

PHILHEALTH OUTPATIENT TB-DOTS BENEFIT PACKAGE

► a strategy to detect and cure TB patients and considered as the most effective strategy for controlling the TB epidemic.

COVERAGE:

 ✓ at least two sputum specimens positive for AFB, with or without radiographic abnormalities consistent with active PTB; or

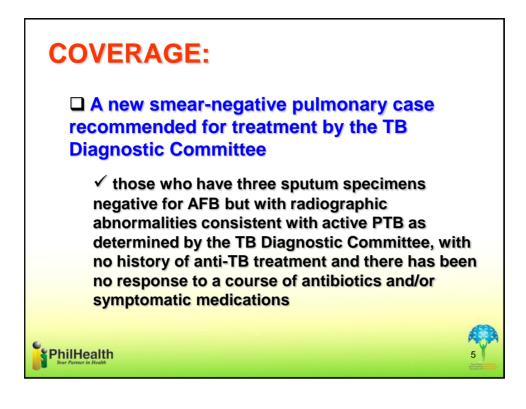
 ✓ One sputum specimen positive for AFB and with radiographic abnormalities consistent with active PTB as determined by a physician; or

 ✓ One sputum specimen positive for AFB with sputum culture positive for Microbacterium tuberculosis



PhilHealth Your Partner in Health

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COVERAGE:

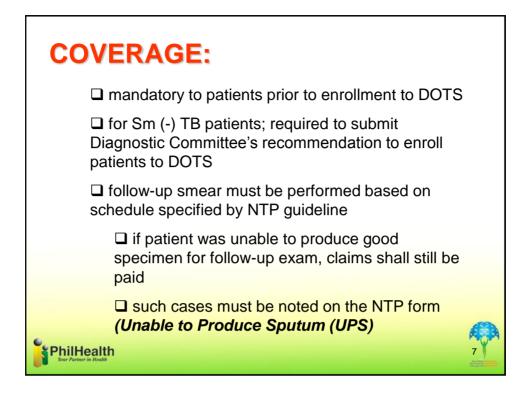
□ A new extrapulmonary TB patient

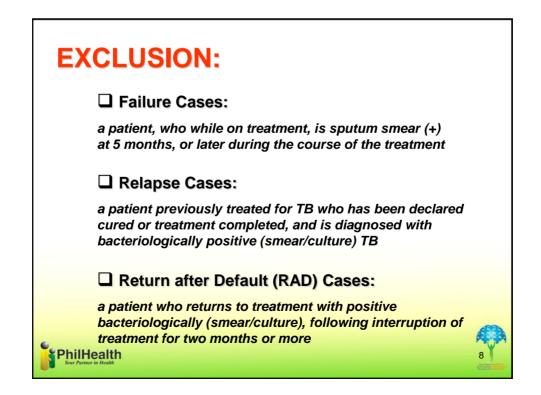
 \checkmark Extrapulmonary TB (EPTB) affects organs other than the lungs.

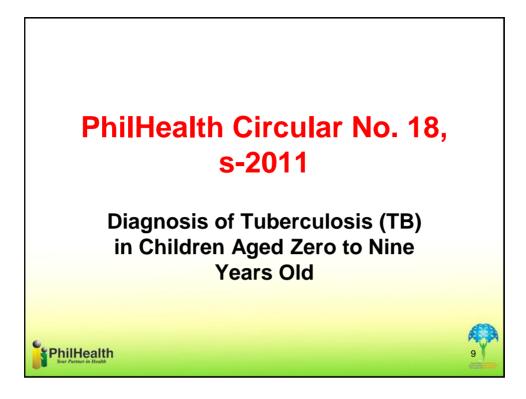
 ✓ Diagnosis for extrapulmonary tuberculosis should be based on one culture positive specimen, or histological or strong clinical evidence consistent with active extrapulmonary tuberculosis. This should be followed by the decision of a clinician to treat with a full course of tuberculosis chemotherapy



