



PHILIPPINE HEALTH INSURANCE CORPORATION

Republic of the Philippines
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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:

SANTOS

EMMANUEL

III

BARBOSA

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/Room No./Floor

Building Name

Lot/Blk/House/Bldg.No

Street

Subdivision/Village

POBLACION DISTRICT I

Barangay

BURAUEN

City/Municipality

LEYTE

Province

PHILLIPINES

Country

6516

Zip Code

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:

SANTOS

RYZEN IMMANU-EL

Last Name

First Name

Name Extension
(JR/SR/III)

TUTONA

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.

EMMANUEL B. SANTOS III

Signature Over Printed Name of Member

Date Signed - -

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

PART V - FOR PHILHEALTH USE ONLY