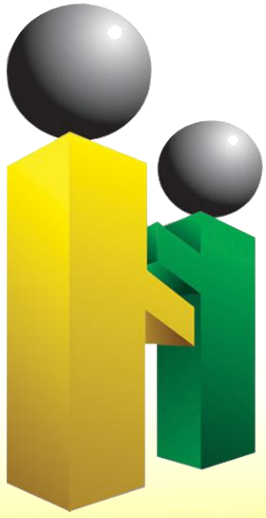


# WELCOME PARTICIPANTS!

PhilHealth
Your Partner in Health

1

# PHILHEALTH OUTPATIENT TB-DOTS BENEFIT PACKAGE

**TB Directly Observed Treatment Shortcourse (DOTS)**

PhilHealth
Your Partner in Health

2

# 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.

PhilHealth
Your Partner in Health

3

# COVERAGE:

- ❑ New cases of smear-positive pulmonary TB
  - ✓ 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

4

# COVERAGE:

- **A new smear-negative pulmonary case recommended for treatment by the TB Diagnostic Committee**
  - ✓ **those who have three sputum specimens negative for AFB but with radiographic abnormalities consistent with active PTB as determined by the TB Diagnostic Committee, with no history of anti-TB treatment and there has been no response to a course of antibiotics and/or symptomatic medications**

PhilHealth
Your Partner in Health

5

# COVERAGE:

- **A new extrapulmonary TB patient**
  - ✓ **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**

PhilHealth
Your Partner in Health

6

# COVERAGE:

- ❑ mandatory to patients prior to enrollment to DOTS
- ❑ for Sm (-) TB patients; required to submit Diagnostic Committee's recommendation to enroll patients to DOTS
- ❑ follow-up smear must be performed based on schedule specified by NTP guideline
  - ❑ if patient was unable to produce good specimen for follow-up exam, claims shall still be paid
  - ❑ such cases must be noted on the NTP form ***(Unable to Produce Sputum (UPS)***

PhilHealth
Your Partner in Health

7

# EXCLUSION:

- ❑ **Failure Cases:**

***a patient, who while on treatment, is sputum smear (+) at 5 months, or later during the course of the treatment***

- ❑ **Relapse Cases:**

***a patient previously treated for TB who has been declared cured or treatment completed, and is diagnosed with bacteriologically positive (smear/culture) TB***

- ❑ **Return after Default (RAD) Cases:**

***a patient who returns to treatment with positive bacteriologically (smear/culture), following interruption of treatment for two months or more***

PhilHealth
Your Partner in Health

8

# PhilHealth Circular No. 18, s-2011

**Diagnosis of Tuberculosis (TB) in Children Aged Zero to Nine Years Old**

PhilHealth
Your Partner in Health



# Declaration of Policy And Objectives

- Direct sputum smear microscopy shall no longer be required for children zero to nine years old who cannot expectorate.

PhilHealth
Your Partner in Health

# Declaration of Policy And Objectives

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

PhilHealth
Your Partner in Health

11

# 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.**

PhilHealth
Your Partner in Health

12

# Declaration of Policy And Objectives

c. Loss of weight/failure to gain weight/faltering weight/loss of appetite.

d. Failure to respond to 2 weeks of appropriate antibiotic therapy for lower respiratory tract infection.

PhilHealth
Your Partner in Health

13

# Declaration of Policy And Objectives

e. Failure to gain previous state of health 2 weeks after a viral infection or exanthema. (e.g., measles)

f. Fatigue/reduced playfulness/lethargy.