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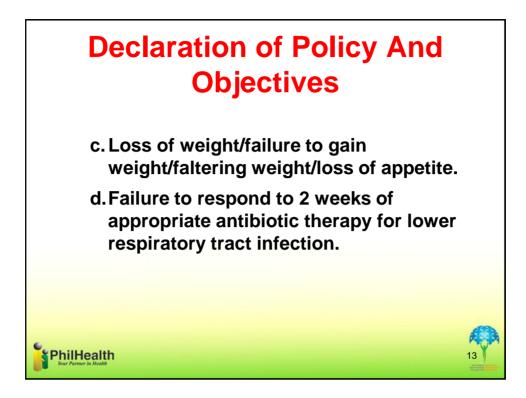
For Children Zero to Nine Years Old with No or Negative Sputum Smear Microscopy, three (3) out of five (5) must be Satisfied:

Declaration of Policy And Objectives

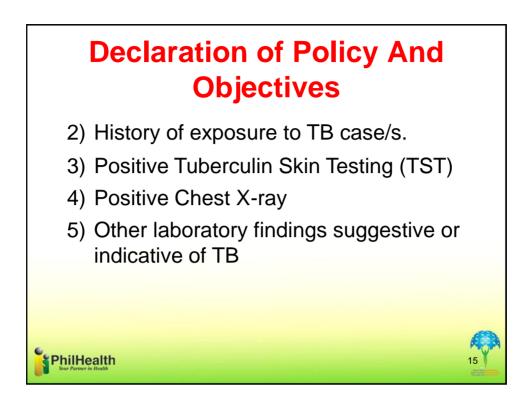
1)TB symptomatic – at least 3 of the following signs and symptoms provided by DOH AO 2008-0011:

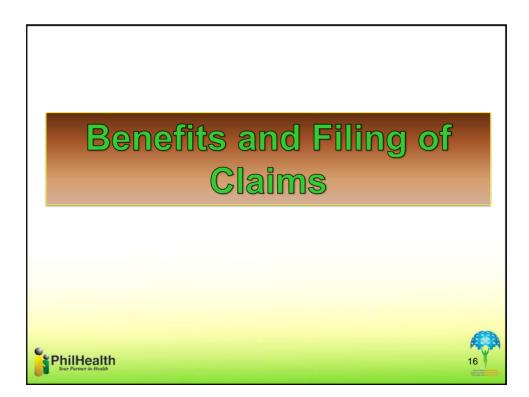
- a. Cough/wheezing for 2 weeks or more.
- b. Unexplained fever for 2 weeks or more after common causes such as malaria or pneumonia have been excluded.

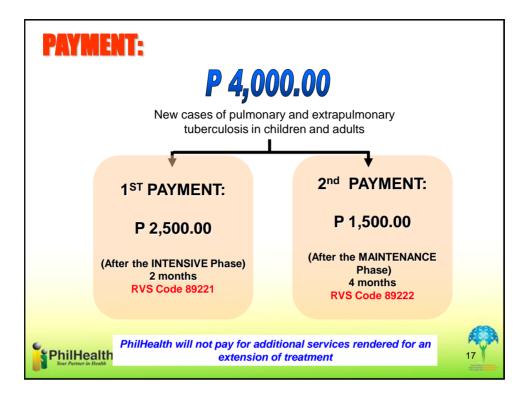
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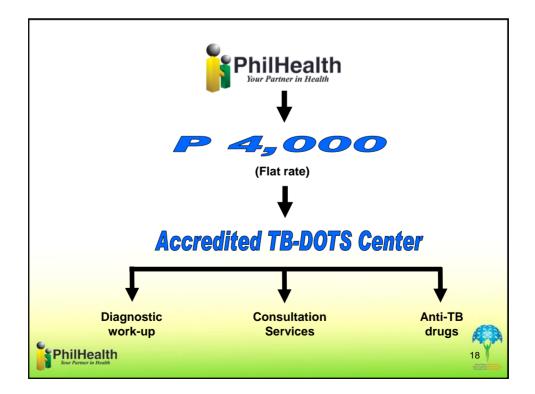








