

Republic of the Philippines  
PHILIPPINE HEALTH INSURANCE CORPORATION  
(Claim Form 2)

CF

Series #

**IMPORTANT REMINDERS:** Please write in CAPITAL LETTERS and CHECK the appropriate boxes.

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**PART I - HEALTH CARE INSTITUTION (HCI) INFORMATION**

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**1. PhilHealth Accreditation Number (PAN) of HCI:**

asdascas

**2. Name of Health Care Institution:**

asdascas

**3. Address:**

Building and Street Name

City/Municipality

Province

asdadasd

asd

asd

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**PART II - PATIENT CONFINEMENT INFORMATION**

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**1. Name of Patient:**

Last Name

First Name

Name Extension

Middle Name

Xhoshiki

Zynnn louie

asdadasd2

saga

**2. Was patient referred by another HCI?**

Yes  No

**3. Confinement Period (From)**

2026-01-23

**Confinement Period (To)**

2026-01-15

**4. Patient Disposition**

Recovered

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**5. Type of Accommodation**

Private

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