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*Republic of the Philippines*

# PHILIPPINE HEALTH INSURANCE CORPORATION

Citystate Centre 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 • Trunkline (02) 441-7444
www.philhealth.gov.ph
email: actioncenter@philhealth.gov.ph

# 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:** 12-123456789-1

**2. Name of Member:**

| Last Name | First Name | Name Extension (JR/SR/III) | Middle Name (ex: DELA CRUZ JUAN JR SIPAG) |
|---|---|---|---|
| SANTOS | EMMANUEL | III | BARBOSA |

**3. Date of Birth:** 08-31-1997 (month - day - year)

**4. Mailing Address:**

**5. Sex:** ☐ Male ☐ Female

| Unit/Room No./Floor | Building Name | Lot/Blk/House/Bldg.No | Street | Subdivision/Village |
|---|---|---|---|---|
| | | | | |

| Barangay | City/Municipality | Province | Country | Zip Code |
|---|---|---|---|---|
| POBLACION DISTRICT I | BURAUEN | LEYTE | PHILLIPPINES | 6516 |

**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:** 13-123456789-7

**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:** 08-17-2024 (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.***

EMMANUEL B. SANTOS III
Signature Over Printed Name of Member

Signature Over Printed Name of Member's Representative

Date Signed 11-23-2025 (month - day - year)

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

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)

## PART V - FOR PHILHEALTH USE ONLY

| Date Received: | LHIO | By: | |
|---|---|---|---|
| | PRO | | LHIO/PRO Signature Over Printed Name |

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# CSF

**(Claim Signature Form)**

Revised September 2018

**IMPORTANT REMINDERS:**

Series # [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

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.**

## PART I - MEMBER AND PATIENT INFORMATION AND CERTIFICATION

**1. PhilHealth Identification Number (PIN) of Member:** 12-123456789-1

**2. Name of Member:**

| SANTOS | EMMANUEL | III | BARBOSA |
|---|---|---|---|
| Last Name | First Name | Name Extension (JR/SR/III) | Middle Name (ex: DELA CRUZ JUAN JR SIPAG) |

**3. Member Date of Birth:** 08-31-1997 (month-day-year)

**4. PhilHealth Identification Number (PIN) of Dependent:** [ ][ ]-[ ][ ][ ][ ][ ][ ][ ][ ][ ]-[ ]

**5. Name of Patient:**

| | | | |
|---|---|---|---|
| Last Name | First Name | Name Extension (JR/SR/III) | Middle Name (ex: DELA CRUZ JUAN JR SIPAG) |

**6. Relationship to Member:** [ ] child [ ] parent [ ] spouse

**7. Confinement Period:**

a. Date Admitted: [ ][ ]-[ ][ ]-[ ][ ][ ][ ] (month-day-year)

b. Date Discharged: [ ][ ]-[ ][ ]-[ ][ ][ ][ ] (month-day-year)

**8. Patient Date of Birth:** [ ][ ]-[ ][ ]-[ ][ ][ ][ ] (month-day-year)

**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 [ ][ ]-[ ][ ]-[ ][ ][ ][ ] (month-day-year)

Signature Over Printed Name of Member's Representative

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

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 II - 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)

## 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 [ ][ ]-[ ][ ]-[ ][ ][ ][ ] (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.

[ ] Patient [ ] Representative

Relationship of the representative to the patient: [ ] Spouse [ ] Child [ ] Parent [ ] Sibling [ ] Others, Specify _____

Reason for signing on behalf of the patient: [ ] Patient is incapacitated [ ] Other reasons: _____

## PART IV - HEALTH CARE PROFESSIONAL INFORMATION

Accreditation No. [ ][ ][ ][ ]-[ ][ ][ ][ ][ ][ ][ ]-[ ]

Signature Over Printed Name

Date Signed [ ][ ]-[ ][ ]-[ ][ ][ ][ ] (month-day-year)

Accreditation No. [ ][ ][ ][ ]-[ ][ ][ ][ ][ ][ ][ ]-[ ]

Signature Over Printed Name

Date Signed [ ][ ]-[ ][ ]-[ ][ ][ ][ ] (month-day-year)

## 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 [ ][ ]-[ ][ ]-[ ][ ][ ][ ] (month-day-year)

Republic of the Philippines
Province of Leyte

# BURAUEN MUNICIPAL HEALTH OFFICE
# ANIMAL BITE TREATMENT CENTER

*LGU Compound, District VII, Burauen, Leyte*
*rhuburauen@gmail.com / Tel Num: 053-8399244*

STATEMENT OF ACCOUNT
## STATEMENT OF ACCOUNT

PATIENT'S NAME: _____

AGE: 1 ADDRESS: Poblacion District I, Burauen, Leyte

FINAL DIAGNOSIS: _____

OTHER DIAGNOSIS 1: _____
2: _____
3: _____

DATE ADMITTED: 11-23-2025

TIME ADMITTED: _____

DATE DISCHARGED: _____

TIME DISCHARGED: _____

FIRST CASE RATE: P90375

SECOND CASE RATE: _____

## SUMMARY OF SERVICES

| PARTICULARS | ACTUAL CHARGES | AMOUNT OF DISCOUNTS | | | PHILHEALTH BENEFITS | | OUT POCKET OF PATIENTS |
|---|---|---|---|---|---|---|---|
| | | VAT EXEMPT | SENIOR CITIZEN/PWD | Place ✓<br>____ PCSO<br>____ DSWD<br>____ DOH (MAP)<br>____ HMO<br>____ 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 | | | | | | | |
| **Subtotal** | ₱ 5,350.00 | | | | ₱ 5,350.00 | | ₱ 0.00 |
| **PROFESSIONAL FEE/S** | | | | | | | |
| MA. QUEENA JOVE Q. SERRANO, MD | ₱ 500.00 | | | | | | |
| **Subtotal** | ₱ 500.00 | | | | ₱ 500.00 | | ₱ 0.00 |
| **TOTAL** | **₱ 5,850.00** | | | | **₱ 5,850.00** | | **₱ 0.00 / NO BALANCE BILLING** |

Prepared by:

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

Date Signed: _____
Contact Number: 09171809112

Conforme:

EMMANUEL B. SANTOS III
Member/Patient/Authorized Representative
Signature over Printed Name

Date Signed: _____
Contact Number : _____
Relationship to the Patient: _____