Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

(Claim Form 1)

CF

Series # ☐☐☐☐☐

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

PART I - MEMBER INFORMATION

1. PhilHealth Identification Number (PIN) of Member:

1 2 3 1 2 5 ☐ ☐ ☐ ☐ ☐ ☐

3. Date of Birth (mm-dd-yyyy):

2 0 2 6 0 1 1 5

2. Name of Member:

Last Name	Kamikaze
First Name	Aizen Minato
Name Extension	JR
Middle Name	Zenin

5. Sex:

☐ Male ☒ Female

4. Mailing Address:

Unit/Room No./Floor	Apt 4B
Building Name	qwdca
Lot/Blk/House/Bldg No	Springfield
Street	
Barangay	
City/Municipality	
Province	

John Doe, , IL 62704, USA

Country

Zip Code

123 Main St,

Pagadian

Palawan

124512

6. Contact Information:

Landline No. (Area Code + Tel. No.)

Mobile No.

Email Address

1436954

097654678

louienf12@gmail.com

7. Patient is the member?

[X] Yes [ ] No

PART II - PATIENT INFORMATION

Patient Name

Kamiworo

Relationship to Member

Love

PhilHealth No. (if any)

2124

Confinement Period (From)

2026-02-03

Confinement Period (To)

2026-02-17

Hospital/Facility

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