A. PERSONAL DATA

SS NUMBER | COMMON REFERENCE NUMBER (IF ANY) | DATE OF BIRTH (MMDDYYYY) | TAX IDENTIFICATION NUMBER (IF ANY)

NAME (LAST NAME) (FIRST NAME) (MIDDLE NAME) (SUFFIX)

LOCAL ADDRESS (RM/FLR/UNIT NO. & BLDG. NAME) (HOUSE/LOT & BLK NO.) (STREET NAME)

(SUBDIVISION) (BARANGAY/DISTRICT/LOCALITY) (CITY/MUNICIPALITY) (PROVINCE) ZIP CODE

TELEPHONE NUMBER (AREA CODE + TEL. NO.) | MOBILE/CELLPHONE NUMBER | E-MAIL ADDRESS

FOREIGN ADDRESS (IF APPLICABLE) | COUNTRY | ZIP CODE

B. CERTIFICATION

I certify that the information provided in this form are true and correct.

PRINTED NAME | SIGNATURE | DATE

If member cannot sign, affix fingerprints. Please read Instruction No. 4 of the form.

Below are the witnesses to fingerprinting:

1) PRINTED NAME | SIGNATURE | DATE

ADDRESS & CONTACT NUMBER

2) PRINTED NAME | SIGNATURE | DATE

ADDRESS & CONTACT NUMBER

RIGHT THUMB | RIGHT INDEX

PART II - TO BE FILLED OUT BY EMPLOYER

A. EMPLOYER DATA

EMPLOYER NUMBER | TAX IDENTIFICATION NUMBER (IF ANY) | TYPE OF EMPLOYER ☐ Business ☐ Household

EMPLOYER NAME

EMPLOYER ADDRESS (RM/FLR/UNIT NO. & BLDG. NAME) (HOUSE/LOT & BLK NO.) (STREET NAME)

(SUBDIVISION) (BARANGAY/DISTRICT/LOCALITY) (CITY/MUNICIPALITY) (PROVINCE) ZIP CODE

TELEPHONE NUMBER (AREA CODE + TEL. NO.) | E-MAIL ADDRESS | WEBSITE (FOR BUSINESS EMPLOYER)

B. ACCIDENT/SICKNESS REPORT

PERIOD OF EMPLOYMENT From (MMDDYYYY) To (MMDDYYYY) | WORKING HOURS Regular : From _____ (A.M./P.M.) To _____ (A.M./P.M.) Overtime: From _____ (A.M./P.M.) To _____ (A.M./P.M.) | OCCUPATION

JOB DESCRIPTION (STATE BRIEF DESCRIPTION OF DUTIES. SPECIFY NAME OF CHEMICALS OR SUBSTANCE TO WHICH THE EMPLOYEE IS EXPOSED, IF ANY. USE SEPARATE SHEET/S, IF NECESSARY).

DATE OF ACCIDENT/SICKNESS (MMDDYYYY) | TIME OF ACCIDENT _____ ☐ A.M. ☐ P.M. | PLACE OF ACCIDENT

DESCRIPTION OF ACCIDENT/SICKNESS (IF VEHICULAR ACCIDENT, STATE PURPOSE OF TRIP. USE SEPARATE SHEET/S, IF NECESSARY.)

C. CERTIFICATION

I certify that the information provided in this form are true and correct and that the reported accident/sickness is duly documented in the company record.

PRINTED NAME OF IMMEDIATE SUPERVISOR | SIGNATURE OF IMMEDIATE SUPERVISOR | POSITION TITLE | DATE

PRINTED NAME OF MANAGER | SIGNATURE OF MANAGER | POSITION TITLE | DATE

---Perforate Here---

Republic of the Philippines
SOCIAL SECURITY SYSTEM
EC MEDICAL REIMBURSEMENT APPLICATION
ACKNOWLEDGEMENT STUB

SS NUMBER/COMMON REFERENCE NO. (IF ANY) | NAME (LAST NAME) (FIRST NAME) (MIDDLE NAME) (SUFFIX)

RECEIVED BY

SIGNATURE OVER PRINTED NAME | POSITION TITLE | DATE & TIME | BRANCH

PART III - TO BE FILLED OUT BY SSS

A. SCREENING RESULTS

FINDINGS

☐ With previously approved EC/Sickness Claim for the same case
Claim Reference Number _____