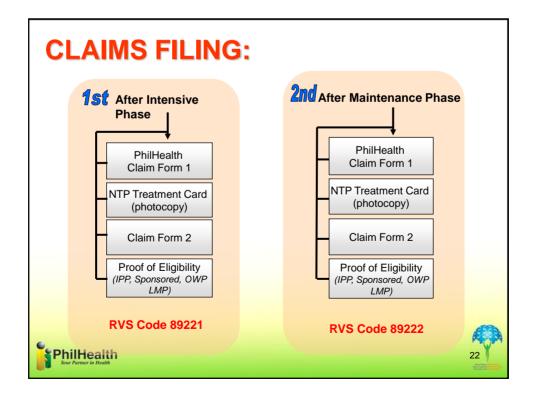


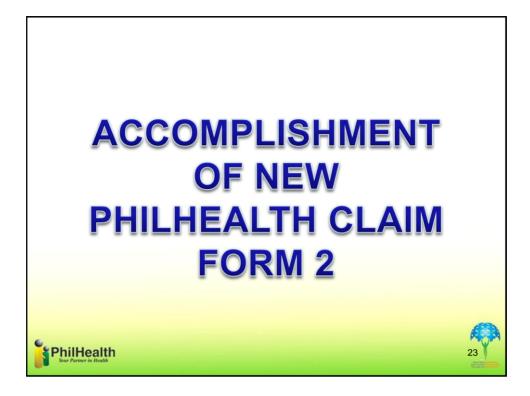


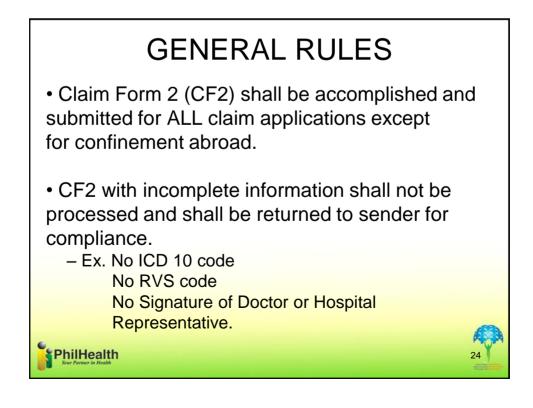
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Overseas Filipino Worker (OWP)	shall start within the date of effectivity of membership as
	stated in the ID Card / Eligibility
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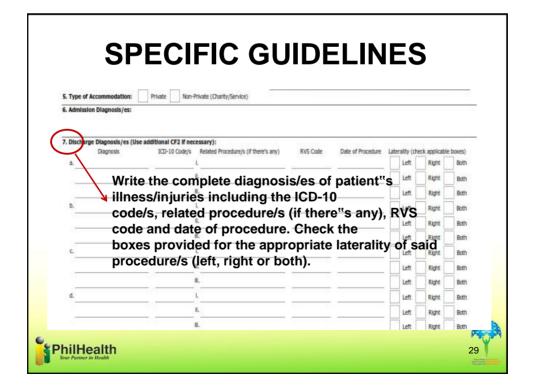




