PhilHealth
Your Partner in Health

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CF1
(Claim Form 1)
revised November 2013

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: 0 - 7 2 5 2 4 1 5 9 3 2 6

2. Name of Member:
DUMANDAN, EDISON SANTIAGO
Last Name | First Name | Name Extension (JR/SR/III) | Middle Name | (example: DELA CRUZ JUAN JR SIPAG)

3. Date of Birth: 0 6 - 0 5 - 1 9 9 6
month | day | year

4. Mailing Address:
252 aromin st.,
Unit/ Room No., Floor | Building Name | Lot/Block/House/Bldg. No. | Street | Subdivision/Village
DISTRICT VI (POB. VI), CUYAPO NUEVA ECIJA
Barangay | City/Municipality | Province | Country | Zip Code

5. Sex: ☐ Male ☐ Female

6. Contact information:
Landline No. (Area Code + Tel. No.): _____ Mobile No.: +631111111111 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 | (example: 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 No. (PEN): 2 0 - 0 4 7 4 3 0 4 6 0 7

2. Contact No.: _____

3. Business Name:
WIRELESS ACCESS FOR HEALTH INITIATIVE INC ODM
Business Name of Employer

4. CERTIFICATION OF EMPLOYER:

This is to certify that all monthly premium contributions for and in behalf of the member, while employed in this company, including the applicable three (3) monthly premium contributions within the past six (6) months period prior to the first day of this confinement, have been deducted/collected and remitted to PhilHealth, and that 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	By:	
	PRO		LHIO/PRO Signature Over Printed Name