# PHILIPPINE

*Republic of the Philippines*

# HEALTH INSURANCE

# CORPORATION

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**IMPORTANT REMINDERS:**

Citystate Centre 709 Shaw Boulevard, Pasig City Call Center (02) 441-7442  Trunkline (02) 441-7444

[www.philhealth.gov.ph](http://www.philhealth.gov.ph/)

email: [actioncenter@philhealth.gov.ph](mailto:actioncenter@philhealth.gov.ph)

Series #

**CF-2**

### (Claim Form 2)

Revised September 2018

PLEASE WRITE IN CAPITAL **LETTERS** AND **CHECK** THE APPROPRIATE BOXES.

This form together with other supporting documents should be filed within sixty (60) calendar days from date of discharge.

All information, fields and trick boxes required in this form are necessary. Claim forms with incomplete information shall not be processed.

**FALSE/INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CRIMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.**

## PART I - HEALTH CARE INSTITUTION (HCI) INFORMATION

B 4 1 0 3 1 3 2 3

1. **PhilHealth Accreditation Number (PAN) of Health Care Institution:**

GEN. TRIAS CHO ANIMAL BITE TREATMENT CENTER

1. **Name of Health Care Institution:**

HOSPITAL RD., BRGY. PINAGTIPUNAN GENERAL TRIAS CAVITE

1. **Address:**

Building Number and Street Name City/Municipality Province

## PART II - PATIENT CONFINEMENT INFORMATION

**${mname}**

**${suffix}**

**${fname}**

**${lname}**

### Name of Patient:

Last Name First Name Name Extension

(JR/SR/III)

Middle Name

(ex: DELA CRUZ JUAN JR SIPAG)

### Was patient referred by another Health Care Institution (HCI)?

**X**

NO YES Name of referring Health Care Institution Building Number and Street Name City/Municipality Province Zip code

**X**

0 8 0 0

1. **Confinement Period:** a. Date Admitted

${date\_admitted}

${date\_discharged}

c. Date Discharge

**X**

month

day

year

b. Time Admitted

d. Time Discharge

:

hour

1 1 0 0

:

min

**X**

AM PM

AM PM

1. **Patient Disposition:** (select only 1)

month day year

hour min

* 1. Improved e. Expired

Time: :

AM PM

month day year hour min

* 1. Recovered f. Transferred/Referred

Name of Referral Health Care Institution

* 1. Home/Discharged Against Medical Advise
  2. Absconded Building Number and Street Name City/Municipality Province Zip code

Reason/s for referral/transfer:

1. **Type of Accomodation:** Private Non-Private (Charity/Service)

### Admission Diagnosis/es:

${body\_site} , CATEGORY ${cat}, ${animal} BITE

1. **Discharge Diagnosis/es** (Use additional CF2 if necessary):

Diagnosis ICD-10 Code/s Related Procedure/s (if there’s any) RVS Code Date of Procedure Laterality (check applicable box)

${d0\_date}

${icd10}

${body\_site}

POST EXPOSURE PROPHYLAXIS 90375

* 1. i.

TRANSDERMAL BITE

ii.

CATEGORY ${cat}

iii.

* 1. i.

ii.

iii.

### Special Considerations:

left left left left left left

right right right right right right

both both both both both both

* 1. For the following repetitive procedures, check box that applies and enumerate the procedure/sessions dates [mm-dd-yyyy]. For chemotherapy, see guidelines. Hemodialysis Blood Transfusion Peritoneal Dialysis Brachytherapy Radiotherapy (LINAC) Chemotherapy Radiotherapy (COBALT) Simple Debridement
  2. For Z-Benefit Package **Z-Benefit Package Code:**
  3. For MCP Package (enumerate four dates [mm-dd-year] of pre-natal check-ups)

1 2 3 4

* 1. For TB DOTS Package Intensive Phase Maintenance Phase
  2. For Animal Bite Package (write the dates [mm-dd-year] when the following doses of vaccine were given)

**Note: Anti Rabies Vaccine (ARV), Rabies Immunoglobulin (RIG)**

${d0\_date} ${d3\_date} ${d7\_date} ${erig\_date}

**Day 0 ARV Day 3 ARV Day 7 ARV RIG Others (Specify)**

${others}

* 1. For Newborn Care Package Essential Newborn Care Newborn Hearing Screening Test Newborn Screening Test

**For Essential Newborn Care** (check applicable boxes)

For Newborn Screening,

*please attach NBS Filter Sitcker here*



Immediate drying of newborn Timely cord clamping Weighing of the newborn BCG vaccination Hepatitis B vaccination

