

**PART V - FOR PHILHEALTH USE ONLY**





**IMPORTANT REMINDERS:** PLEASE WRITE IN CAPITAL **LETTERS** AND **CHECK** THE APPROPRIATE BOXES.  
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.**

Series # 

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**PART I - MEMBER AND PATIENT INFORMATION AND CERTIFICATION**

1. PhilHealth Identification Number (PIN) of Member:

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2. Name of Member:

<div>Last Name</div>	<div>First Name</div>	<div>Name Extension (JR/SR/III)</div>	<div>Middle Name (ex: DELA CRUZ JUAN JR SIPAG)</div>
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3. Member Date of Birth:

<div>month</div>	<div>day</div>	<div>year</div>
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4. PhilHealth Identification Number (PIN) of Dependent:

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5. Name of Patient:

<div>Last Name</div>	<div>First Name</div>	<div>Name Extension (JR/SR/III)</div>	<div>Middle Name (ex: DELA CRUZ JUAN JR SIPAG)</div>
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6. Relationship to Member:

☐ child

☐ parent

☐ spouse

7. Confinement Period:

a. Date Admitted:

<div>month</div>	<div>day</div>	<div>year</div>
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b. Date Discharged:

<div>month</div>	<div>day</div>	<div>year</div>
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8. Patient Date of Birth:

<div>month</div>	<div>day</div>	<div>year</div>
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9. CERTIFICATION OF MEMBER:

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

<div>month</div>	<div>day</div>	<div>year</div>
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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

☐ Sibling

☐ Child

☐ Others, Specify

Reason for signing on behalf of the member

☐ Member is incapacitated

☐ Other reasons:

**PART II - EMPLOYER'S CERTIFICATION** (for employed members only)

1. PhilHealth Employer Number (PEN):

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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

<div>month</div>	<div>day</div>	<div>year</div>
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**PART III - CONSENT TO ACCESS PATIENT RECORD/S**

I hereby consent to the submission and examination of the patient's pertinent medical records for the purpose of verifying the veracity of this claim to effect efficient processing of benefit payment.

I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any legal liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim for reimbursement before PhilHealth.

Signature Over Printed Name of Member/Patient/Authorized Representative

Date Signed

<div>month</div>	<div>day</div>	<div>year</div>
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If member/representative is unable to write, put right thumbmark. Member/Representative should be assisted by an HCI representative. Check the appropriate box.

☐ Patient

☐ Representative

Relationship of the representative to the patient

☐ Spouse

☐ Sibling

☐ Child

☐ Others, Specify

Reason for signing on behalf of the patient

☐ Patient is incapacitated

☐ Other reasons:

**PART IV - HEALTH CARE PROFESSIONAL INFORMATION**

Accreditation No.

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Signature Over Printed Name

Date Signed

<div>month</div>	<div>day</div>	<div>year</div>
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Accreditation No.

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Signature Over Printed Name

Date Signed

<div>month</div>	<div>day</div>	<div>year</div>
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**PART V - PROVIDER INFORMATION AND CERTIFICATION**

1. PhilHealth Benefits:

ICD 10 or RVS Code:

1. First Case Rate

2. Second Case Rate

I certify that services rendered were recorded in the patient's chart and health care institution records and that the herein information given are true and correct.

Signature Over Printed Name of Authorized HCI Representative

Official Capacity/Designation

Date Signed

<div>month</div>	<div>day</div>	<div>year</div>
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Republic of the Philippines  
Province of Leyte  
**BURAUEN MUNICIPAL HEALTH OFFICE**  
**ANIMAL BITE TREATMENT CENTER**

LGU Compound, District VII, Burauen, Leyte  
[rhuburauen@gmail.com](mailto:rhuburauen@gmail.com) / Tel Num: 053-8399244



## STATEMENT OF ACCOUNT

PATIENT'S NAME: \_\_\_\_\_

DATE ADMITTED: \_\_\_\_\_

AGE: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

TIME ADMITTED: \_\_\_\_\_

FINAL DIAGNOSIS: \_\_\_\_\_

DATE DISCHARGED: \_\_\_\_\_

OTHER DIAGNOSIS 1: \_\_\_\_\_

TIME DISCHARGED: \_\_\_\_\_

2: \_\_\_\_\_

FIRST CASE RATE: \_\_\_\_\_

3: \_\_\_\_\_

SECOND CASE RATE: \_\_\_\_\_

### SUMMARY OF SERVICES

PARTICULARS	ACTUAL CHARGES	AMOUNT OF DISCOUNTS			PHILHEALTH BENEFITS		OUT POCKET OF PATIENTS
		VAT EXEMPT	SENIOR CITIZEN/PWD	Place ✓ ____ PCSO ____ DSWD ____ DOH (MAP) ____ HMO ____ OTHERS	FIRST CASE RATE AMOUNT	SECOND CASE RATE AMOUNT	OUT OF POCKET OF PATIENT
HCI FEES	₱ 1,195.00						₱ 0.00
Room and Board							₱ 0.00
Drugs and Medicines	₱ 2,400.00						₱ 0.00
Laboratory and Diagnostics							₱ 0.00
Delivery Room Fee							₱ 0.00
Medical Supplies	₱ 1,755.00						₱ 0.00
Others							
<b>Subtotal</b>	<b>₱ 5,350.00</b>				<b>₱ 5,350.00</b>		<b>₱ 0.00</b>
<b>PROFESSIONAL FEE/S</b>							
	₱ 500.00						
<b>Subtotal</b>	<b>₱ 500.00</b>				<b>₱ 500.00</b>		<b>₱ 0.00</b>
<b>TOTAL</b>	<b>₱ 5,850.00</b>				<b>₱ 5,850.00</b>		<b>₱ 0.00 / NO BALANCE BILLING</b>

Prepared by:

Conforme:

**KEVIN REY C. MAGSAMBOL, RN**  
Public Health Nurse / PhilHealth In Charge

\_\_\_\_\_  
Member/Patient/Authorized Representative  
Signature over Printed Name

Date Signed: \_\_\_\_\_  
Contact Number: 09171809112

Date Signed: \_\_\_\_\_  
Contact Number : \_\_\_\_\_  
Relationship to the Patient: \_\_\_\_\_