Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

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CF-1

(Claim Form 1)

Revised September 2018

Series # ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

IMPORTANT REMINDERS:

PLEASE WRITE IN CAPITAL **LETTERS** AND **CHECK** THE APPROPRIATE BOXES.
For **local availment**, this form together with other PhilHealth claim forms and other supporting documents should be filed within 60 days from date of discharge.
For **availment of benefits abroad**, this form together with other supporting documents should be filed within 180 days from date of discharge.
Representative of the Health Care Institutions (HCI) shall assist the member/authorized representative in filling out this form.
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 INFORMATION

1. PhilHealth Identification Number (PIN) of Member: ☐☐-☐☐☐☐☐☐☐☐-☐

2. Name of Member:

Last Name _____ First Name _____ Name Extension (JR/SR/III) _____ Middle Name (ex: DELA CRUZ JUAN JR SIPAG) _____

3. Date of Birth: ☐☐-☐☐-☐☐☐☐ (month-day-year)

4. Mailing Address:

Unit/Room No./Floor _____ Building Name _____ Lot/Blk/House/Bldg.No _____ Street _____ Subdivision/Village _____

Barangay _____ City/Municipality _____ Province _____ Country _____ Zip Code _____

5. Sex: ☐ Male ☐ Female

6. Contact Information:

Landline No. (Area Code + Tel. No.) _____ Mobile No. _____ Email Address _____

7. Patient is the member? ☐ Yes, Proceed to Part III ☐ No, Proceed to Part II

PART II - PATIENT INFORMATION (To be filled-out only if the patient is a dependent)

1. PhilHealth Identification Number (PIN) of Dependent: ☐☐-☐☐☐☐☐☐☐☐-☐

2. Name of Patient:

Last Name _____ First Name _____ Name Extension (JR/SR/III) _____ Middle Name (ex: DELA CRUZ JUAN JR SIPAG) _____

3. Date of Birth: ☐☐-☐☐-☐☐☐☐ (month-day-year)

4. Relationship to Member: ☐ Child ☐ Parent ☐ Spouse

5. Sex: ☐ Male ☐ Female

PART III - MEMBER CERTIFICATION

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

Date Signed ☐☐-☐☐-☐☐☐☐ (month-day-year)

_____
Signature Over Printed Name of Member's 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.
☐ Member ☐ Representative

Relationship of the representative to the member: ☐ Spouse ☐ Child ☐ Parent ☐ Sibling ☐ Others, Specify _____

Reason for signing on behalf of the member: ☐ Member is incapacitated ☐ Other reasons: _____

PART IV - EMPLOYER'S CERTIFICATION (for employed members only)

1. PhilHealth Employer Number (PEN): ☐☐-☐☐☐☐☐☐☐☐-☐ **2. Contact No.:** _____

3. Business Name:

_____
Business Name of Employer

4. CERTIFICATION 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."

_____ Signature Over Printed Name of Employer/Authorized Representative
_____ Official Capacity/Designation
Date Signed ☐☐-☐☐-☐☐☐☐ (month-day-year)

PART V - FOR PHILHEALTH USE ONLY

Date Received: LHIO / PRO

By: _____ LHIO/PRO Signature Over Printed Name