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PHILHEALTH IDENTIFICATION NUMBER (PIN)

REMINDERS:

1. Your PhilHealth Identification Number (PIN) is your unique and permanent number.
2. Always use your PIN in all transactions with PhilHealth.
3. For Updating/Amendment check the appropriate box and provide details to be accomplished and submit corresponding supporting documents.
4. Please read instructions at the back before filling-out this form.

PURPOSE:

☐ REGISTRATION ☐ UPDATING/AMENDMENT

Preferred KonSulTa Provider

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I. PERSONAL DETAILS

	LAST NAME	FIRST NAME	NAME EXTENSION (Jr./Sr./III)	MIDDLE NAME	NO MIDDLE NAME (Check if applicable only)	MONONYM																								
MEMBER					<input type="checkbox"/>	<input type="checkbox"/>																								
MOTHER's MAIDEN NAME					<input type="checkbox"/>	<input type="checkbox"/>																								
SPOUSE (If Married)					<input type="checkbox"/>	<input type="checkbox"/>																								
DATE OF BIRTH		PLACE OF BIRTH (City/Municipality/Province/Country) (Please indicate country if born outside the Philippines)		PHILSYS ID NUMBER (Optional)																										
<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>m</td><td>m</td><td>d</td><td>d</td><td>y</td><td>y</td><td>y</td><td>y</td> </tr> </table>										m	m	d	d	y	y	y	y			<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>										
m	m	d	d	y	y	y	y																							
SEX	CIVIL STATUS	CITIZENSHIP		TAX PAYER IDENTIFICATION NUMBER (TIN) (Optional)																										
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Annulled <input type="checkbox"/> Married <input type="checkbox"/> Widow/er <input type="checkbox"/> Legally Separated	<input type="checkbox"/> FILIPINO <input type="checkbox"/> FOREIGN NATIONAL <input type="checkbox"/> DUAL CITIZEN		<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>																										

II. ADDRESS and CONTACT DETAILS

PERMANENT HOME ADDRESS					Home Phone Number	
Unit/Room No./Floor	Building Name	Lot/Block/Phase/House Number	Street Name		(COUNTRY CODE + AREA CODE + TELEPHONE NUMBER)	
Subdivision	Barangay	Municipality/City	Province/State/Country (If abroad)	ZIP Code	Mobile Number (Required)	
MAILING ADDRESS <input type="checkbox"/> SAME AS ABOVE					Business (Direct Line)	
Unit/Room No./Floor	Building Name	Lot/Block/Phase/House Number	Street Name		E-mail Address (Required for OFW)	
Subdivision	Barangay	Municipality/City	Province/State/Country (If abroad)	ZIP Code		

III. DECLARATION OF DEPENDENTS

(Use additional form if necessary)

LAST NAME	FIRST NAME	NAME EXTENSION (Jr./Sr./III)	MIDDLE NAME	RELATIONSHIP	DATE OF BIRTH (mm-dd-yyyy)	CITIZENSHIP	NO MIDDLE NAME (Check if applicable only)	MONONYM	Check if with Permanent Disability
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IV. MEMBER TYPE

DIRECT CONTRIBUTOR

- | | | |
|--|--|--|
| <input type="checkbox"/> Employed Private | <input type="checkbox"/> Kasambahay | <input type="checkbox"/> Family Driver |
| <input type="checkbox"/> Employed Government | <input type="checkbox"/> Migrant Worker | |
| <input type="checkbox"/> Professional Practitioner | <input type="checkbox"/> Land-Based | <input type="checkbox"/> Sea-Based |
| <input type="checkbox"/> Self-Earning Individual | <input type="checkbox"/> Lifetime Member | |
| <input type="checkbox"/> Individual | <input type="checkbox"/> Filipinos with Dual Citizenship / Living Abroad | |
| <input type="checkbox"/> Sole Proprietor | <input type="checkbox"/> Foreign National | |
| <input type="checkbox"/> Group Enrollment Scheme | PRA SRRV No. _____ | |
| | ACR I-Card No. _____ | |