PhilHealth
Your Partner in Health

14

# Declaration of Policy And Objectives

2) History of exposure to TB case/s.
3) Positive Tuberculin Skin Testing (TST)
4) Positive Chest X-ray
5) Other laboratory findings suggestive or indicative of TB

PhilHealth
Your Partner in Health

15

# Benefits and Filing of Claims

PhilHealth
Your Partner in Health

16

# PAYMENT:

## P 4,000.00

New cases of pulmonary and extrapulmonary tuberculosis in children and adults

**1ST PAYMENT:**

**P 2,500.00**

**(After the INTENSIVE Phase)**
**2 months**
**RVS Code 89221**

**2nd PAYMENT:**

**P 1,500.00**

**(After the MAINTENANCE Phase)**
**4 months**
**RVS Code 89222**

PhilHealth Your Partner in Health

***PhilHealth will not pay for additional services rendered for an extension of treatment***

17

PhilHealth Your Partner in Health

## P 4,000

**(Flat rate)**

## Accredited TB-DOTS Center

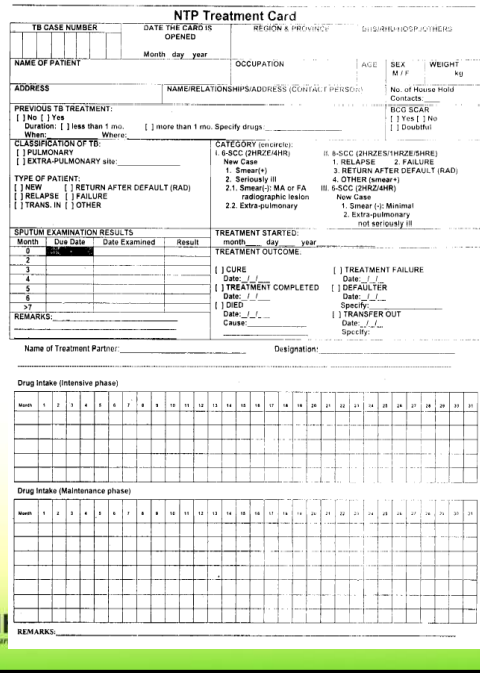
**Diagnostic work-up**

**Consultation Services**

**Anti-TB drugs**

PhilHealth Your Partner in Health

18



NTP Treatment Card

TB CASE NUMBER | DATE THE CARD IS OPENED (Month day year) | REGION & PROVINCE | DISTRICT/HOSP./OTHERS

NAME OF PATIENT | OCCUPATION | AGE | SEX M / F | WEIGHT kg

ADDRESS | NAME/RELATIONSHIPS/ADDRESS (CONTACT PERSON) | No. of House Hold Contacts:

PREVIOUS TB TREATMENT:
[ ] No [ ] Yes
Duration: [ ] less than 1 mo. [ ] more than 1 mo. Specify drugs:
When: Where:

BCG SCAR
[ ] Yes [ ] No
[ ] Doubtful

CLASSIFICATION OF TB:
[ ] PULMONARY
[ ] EXTRA-PULMONARY site:

TYPE OF PATIENT:
[ ] NEW [ ] RETURN AFTER DEFAULT (RAD)
[ ] RELAPSE [ ] FAILURE
[ ] TRANS. IN [ ] OTHER

CATEGORY (encircle):
I. 6-SCC (2HRZE/4HR)
New Case
1. Smear(+)
2. Seriously ill
2.1. Smear(-); MA or FA radiographic lesion
2.2. Extra-pulmonary

II. 8-SCC (2HRZES/1HRZE/5HRE)
1. RELAPSE 2. FAILURE
3. RETURN AFTER DEFAULT (RAD)
4. OTHER (smear+)

III. 6-SCC (2HRZ/4HR)
New Case
1. Smear (-); Minimal
2. Extra-pulmonary not seriously ill

SPUTUM EXAMINATION RESULTS

| Month | Due Date | Date Examined | Result |
|---|---|---|---|
| 0 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| >7 | | | |

REMARKS:

TREATMENT STARTED:
month day year

TREATMENT OUTCOME:
[ ] CURE Date:
[ ] TREATMENT COMPLETED Date:
[ ] DIED Date: Cause:
[ ] TREATMENT FAILURE Date:
[ ] DEFAULTER Date: Specify:
[ ] TRANSFER OUT Date: Specify:

Name of Treatment Partner: Designation:

Drug Intake (Intensive phase)

| Month | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

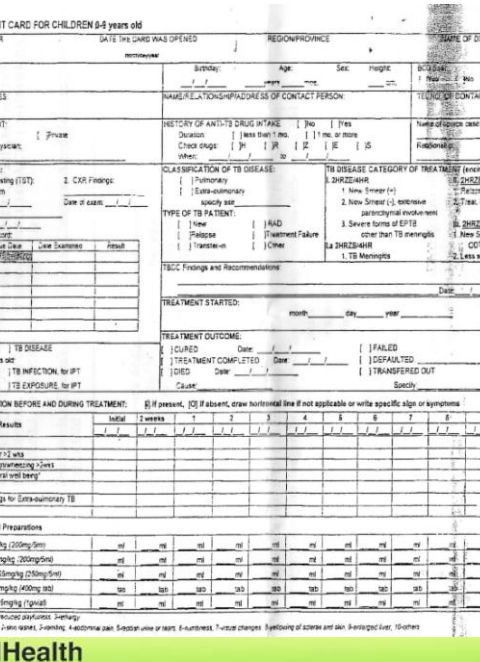
Drug Intake (Maintenance phase)

| Month | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

REMARKS:

NTP Treatment Card

19



NTP TREATMENT CARD FOR CHILDREN 0-9 years old

TB CASE NUMBER | DATE THIS CARD WAS OPENED (month/day/year) | REGION/PROVINCE | NAME OF DOTS FACILITY

NAME OF PATIENT: | Birthday: | Age: | Sex: | Height: | BCG SCAR: [ ] Yes [ ] No [ ] Doubtful

COMPLETE ADDRESS: | NAME/RELATIONSHIP/ADDRESS OF CONTACT PERSON: | TELNO. OF CONTACT PERSON:

SOURCE OF PATIENT: [ ] Public [ ] Private
Name of Referring Physician:

HISTORY OF ANTI-TB DRUG INTAKE: [ ] No [ ] Yes
Duration [ ] less than 1 mo. [ ] 1 mo. or more
Check drugs: [ ] H [ ] R [ ] Z [ ] E [ ] S
When: / / to / /

Name of source case (if known):
Relationship:

DIAGNOSTIC TESTS:
1. Tuberculin Skin Testing (TST): Result: mm Date read: / /
2. CXR Findings: Date of exam: / /
3. Other exam: Date of exam: / /
4. DSM Results Record:

| Month | Due Date | Date Examined | Result |
|---|---|---|---|
| 0 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| >7 | | | |

CLASSIFICATION OF TB DISEASE:
[ ] Pulmonary
[ ] Extra-pulmonary specify site
TYPE OF TB PATIENT:
[ ] New [ ] RAD
[ ] Relapse [ ] Treatment Failure
[ ] Transfer-in [ ] Other

TB DISEASE CATEGORY OF TREATMENT (encircle):
I. 2HRZE/4HR
1. New Smear (+)
2. New Smear (-), extensive parenchymal involvement
3. Severe forms of EPTB other than TB meningitis
Ia 2HRZE/4HR
1. TB Meningitis
II. 2HRZES/1HRZE/5HRE
1. Relapse 2. RAD
3. Treat. Failure 4. Other (specify)
III. 2HRZ/4HR
1. New Smear (-)
CXR & those other than Cat. I
2. Less severe forms of EPTB

TBCC Findings and Recommendations: Date: / /

TREATMENT STARTED: month day year

TREATMENT OUTCOME:
[ ] CURED Date: / /
[ ] TREATMENT COMPLETED Date: / /
[ ] DIED Date: / / Cause:
[ ] FAILED Date: / /
[ ] DEFAULTED Date: / /
[ ] TRANSFERED OUT Date: / / Specify:

DIAGNOSIS: [ ] TB DISEASE
Children 0-4 years old:
[ ] TB INFECTION, for IPT
[ ] TB EXPOSURE, for IPT

CLINICAL EXAMINATION BEFORE AND DURING TREATMENT: (/) if present, (O) if absent, draw horizontal line if not applicable or write specific sign or symptoms

| Date Examined/Results | Initial / / | 2 weeks / / | 1 / / | 2 / / | 3 / / | 4 / / | 5 / / | 6 / / | 7 / / | 8 / / | 9 / / | 10 / / |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Weight in Kg. | | | | | | | | | | | | |
| Unexplained fever >2 wks | | | | | | | | | | | | |
| Unexplained cough/wheezing >2wks | | | | | | | | | | | | |
| Unexplained general well being* | | | | | | | | | | | | |
| Poor appetite | | | | | | | | | | | | |
| Positive PE findings for Extra-pulmonary TB | | | | | | | | | | | | |
| Side Effects** | | | | | | | | | | | | |

DRUGS: Dosages and Preparations

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Isoniazid (H) 5mg/kg (200mg/5ml) | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml |
| Rifampicin (R) 10mg/kg (200mg/5ml) | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml |
| Pyrazinamide (Z) 35mg/kg (250mg/5ml) | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml |
| Ethambutol (E) 20mg/kg (400mg tab) | tab | tab | tab | tab | tab | tab | tab | tab | tab | tab | tab | tab | tab |
| Streptomycin (S) 15mg/kg (1gm/vial) | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml |

* 1=fatigue, 2=reduced playfulness, 3=lethargy
** 1=dizziness, 2=skin rashes, 3=vomiting, 4=abdominal pain, 5=decision visual or taste, 6=numbness, 7=visual changes, 8=yellowing of sclerae and skin, 9=enlarged liver, 10=others

NTP Treatment Card for children 0 to 9 yrs. old

20

# MEMBER'S ELIGIBILITY:

| TYPE OF MEMBERSHIP | ELIGIBILITY |
|---|---|
| ❑ **Employed** | **3 monthly contributions** within the immediate 6 months prior to enrollment at the DOTS Center |
| ❑ **Individually Paying Program** | |
| ❑ **Sponsored and Indigent**<br>❑ **Overseas Filipino Worker (OWP)** | Enrollment at the DOTS Center shall start **within the date of effectivity of membership** as stated in the ID Card / Eligibility Certificate |
| ❑ **Lifetime Members** | Lifetime Member Identification Card |

21

# CLAIMS FILING:

**1st After Intensive Phase**

- PhilHealth Claim Form 1
- NTP Treatment Card (photocopy)
- Claim Form 2
- Proof of Eligibility *(IPP, Sponsored, OWP LMP)*

**RVS Code 89221**

**2nd After Maintenance Phase**

- PhilHealth Claim Form 1
- NTP Treatment Card (photocopy)
- Claim Form 2
- Proof of Eligibility *(IPP, Sponsored, OWP LMP)*

**RVS Code 89222**

22

# ACCOMPLISHMENT OF NEW PHILHEALTH CLAIM FORM 2

PhilHealth
Your Partner in Health

23

## GENERAL RULES

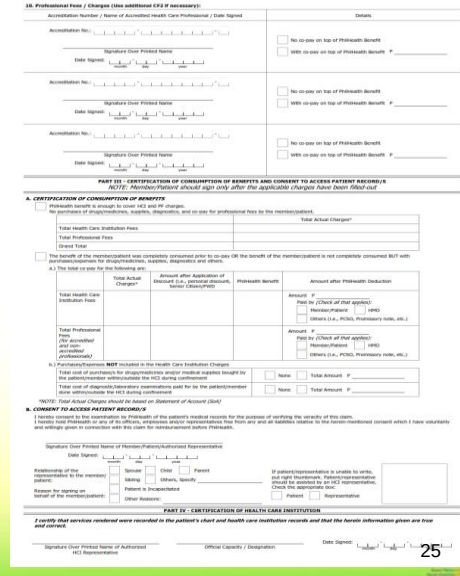
- Claim Form 2 (CF2) shall be accomplished and submitted for ALL claim applications except for confinement abroad.