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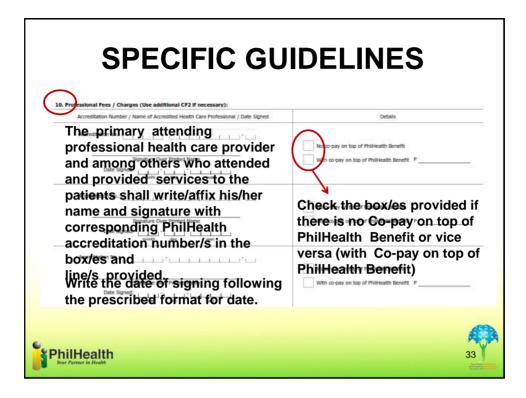
PhilHealth			Claim Form 2) claim Form 2) claim Form 2013
IMPORTANT REMINDERS: PLEASE WRITE IN CAPITAL LETTERS AND CHECK This form together with other supporting document Al information, fields and tick boxes required in this FALSE / INCORRECT INFORMATION OR MISR	ts should be filed within sixty (60) calendar da s form are necessary. Claim forms with incom	olete Information shall not be processed. CRIMINAL, CIVIL OR ADMINISTRATIVE LI	ABILITIES.
1. PhilHealth Accreditation Number (PAN) of			Facility
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6. Admission Diagnosis/es: PULM(ONARY TUBERCULOSI	S				
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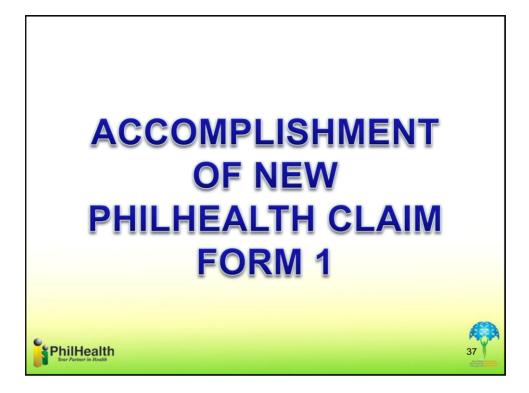
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Radiotherapy (COBA b. For Z-Benefit Package c. For MCP Package (enumer 1	LT) Z-Benefit Package Code state four dates (mm-dd-yyy) 2		3	ridement	•
	Day 3 ARV	r] when the following doses of v		RIG	e (ARV), Rables Immunoglobulin (RIG) Others (Specify) For Newborn Screening, plasse attach NB5 Filter Sucker here
Immediate drying Early skin-to-skin o	contact Eye proph	ord clamping Weighing of hylaxis Vitamin K a	of the newborn administration	BCG vaccination Non-separation of moth	Hepatitis B vaccination her/baby for early breastleeding initiation
9. PhilHealth Benefits	Treatment Package Labors	89222	b. Second	d Case Rate	



EXAMPLE	
Professional Fees / Charges (Use additional CF2 if necessary): Accreditation Number / Name of Accredited Health Care Professional / Date Signed	Details
	Utas
Accreditation No.: 1, 5, 0, 2, 1, 2, 3, 4, 5, 6	
DR. PEDROA. GOMEZ	No co-pay on top of PhilHealth Benefit
	With co-pay on top of PhilHealth Benefit P
Date Signed: 0,3,-0,5-2,0,1,4	
Accreditation No.:	*****
	No co-pay on top of PhilHealth Benefit
Signature Over Printed Name	With co-pay on top of PhilHealth Benefit P
Date Signed: * * * *	
Accreditation No.:	
	No co-pay on top of PhilHealth Benefit
Signature Over Printed Name	With co-pay on top of PhilHealth Benefit P
Date Signed:	

