

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:**

2  3  2  3  4

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

2  0  2  6  0  1  2  8

**2. Name of Member:**

Last Name

First Name

Name Extension

Middle Name

Toress

Fernando Jose

Labrador

**5. Sex:**

Male  Female

**4. Mailing Address:**

Unit/Rom No./Floor

Building Name

Lot/Blk/House/Bldg No

Street

Santa Ignacia

Apt 4B

Morales

Springfield

Barangay

City/Municipality

Province

|                |
|----------------|
| Country        |
| Zip Code       |
| Poblacion West |
| Santa Ignacia  |
| Tarlac         |
| 202423         |

**6. Contact Information:**

|                                     |
|-------------------------------------|
| Landline No. (Area Code + Tel. No.) |
| Mobile No.                          |
| Email Address                       |
| 098875567                           |
| 09765467845                         |
| F1@gmail.com                        |

**7. Patient is the member?**

Yes  No

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**PART II - PATIENT INFORMATION**

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**Patient Name**

FJ

**Relationship to Member**

Mother

**PhilHealth No. (if any)**

21246

**Confinement Period (From)**

2026-02-03

**Confinement Period (To)**

2026-02-17

**Hospital/Facility**

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