- CF2 with incomplete information shall not be processed and shall be returned to sender for compliance.
  - Ex. No ICD 10 code
    No RVS code
    No Signature of Doctor or Hospital Representative.

PhilHealth
Your Partner in Health

24

# PHILHEALTH CLAIM FORM 2



25

PhilHealth
*Your Partner in Health*

This form may be reproduced and is NOT FOR SALE

**CF2**
**(Claim Form 2)**
**revised November 2013**

Series # _____

**IMPORTANT REMINDERS:**
PLEASE WRITE IN CAPITAL **LETTERS** AND **CHECK** THE APPROPRIATE BOXES.
This form together with other supporting documents should be filed within sixty (60) calendar days from date of discharge.
All information, fields and tick boxes 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 - HEALTH CARE INSTITUTION (HCI) INFORMATION**

1. PhilHealth Accreditation Number (PAN) of Health Care Institution: H 1 2 3 4 5 6 7 8 ➡ **Facility**
2. Name of Health Care Institution: XYZ DOTS CENTER
3. Address: 123 JUANITO ST., BGY. MAYABONG, QUEZON CITY
   (Building Number and Street Name / City/Municipality / Province)

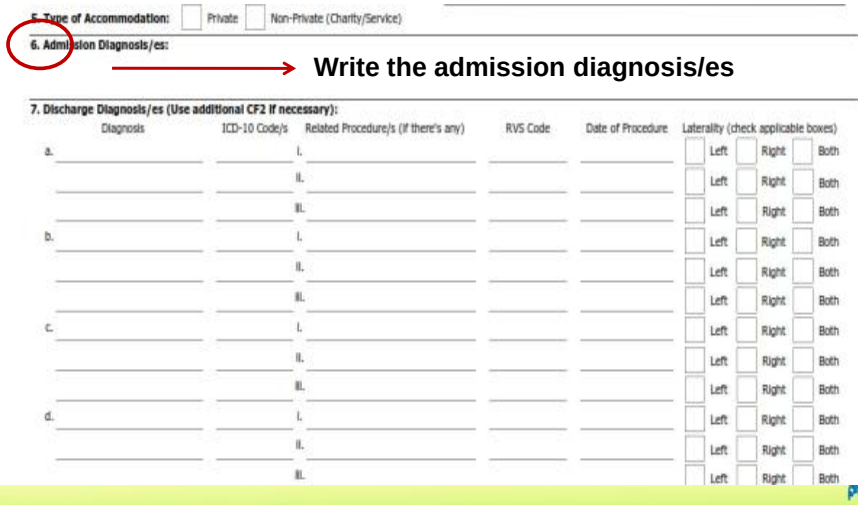
**PART II - PATIENT CONFINEMENT INFORMATION**

1. Name of Patient: DELA CRUZ, (Last Name) JUAN (First Name) SR. (Name Extension: JR/SR/III) SIPAG (Middle Name)
   (example: DELA CRUZ JUAN JR SIPAG)
2. Was patient referred by another Health Care Institution (HCI)?
   ✓ NO ☐ YES _____ (Name of Referring Health Care Institution) _____ (Building Number and Street Name) _____ (City/Municipality) _____ (Province) _____ (Zip Code)
3. Confinement Period: a. Date Admitted: 0 1 (month) - 0 3 (day) - 2 0 1 4 (year) b. Time Admitted: ____ (hour) : ____ (min) ☐ AM ☐ PM
   c. Date Discharged: 0 1 (month) - 0 5 (day) - 2 0 1 4 (year) d. Time Discharged: ____ (hour) : ____ (min) ☐ AM ☐ PM
4. Patient Disposition: (select only 1)
   ✓ a. Improved
   ☐ b. Recovered
   ☐ c. Home/Discharged Against Medical Advise
   ☐ d. Absconded
   ☐ e. Expired, Date: ____ (month) - ____ (day) - ____ (year) Time: ____ (hour) : ____ (min) ☐ AM ☐ PM
   ☐ f. Transferred/Referred _____ (Name of Referral Health Care Institution) _____ (Building Number and Street Name) _____ (City/Municipality) _____ (Province) _____ (Zip Code)
   Reason/s for referral/transfer: _____