Partiketable benefit is enough to cover HGI and FF charges. No purchases of dirugs/medicines, supplies, diagnostics, and co-pay for professional fees by the member/patient. Total Health Care Institution Fees Total Health Care Institution Fees P2,500 Total Professional Fees rand P2,500 Total Professional Fees P2,500 Total Professional Fees P2,500 Total Actual Charges* P2,500 Total Professional Fees Total Actual Charges* P2,500 Total Professional Fees P3,500 Total Professional Fees P3,500 Total Actual Charges* P3,500 Total Actual Charges P3,500 Total Actual Charges P3,500 Total Actual Charges P3,500 Total Actual Professional Fees Total Actual Charges P3,500 Total Professional Fees Total Actual Charges P3,500 Total Professional Fees Total Actual Charges P3,500 Total Professional Fees P3,500 Total Professional Fees P3,500 Total Actual Professional Fees P3,500 P3,500	No purchases of drugs/medicines, supplies, diagnostics, and co-pay for professional fees by the member/patient. Total Actual Charges* Total Actual Charges Total Health Care Institution Fees P2,500 Total Health Care Serier Charges, and co-pay for professional fees by the member/patient is not completely consumed BUT with consumed BUT with consumed BUT with Charges* Total Health Care Total Actual Charges* Amount after Application of Baccurd (i.e., personal discount, Serier Charges* Total Professional Fees Total Actual Charges Total Actual Total Actual Total Actual Total Actual Total Actual Total Actual Charges* Total Actual Charges* Total Actual Total Actual Total Actual Charges* Total Actual Total Actual Charges* Total Actual Charges* Total Actual To	TIFICATION OF CONS	UMPTION OF BE	NEFITS		
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B. CONSENT TO ACCESS PATIENT RECORD/S		
	IN CASE PATIENT IS UNABLE and Representative TO SIGN	Ŷ
Relationship of the representative to the membery potent: Reason for signing on behalf of the member/patient: Other Reasons:	Parent If patient/representative is unable to write, put right thumbmark. Patient/representative should be assisted by an HCI representative.	
Uther Measons.		
PART 1 I certify that services rendered were recorded in the pa	IV - CERTIFICATION OF HEALTH CARE INSTITUTION ablent's chart and health care institution records and that the herein information given are true	
PARTI		1



	This form may be reproduced and is NOT FOR S FIL buse Purpose in Himshin Textual form 11 revised November 2013
	INVESTMENT DEVICES. NAME OF A CONTRACT DEVICES DEVICE DEVICES
	PART I - MEMBER INFORMATION
	2. Philleealth Identification Number (PIN) of Member:
	A Reame of Members A Caller of Shifty A Caller of Shifty A Shifty Adversary
	Und/Soom Sin, Proor Building Same Led, Stock/Houng/Edg. Sin. Street Subdivision/Village
	Bernyst ClayManapadly Provins Country 2g Cube 6. Contact Information(: Lodies Tot, No.): Proof Address: Lodies Tot, No.): Enall Address:
	Linder No. (Well Loop 4 Int. No.): Your Model No.: Linder No.: Linder No.: Linder Address: Linder Address: No, proceed to Part II No, proceed to Part II
	PART II - PATIENT INFORMATION (To be filled-out only if the patient is a dependent)
	Phillealth Identification Number (PIN) of Dependent:
PHILHEALTH	Leel Name Pred Name Name Eduration (30/55/03) Hödeln Name (assessed DELA CALLI ZUAN 38 12016C)
	4. Relationship to Member: Orid Farent Spoule S. See: Male Formale PART III - MEMBER CRATIFICATION
CLAIM FORM 1	PART III - MEMBER CERTIFICATION Under the penalty of law, I aftest that the information I provided in this Form are true and accurate to the best of my inswindige.
	Signature Over Printed Name of Henter Signature Over Printed Name of Henter's Representative Date Signet:
	Image: Control for the structure for the st
	Other reasons: PART IV - EMPLOYER'S CERTIFICATION (for employed members only)
	PARTIV - EMPLOYER'S CERTIFICATION (for employed members only) 1. Phillealth Employer No. (PER): 2. Contact No.!
	3. Business Name:
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	PART Y - FOR PHILISEALTH USE ONLY
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PhilHealth	This form may be reproduced and is NOT FOR SALE
Vour Partner In Health HORTAR REMINESS PLAGE WITTE IN CAPTUAL LESS AND CREEK THE APPROPRIATE DODES. PLAGE WITTE IN CAPTUAL LESS AND CREEK THE APPROPRIATE DODES. PLAGE WITTE IN CAPTUAL LESS AND CREEK THE APPROPRIATE DODES. Revenentative of the Health Care Institutions (HCI) and assist the member/authorized representative All information required in this form are encessary. Cale information that Les Subject To CR PLAGE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CR PLAGE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CR PLAGE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CR PLAGE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CR PLAGE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CR PLAGE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CR PLAGE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CR PLAGE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CR PLAGE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CR PLAGE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CR PLAGE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CR PLAGE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CR PLAGE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CR PLAGE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CR PLAGE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CR PLAGE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CR PLAGE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CR PLAGE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CR PLAGE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CR PLAGE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CR PLAGE / INCORRECT INFORMATION SHALL BE SUBJECT TO CR PLAGE / INFORMATION SHALL BE SUBJECT TO CR PLAGE / INFORMATION CR PLA	Filed within 180 days from date of discharge. ein filling out this form. be processed. IIMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.
1. PhilHealth Identification Number (PIN) of Member: 1 2 3 4 5 6 7 8 9 1 0 2. Name of Member: CRUZ, JUAN SR. SIPAG	
143 MASINOP ST., Cardy Same BGY. LINGAP QUEZON CITY we find the first set of	3adabasan/Yillinga 2ga Casla 33-4567 Email Address juandelacruz@yahoo.com
7. Patient is the member? Ves, proceed to Part III 🗹 No, proceed to Part II	
PhilHealth Your Partner In Houlth	39

