*Republic of the Philippines*

**PHILIPPINE HEALTH INSURANCE CORPORATION**

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

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

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**IMPORTANT REMINDERS:**

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

Series #

**CSF**

**(Claim Signature Form)**

Revised September 2018

All information 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 - MEMBER AND PATIENT INFORMATION AND CERTIFICATION

1. **PhilHealth Identification Number (PIN) of Member:**
2. **Name of Member: 3. Member Date of Birth:**

Last Name

First Name Name Extension

(JR/SR/III)

Middle Name

(ex: DELA CRUZ JUAN JR SIPAG)

month day year

1. **PhilHealth Identification Number (PIN) of Dependent:**
2. **Name of Patient: 6. Relationship to Member:**

child parent spouse

Last Name

First Name Name Extension

(JR/SR/III)

Middle Name

(ex: DELA CRUZ JUAN JR SIPAG)

1. **Confinement Period: 8. Patient Date of Birth:**
   1. Date Admitted:
   2. Date Discharged:

month day year month day year

month day year

**9. CERTIFICATION OF MEMBER:**

## *Under the penalty of law, I attest that the information I provided in this Form are true and accurate to the best of my knowledge.*

Signature Over Printed Name of Member Signature Over Printed Name of Member’s Representative

Date Signed Date Signed

month day year month day year

If member/representative is unable to write, put right thumbmark. Member/Representative should be assisted by an HCI representative. Check the appropriate box.

Member Representative

Relationship of the Spouse Child Parent

representative to the member Sibling Others, Specify

Reason for signing on Member is incapacitated

behalf of the member Other reasons:

**PART II - EMPLOYER’S CERTIFICATION** (for employed members only)

1. **PhilHealth Employer Number (PEN):**
2. **Business Name:**
3. **CERTIFICATION OF EMPLOYER:**
4. **Contact No.:**

Business Name of Employer

## *“This is to certify that the required 3/6 monthly premium contributions plus at least 6 months contributions preceding the 3 months qualifying contributions within 12* month period prior to the first day of confinement (sufficient regularity) have been regularly remitted to PhilHealth. Moreover, the information supplied by the member or his/her representative on Part I are consistent with our available records.”

Date Signed

Signature Over Printed Name of Employer/Authorized Representative Official Capacity/Designation

# PART III - CONSENT TO ACCESS PATIENT RECORD/S

month

day

year

## *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 legal liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim for reimbursement before PhilHealth.***

Signature Over Printed Name of Member/Patient/Authorized Representative

Date Signed

month day year

If member/representative is unable to write, put right thumbmark. Member/Representative should be assisted by an HCI representative. Check the appropriate box.

Patient Representative

Accreditation No.

Relationship of the Spouse Child Parent

representative to the patient Sibling Others, Specify

Reason for signing on Patient is incapacitated

behalf of the patient Other reasons:

# PART IV - HEALTH CARE PROFESSIONAL INFORMATION

Date Signed

Accreditation No. Accreditation No.

Signature Over Printed Name

Date Signed Signature Over Printed Name

Date Signed Signature Over Printed Name

# PART V - PROVIDER INFORMATION AND CERTIFICATION

month day year

month day year

month day year

**1. PhilHealth Benefits: ICD 10 or RVS Code:** 1. First Case Rate 2. Second Case Rate

## *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.*

Date Signed

Signature Over Printed Name of Authorized HCI Representative Official Capacity/Designation



month

day

year