



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

This form may be reproduced and
is NOT FOR SALE

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