1. PhilHealth Identification Number (PIN) of Dependent:	e filled-out only if the patient is a dep	enaciat)
2. Name of Patient:	RENTA	3. Date of Birth: 08 - 26 - 198
Last Nerne Pint Name Name Extension (JR/SR/III)	Middle Name (example: DELA CRUZ JUAN gouse	JR SBMG) 5. Sex: Male ✓ Female
	PART III - MEMBER CERTIFICATIO	N
If member /representative is unable to write, put right thumbmark. Member/representative should be available by an HET greerestative Check the appropriate box: Member Representative	Relationship of the representative to the ment Reason for signing on behalf of the member:	month dar year Spouse Child Parent ber: Sbling Others, Spochy Member is incapacitated Other reasons:

September 10 Health	This form may be reproduced and is NOT FOR SALE CF1 (Claim Form 1) revised November 2013
IMPORTANT REMINDERS: PLEASE WITTE IN CAPITAL LETTERS AND CHECK THE APPROPRIATE BOXES. For local availance, this form together with other Philieath claim forms and other supporting docu- For availancet of benefits abroad, this form together with other supporting documents should be f Representative of the Health Carls infinition (HCI) data assut the memberguintorie regresenta- al information regulated in this form are necessary. Cam forms with incomplete Information also in or. PALSE / INCORRECT INFORMATION on MISSIEPRESENTATION SHALL BE SUBJECT TO CR.	Ted within 180 days from date of discharge. e in filing out this form. be processed. IMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.
PART I - MEMBER INFOR	
	3. Date of Birth: 0,5 - 0,1 - 1,980 marth day - 1,980
4. Mailing Address: 143 MASINOP ST.,	5. Sex: V Male Female
BGY. LINGAP QUEZON CITY	Subdythin//Wilege
Cardy Cardy Cardy Cardy Cardy Cardy Cardy Cardy Cardy Cardy Cardy Cardy Cardy Cardy Cardy Cardy C	23-4567 Erreit Address juandelacruz@yahoo.com
6	
PhilHealth Nour Parmer in Itealth	41

(To be filled-out only if the patient is a dependent)		
2. Name of Patient:		3. Date of Birth:
Last Name First Name Name Last Name Child Parent	/III) Middle Name (souropie: DELA CRUZ) Spouse	UAN IR SIPAG) 5. Sex: Male Female
If member/representative If member/representative If member/representative If member/representative If member/representative If member/representative Check the appropriate box: If member representative	121014 Dr. prevention of the representative to the n Reason for signing on behalf of the member:	Sibling Others, Specify

2. Contact No.: 362-369123
Date Signed: 011 - 055 - 2014
DNLY