Early skin-to-skin contact Eye Prophylaxis Vitamin K administration Non-separation of mother/baby for early breastfeeding initiation

* 1. For Outpatient HIV/AIDS Treatment Package **Laboratory Number:**

### PhilHealth Benefits:

${icd10} / 90375

**ICD 10 or RVS Code:** a. First Case Rate 2. Second Case Rate

|  |  |
| --- | --- |
| **10.Accreditation Number/Name of Accredited Health Care Professional/Date Signed and Professional Fees/Charges**  (Use additional CF2 if necessary): | |
| Accreditation number/Name of Accredited Health Care Professional/Date Signed  **${hcp1\_number}** | Details |
| Accreditation No.:  **\***  **${hcp1\_name}**  Signature Over Printed Name  ${hcp1\_date}  Date Signed:  month day year  **${hcp1\_opt\_number}** | No co-pay on top of PhilHealth Benefit  With co-pay on top of PhilHealth Benefit P |
| Accreditation No.:  **${hcp1\_opt\_name}**  Signature Over Printed Name  ${hcp1\_opt\_date}  Date Signed:  month day year | No co-pay on top of PhilHealth Benefit  With co-pay on top of PhilHealth Benefit P |
| Accreditation No.:  Signature Over Printed Name  Date Signed:  month day year | No co-pay on top of PhilHealth Benefit  With co-pay on top of PhilHealth Benefit P |
| **PART III - CERTIFICATION OF CONSUMPTION OF BENEFITS AND CONSENT TO ACCESS PATIENT RECORD/S**  NOTE: Member/Patient should sign only after the applicable charges have been filled-out | |
| **A.CERTIFICATION OF CONSUMPTION OF BENEFITS:**  **x………00……**  PhilHealth benefit is enough to cover HCI and PF Charges.  No purchase of drugs/medicines, supplies, diagnostics, and co-pay for professional fees by the member/patient.  PHP 5,265.00  PHP 585.00  **PHP 5,850.00**  The benefit of the member/patient was completely consumed prior to co-pay OR the benefit of the member/patient is not completely consumed BUT with purchases/expenses for drugs/medicines, supplies, diagnostics and others.   1. The total co-pay for the following are:        1. Purchases/Expenses **NOT** included in the Health Care Institution Charges       **\* NOTE:** Total Actual Charges should be based on Statement of Account (SOA)  **B.CONSENT TO ACCESS PATIENT RECORD/S:**  ***I hereby consent to the submission and examination of the patient’s pertinent medical records for the purpose of verifying the veracity of this claim to effect efficient processing of benefit payment.***  ***I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all legal liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim for reimbursement before PhilHealth.***  ${get\_name}  **\***  Signature Over Printed Name of Member/Patient/Authorized Representative If patient/representative Date Signed: is unable to write, put  ${date\_admitted}  month day year right thumbmark. Patient/  Representative should be Relationship of the representative to Spouse Child Parent assisted by an HCI representative. the member/patient: Sibling Others, Specify  Reason for signing on behalf of the Patient is Incapacitated Patient member/patient: Other Reasons Representative | |
| **PART IV - CERTIFICATION OF CONSUMPTION OF HEALTH CARE INSTITUTION** | |
| ***I certify that services rendered were recorded in the patient’s chart and health care institution records and that the herein information given are true and correct.***  ${hcp2\_date}  **\***  JONATHAN P. LUSECO, RN, MD CITY HEALTH OFFICER II  Date Signed:  Signature Over Printed Name of Authorized HCI Representative Official Capacity/Designation month day year | |

|  |  |
| --- | --- |
|  | Total Actual Charges\* |
| Total Health Care Institution Fees |  |
| Total Professional Fees |  |
| Grand Total |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Total Actual Charges\* | Amount after Application of Discount (i.e., personal  discount, Senior Citizen/PWD) | PhilHealth Benefit | Amount after PhilHealth Deduction |
| Total Health Care Institution Fees |  |  |  | Amount P Paid by (check all that applies):  Member/Patient HMO  Others (i.e., PCSO, Promisory note, etc.) |
| Total Professional Fees (for accredited and non-accredited professionals) |  |  |  | Amount P Paid by (check all that applies):  Member/Patient HMO  Others (i.e., PCSO, Promisory note, etc.) |

|  |  |
| --- | --- |
| Total cost of purchase/s for drugs/medicines and/or medical supplies bought by the patient/member within/outside the HCI during confinement | None Total Amount P |
| Total cost of diagnostic/laboratory examinations paid by the patient/member done within/outside the HCI during confinement | None Total Amount P |