



# PHILIPPINE HEALTH INSURANCE CORPORATION

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# CF-1

(Claim Form 1)

Revised September 2018

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 (ex: DELA CRUZ JUAN JR SIPAG)

### 3. Date of Birth:

-  -  month day year

### 4. Mailing Address:

Unit/Rom No./Floor  Building Name  Lot/Blk/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 (ex: 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

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



Signature Over Printed Name of Member's Representative

Date Signed  -  -  month day year

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 Number (PEN):  -  -  -  -

2. Contact No.: \_\_\_\_\_

### 3. Business Name:

Business Name of Employer

### 4. CERTIFICATION OF EMPLOYER:

*"This is to certify that the required 3/6 monthly premium contributions plus at least 6 months contributions preceding the 3 months qualifying contributions within 12 month period prior to the first day of confinement (sufficient regularity) have been regularly remitted to PhilHealth. Moreover, 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

Date Received:

LHIO
PRO

By:

LHIO/PRO Signature Over Printed Name
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