



PHILIPPINE HEALTH INSURANCE CORPORATION

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is NOT FOR SALE

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(Claim Signature Form)

Revised September 2018

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 #

PART I - MEMBER AND PATIENT INFORMATION AND CERTIFICATION

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)

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)

7. Confinement Period:

a. Date Admitted: - - month day year

b. Date Discharged: - - 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

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

Reason for signing on behalf of the member

Spouse Child Parent

Sibling Others, Specify _____

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 _____

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
rhubrauen@gmail.com / Tel Num: 053-8399244

**STATEMENT OF ACCOUNT
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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 DSDW DOH (MAP) HMO OTHERS	FIRST CASE RATE AMOUNT	SECOND CASE RATE AMOUNT	
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							
	₱ 500.00						
Subtotal	₱ 500.00				₱ 500.00		₱ 0.00
TOTAL	₱ 5,850.00				₱ 5,850.00		₱ 0.00 / NO BALANCE BILLING

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: _____