EHCBA Form
Series of Sept. 2020

BJMP MUTUAL BENEFIT ASSOCIATION, INCORPORATED (BJMPMBAI)
144 Mindanao Avenue, Bahay Toro, Quezon City
Tel. 02-926-6963 / 02-542-6671

Application No. _____
Date Received: _____

EMERGENCY HOSPITALIZATION CASH BENEFIT ASSISTANCE EVALUATION & CLAIM FORM (EHCBA)

☐ **Hospitalized**
☐ **Deceased**

Rank/Designation	**Member's Name/Beneficiary (Last, First, MI)**	**Present Unit Assignment / Address:**
Residential / Provincial Address:		**Contact No.**
Place of Confinement (Name of Hospital/Clinic and Address):		**Date of Confinement:**

I attest to the truthfulness of all matters indicated in this claim form and I am aware that any misrepresentation made by me shall cause the filing of criminal and disciplinary actions and may result to disallowance/refund of the claim.

_____
(Signature over Printed Name of the Claimant)

Date of Death (for deceased claimant) _____
(Additional Attachment: Death Certificate)

Bank Account no. _____

This portion to be filled-out by Physician (BJMPMBAI):			Evaluated by:
No. of Days of Confinement:	**Final Diagnosis:**	☐ **Less serious illness / injury**	
		☐ **Serious illness / injury**	Signature over Printed Name

Below to be filled-out and evaluated by BJMPMBAI Mgt. & Staff:

Supporting Documents Attached (Please check the box):

Immediate Release / Initial Claim

- ☐ Spot/Incident Report from PNP or BJMP Regional Director *or* Immediate Supervisor (immediate release)
- ☐ Certificate of Confinement or Medical Certificate signed by Attending Physician/Hospital Staff
- ☐ Photos of the injured / sick member taken while in a hospital
- ☐ Photocopy of Automated Teller Machine (ATM) with Account Number
- ☐ Certified True copy of BJMPMBAI ID or BJMP ID / Government issued ID / Valid ID

Daily Hospital Allowance Claim

- ☐ Certification of hospital confinement from the BJMPMBAI Regional In-Charge or the Regional Executive Senior Jail Officer (RESJO)
- ☐ Certification of the Jail Nurse (on the conducted hospital visitation)
- ☐ Original copy of Hospital Records or Details of consultation and treatment
- ☐ Original or True copy of Hospital Admitting History and Discharge Summary or Medical Abstract
- ☐ Records or details of operations (if surgical operation was performed)
- ☐ Results of Laboratory Procedures and Diagnostic Examinations
- ☐ Itemized Hospital Statement of Accounts (showing date of admission & discharge)
- ☐ Photos of the injured / sick member taken while in a hospital
- ☐ Photocopy of Automated Teller Machine (ATM) with Account Number
- ☐ Certified True copy of BJMPMBAI ID or BJMP ID / Government issued / Valid ID

Computation:

Immediate Release/Initial Claim		**P** _____
Daily Hospital Cash Allowance	P_____ x _____days	_____
TOTAL AMOUNT OF CLAIM		**P** _____

Checked the Completeness of Documents:

_____
Signature over Printed Name

Recommend Approval:

_____
Signature over Printed Name

Approved by:

_____
Signature over Printed Name