MITSUKOSHI MOTORS PHILIPPINES, INC.		
POLICY AND PROCEDURE		
POLICY TITLE :	**PHILHEALTH BENEFITS**	Ref. No.
DEPARTMENT :	HUMAN RESOURCES DEPARTMENT	HRD-16-01-018
TO :	BRANCH MANAGER, CASHIER, ASST. CASHIER, CREDIT SUPERVISOR, ACCOUNT COUNSELOR, MARKETING ASSISTANT, BRANCH MECHANIC	JANUARY 05, 2016

OBJECTIVE:

1. To provide employees with the standard procedures on health services through PhilHealth

2. To implement processing of Philhealth Benefits availment.

POLICY:

1. The PhilHealth contribution shall be paid equally by the company and employee based on 2.5 % of basic salary of the latter or 1.25% each for employer and employee. With salary bracket ceiling pegged at P 35,000.00.

2. The employee can avail of the PhilHealth benefit provided they have complied with the minimum of three (3) months active contribution prior to confinement.

   2.1 The employees shall be entitled to out-patient coverage and other benefit packages under National Health Insurance Program.

3. Supporting documents and information should be complete to process the next steps. It is the employee's responsibility to ensure completeness of relevant documents to expedite processing of benefits. Failure to comply with the mandatory requirements shall mean no processing of any loans or request.

PROCEDURE:

1. Hospitalization of Member-Only patients that resort to confinement can avail of this benefit.

   1.1. Employee

      1.1.1. Shall inform the HR Associate Benefit- In-Charge for the following:

         1.1.1.1. PhilHealth Certification

         1.1.1.2. PhilHealth Claim form 1 or CF1

1.1.2. In case the employee is not capable to write a letter of request, he can be assisted by any of his/her immediate family.

1.2. HR Department-Benefit-In-Charge

1.2.1. Receive letter of request from employee for PhilHealth benefit.

1.2.2. Prepare PhilHealth Certification and PhilHealth Claim Form (CF1).

1.2.3. Upon completion, obtain signature of authorized signatory of the company.

1.3.3.1. The release of the PhilHealth Certification and PhilHealth Claim Form will take about 2 days.

1.3.4. Forward PhilHealth Cerificate and PhilHealth Claim Form to employee or his/her immediate family member.

2. Hospitalization of a Family Member

2.1. Family member can avail the PhilHealth benefits of the employee declared as dependents of the latter.

2.1.1. For Married Members

2.1.1.1. Spouse that are unemployed
2.1.1.2. Children
- Twenty One (21) years old and below
- Disabled – Regardless of age

2.1.1.3.Parents:
- 60 Years old and above
- Disabled – Regardless of age

2.1.2. Single Members
2.1.2.1 Parents
- 60 years old and above
- Disabled –regardless of age

2.2. To update or declare a new dependents
2.2.1. Employee
2.2.1.1.Go to the nearest PhilHealth office.
2.2.1.2.Fill up PhilHealth Member's Registration Form (PMRF) or Recent Member's Data Record (MDR).
2.2.1.3 Attach photocopy of Birth Certificate of dependent/s.
2.2.1.4 Get a copy of the updated MDR.

PHILHEALTH CLAIM FORM (CF 1)

PhilHealth
Your Partner in Health

This form may be reproduced and is NOT FOR SALE

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: _ _ - _ _ _ _ _ _ _ _ _ - _

2. Name of Member:

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. Mailing Address:

Unit/ Room No., Floor | Building Name | Lot/Block/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 | (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. Contact No.: ____________

3. Business Name:

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
	PRO

By:	
	LHIO/PRO Signature Over Printed Name