PhilHealth
*Your Partner in Health*

26

# SPECIFIC GUIDELINES

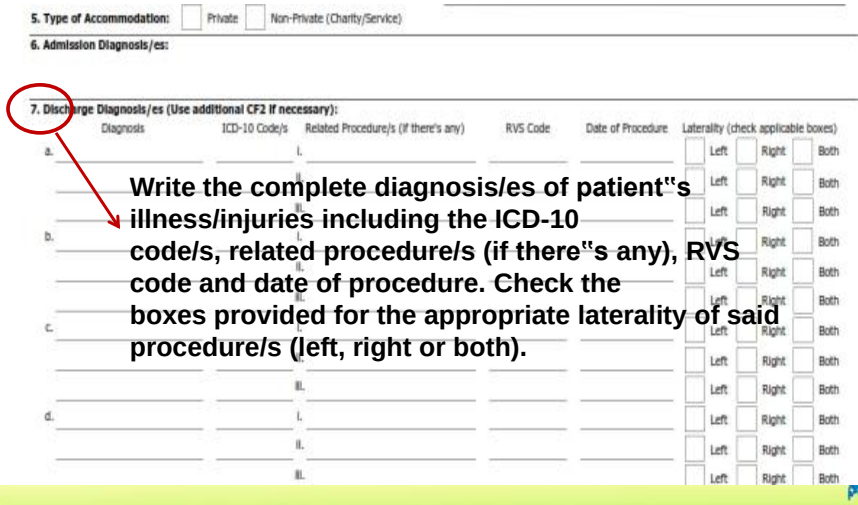



**Write the admission diagnosis/es**

PhilHealth
Your Partner in Health



# SPECIFIC GUIDELINES




**Write the complete diagnosis/es of patient"s illness/injuries including the ICD-10 code/s, related procedure/s (if there"s any), RVS code and date of procedure. Check the boxes provided for the appropriate laterality of said procedure/s (left, right or both).**

PhilHealth
Your Partner in Health

**EXAMPLE**

**5. Type of Accommodation:** ☐ Private ☐ Non-Private (Charity/Service)

**6. Admission Diagnosis/es:**

**PULMONARY TUBERCULOSIS**

**7. Discharge Diagnosis/es (Use additional CF2 if necessary):**

| | Diagnosis | ICD-10 Code/s | Related Procedure/s (if there's any) | RVS Code | Date of Procedure | Laterality (check applicable boxes) |
|---|---|---|---|---|---|---|
| a. | **PULMONARY TUBERCULOSIS** | **A16.9** | i. | **89221** | | ☐ Left ☐ Right ☐ Both |
| | | | ii. | | | ☐ Left ☐ Right ☐ Both |
| | | | iii. | | | ☐ Left ☐ Right ☐ Both |
| b. | | | i. | | | ☐ Left ☐ Right ☐ Both |
| | | | ii. | | | ☐ Left ☐ Right ☐ Both |
| | | | iii. | | | ☐ Left ☐ Right ☐ Both |
| c. | | | i. | | | ☐ Left ☐ Right ☐ Both |
| | | | ii. | | | ☐ Left ☐ Right ☐ Both |
| | | | iii. | | | ☐ Left ☐ Right ☐ Both |
| d. | | | i. | | | ☐ Left ☐ Right ☐ Both |
| | | | ii. | | | ☐ Left ☐ Right ☐ Both |
| | | | iii. | | | ☐ Left ☐ Right ☐ Both |