☐ In order, may proceed to Medical Evaluation

☐ With deficiency/discrepancy noted, please see attached Medical Claims Compliance Letter

RECEIVED AND SCREENED BY

SIGNATURE OVER PRINTED NAME	DATE & TIME	BRANCH

B. MEDICAL EVALUATION

LOGGED BY		EVALUATED BY		REVIEWED BY	
SIGNATURE OVER PRINTED NAME	DATE & TIME	SIGNATURE OVER PRINTED NAME	DATE & TIME	SIGNATURE OVER PRINTED NAME	DATE & TIME

C. PROCESSING

REMARKS

PROCESSED AND ENCODED BY		REVIEWED BY	
SIGNATURE OVER PRINTED NAME	DATE & TIME	SIGNATURE OVER PRINTED NAME	DATE & TIME

D. POST-PROCESSING (IF WITH POSSIBLE ER LIABILITY)

REMARKS

PROCESSED BY		REVIEWED BY	
SIGNATURE OVER PRINTED NAME	DATE & TIME	SIGNATURE OVER PRINTED NAME	DATE & TIME

INSTRUCTIONS

1. Fill out this form in one (1) copy.
2. Always indicate "**N/A**" or "**Not Applicable**", if the required data is not applicable.
3. Present valid identification cards/documents. Refer to attached "List of Filer's Valid Identification (ID) Cards/Documents.
4. If member cannot sign, witnesses to fingerprinting shall be as follows:

   Filed by member
   - SSS receiving personnel who shall affix his/her signature on the portion provided in Part I-B.

   Filed by authorized representative/employer/employer's representative/ company representative
   - Two (2) witnesses. One (1) witness is the authorized representative/ employer/ employer's representative/ company representative himself and the other one (1) could be any person. Both should affix their signatures and indicate their addresses and contact numbers on the portions provided in Part I-B.
5. Submit the following documentary requirements, whichever is applicable, to the nearest SSS branch office:

   BASIC DOCUMENTS

   a. Properly accomplished EC Medical Reimbursement Application Forms 1 & 2
   b. Photocopy of page in the company record or any proof containing the description/information of the sickness/accident
   c. Accident Report
   d. Other documents

   For work-related sickness/illness
   - Pre-employment physical examination report; Chest X-ray; ECG, if available
   - Certificate of Length of Service certified by employer; and
   - Certified true copy of hospital abstract

   For work-related accidents
   - Employee's destination and purpose of trip certified by employer; and
   - Police report, if vehicular accident/medico-legal incident

   ADDITIONAL SUPPORTING DOCUMENTS

   For Employer/Member Payee

   a. Original Official Receipt/s (OR) with BIR permit number of medical expenses including professional fees. In the absence of the original copies of OR which are in custody of Philhealth or any Health Maintenance Organization (HMO), the medical expenses may be proved by photocopies of OR stamped with "certified true copy" by the Philhealth official or HMO authorized representative in custody of the OR.
   b. Original copy of charge slips/statement of accounts with itemized list or breakdown of expenses

   For Hospital/Clinic Payee/Provider

   a. Original copy of charge slips/statement of accounts with itemized list or breakdown of expenses.

   For Doctor Payee

   a. Clinical records showing the following:
      - Services rendered
      - Number and date/s of consultation/s or visit/s, if hospitalized
   b. Operating Room Record, if applicable
6. Use another sheet of Form 2, if there are more than three (3) payees/claimants.

   If employee is deceased, the person who signed the application should indicate his/her relationship to the employee beside his/her name.
7. This form can be downloaded thru the SSS website at *www.sss.gov.ph.*

REMINDER

EC Medical Reimbursement Application should be filed within three (3) years from date of sickness/accident.

WARNING

ANY PERSON WHO MAKES ANY FALSE STATEMENT IN THIS APPLICATION OR SUBMITS ANY FALSIFIED DOCUMENT IN CONNECTION WITH THIS CLAIM SHALL BE LIABLE CRIMINALLY UNDER SECTION 28 OF R.A. 8282 OR UNDER PERTINENT PROVISION OF THE REVISED PENAL CODE OF THE PHILIPPINES.