



PHILIPPINE HEALTH INSURANCE CORPORATION  
TASK FORCE INFORMATICS  
CityState Centre, 709 Shaw Blvd. corner Oranbo Drive, Pasig City  
contact nos. 441-7444 local 7585

IMPORTANT REMINDERS:

1. PLEASE WRITE IN BLOCK LETTERS AND CHECK THE APPROPRIATE BOXES.
2. All information required in this form is necessary and HIS shall not process where form is not properly accomplished.
3. Please use back page for sample output.
4. Please attach official letter if requesting party is non-Internal.

Control NO. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(YR) (Month) (NO)

Date Received: \_\_\_\_\_

TFI Form as of January 2015

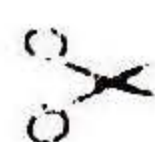
DATA REQUEST FORM

ONE required output for ONE request form.

Requested by _____ (Signature over Printed Name):		Office/Department/Section/Unit:		Contact No:	
Date Requested:		Email address:			
Purpose: Data provided may only be used for the purpose stated herein.		<input type="checkbox"/> Presentation <input type="checkbox"/> Research		Approved by (Dept. Head/Supervisor): _____ (Signature over Printed Name)	
Data Format: <input type="checkbox"/> Excel <input type="checkbox"/> Text File		Email address:			
Data (Check appropriate box)		Data Disaggregation			
<u>CLAIMS PAYMENT / UTILIZATION</u> <input type="checkbox"/> Illnesses (pls provide the code/s) for medical: ICD 10 codes for surgical: RVS codes <input type="checkbox"/> By Package <input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient		<input type="checkbox"/> By PhRO <input type="checkbox"/> By Province <input type="checkbox"/> By Municipality <input type="checkbox"/> By Hospital Sector <input type="checkbox"/> By Hospital Category <input type="checkbox"/> By Member Sector <input type="checkbox"/> By Case Type <input type="checkbox"/> Total No <input type="checkbox"/> Total Amount <input type="checkbox"/> Others (Specify)			
<u>ACCREDITATION</u> <input type="checkbox"/> Institutions <input type="checkbox"/> Others (Specify) <input type="checkbox"/> Professionals					
Data Requirements: (Use the back sheet for your expected output format)					
Date Needed:		Reference Period			

For TFI use only:

Screened by: _____ Julita A. Presbitero		Date:		<input type="checkbox"/> Approved <input type="checkbox"/> Denied		Date:	
				Arturo C. Alcantara, M.D. MS IV			
Reason for Denial:							
Processed by: Loren A. Porciuncula Reynaldo G. Ocumen Allan F. Santilla Herbert Ronan V. Cruz		Date:		Checked by: _____		Date:	
Released by: _____		Date:		Conforme: _____ (Signature over Printed Name)		Date:	
Media: <input type="checkbox"/> USB <input type="checkbox"/> Email <input type="checkbox"/> Others (Specify)							
Remarks:							



Acknowledgement Slip:

Control No. (yy/mm/no): \_\_\_\_\_

Received by _____ (Signature over Printed Name)		Date:		Remarks:	
You may follow-up this request using the TFI control number or call us at local 7585.					