INDIRECT CONTRIBUTOR

- | | |
|---|---|
| <input type="checkbox"/> Listahanan | <input type="checkbox"/> LGU-sponsored |
| <input type="checkbox"/> 4Ps/MCCT | <input type="checkbox"/> NGA-sponsored |
| <input type="checkbox"/> Senior Citizen | <input type="checkbox"/> Private-sponsored |
| <input type="checkbox"/> PAMANA | <input type="checkbox"/> Person with Disability |
| <input type="checkbox"/> KIA/KIPO | PWD ID No. _____ |
| <input type="checkbox"/> Bangsamoro/Normalization | |

For PhilHealth Use only:

- ☐ Point of Service (POS) Financially Incapable
- ☐ Financially Incapable

PROFESSION: (Except Employed, Lifetime Members and Sea-based Migrant Worker)

MONTHLY INCOME:

PROOF OF INCOME:

V. UPDATING/AMENDMENT

Please check:	FROM	TO
<input type="checkbox"/> Change/Correction of Name (Last Name, First Name, Name Extension (Jr./Sr./III) Middle Name)		
<input type="checkbox"/> Correction of Date of Birth		
<input type="checkbox"/> Correction of Sex		
<input type="checkbox"/> Change of Civil Status		
<input type="checkbox"/> Updating of Personal Information/Address/ Telephone Number/Mobile Number/e-mail Address		

Under penalty of law, I hereby attest that the information provided, including the documents I have attached to this form, are true and accurate to the best of my knowledge. I agree and authorize PhilHealth for the subsequent validation, verification and for other data sharing purposes only under the following circumstances:

- As necessary for the proper execution of processes related to the legitimate and declared purpose;
- The use or disclosure is reasonably necessary, required or authorized by or under the law; and,
- Adequate security measures are employed to protect my information.



Please affix right thumbmark if unable to write

Member's Signature over Printed Name

Date

FOR PHILHEALTH USE ONLY**RECEIVED BY:**

Full Name:

PRO/LHIO/Branch:

Date & Time:

INSTRUCTIONS

1. All information should be written in UPPER CASE/CAPITAL LETTERS. If the information is not applicable, write "N/A."
2. All fields are mandatory unless indicated as optional. By affixing your signature, you certify the truthfulness and accuracy of all information provided.
3. A properly accomplished PMRF shall be accompanied by a valid proof of identity for first time registrants, and supporting documents to establish relationship between member and dependent/s for updating or request for amendment.
4. On the PURPOSE, check the appropriate box if for **Registration** or for **Updating/Amendment** of information.
5. Indicate preferred KonSulTa provider near the place of work or residence.
6. For PERSONAL DETAILS, all name entries should follow the format given below. Check the appropriate box if registrant has no middle name and/or with single name (mononym).

LAST NAME

SANTOS

FIRST NAME

JUAN ANDRES

NAME EXTENSION (Jr./Sr./III)

III

MIDDLE NAME

DELA CRUZ

7. Indicate registrant's/member's name as it appears in the birth certificate.
8. The full mother's maiden name of registrant/member must be indicated as it appears in the birth certificate.
9. Indicate the full name of spouse if registrant/member is married.
10. Indicate the complete permanent and mailing addresses and contact numbers.
11. For updating/amendment, check the appropriate box to be updated/amended and indicate the correct data.
12. For MEMBER TYPE, check the appropriate box which best describes your current membership status.
13. For Direct Contributors, except employed, sea-based migrant workers and lifetime members, indicate the profession, monthly income and proof of income to be submitted.
14. For Self-earning individuals, Kasambahays and Family Drivers, indicate the actual monthly income in the space provided.
15. In declaring dependents, provide the full name of the living spouse, children below 21 years old, and parents who are 60 years old and above totally dependent to the member.
16. Dependents with disability shall be registered as principal members in accordance with Republic Act 11228 on mandatory PhilHealth coverage for all persons with disability (PWD).
17. The registrant must affix his/her signature over printed name (or right thumbmark if unable to write) and indicate the date when the PMRF was signed.