PhilHealth
*Your Partner in Health*

30

**8. Special Considerations:**

a. *For the following repetitive procedures, check box that applies and enumerate the procedure/session dates [mm-dd-yyyy]. For chemotherapy, see guidelines.*

| | | | |
|---|---|---|---|
| ☐ Hemodialysis | | ☐ Blood Transfusion | |
| ☐ Peritoneal Dialysis | | ☐ Brachytherapy | |
| ☐ Radiotherapy (LINAC) | | ☐ Chemotherapy | |
| ☐ Radiotherapy (COBALT) | | ☐ Simple Debridement | |

b. *For Z-Benefit Package* **Z-Benefit Package Code:** _____

c. *For MCP Package (enumerate four dates [mm-dd-yyyy] of pre-natal check-ups)*

**1** _____ **2** _____ **3** _____ **4** _____

d. *For TB DOTS Package* ☑ ntensive Phase ☑ Maintenance Phase

e. *For Animal Bite Package (write the dates [mm-dd-yyyy] when the following doses of vaccine were given)* ***NOTE: Anti Rabies Vaccine (ARV), Rabies Immunoglobulin (RIG)***

**Day 0 ARV** _____ **Day 3 ARV** _____ **Day 7 ARV** _____ **RIG** _____ **Others (Specify)** _____

f. *For Newborn Care Package* ☐ Essential Newborn Care ☐ Newborn Hearing Screening Test ☐ Newborn Screening Test **For Newborn Screening,** *please attach NBS Filter Sticker here*

**For Essential Newborn Care, (check applicable boxes)**

| | | | | |
|---|---|---|---|---|
| ☐ Immediate drying of newborn | ☐ Timely cord clamping | ☐ Weighing of the newborn | ☐ BCG vaccination | ☐ Hepatitis B vaccination |
| ☐ Early skin-to-skin contact | ☐ Eye prophylaxis | ☐ Vitamin K administration | ☐ Non-separation of mother/baby for early breastfeeding initiation | |

g. *For Outpatient HIV/AIDS Treatment Package* **Laboratory Number:** _____

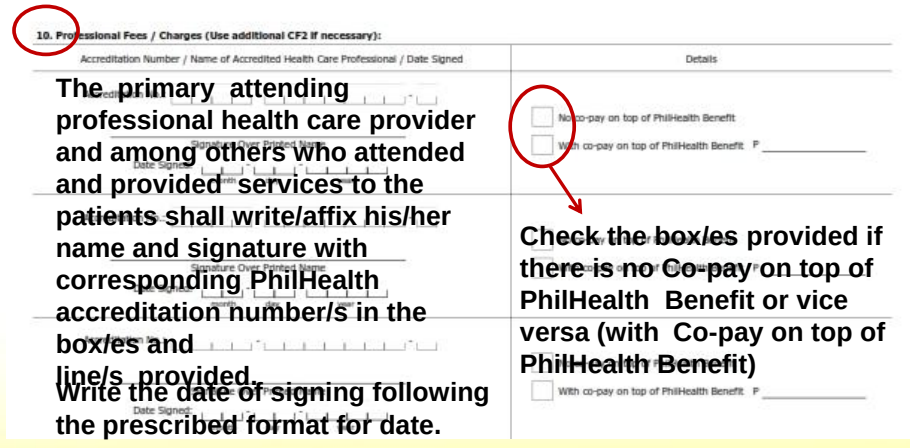
**9. PhilHealth Benefits**

**ICD 10 or RVS Code:** a. First Case Rate **89222** b. Second Case Rate _____

PhilHealth
*Your Partner in Health*

31

# SPECIFIC GUIDELINES




**The primary attending professional health care provider and among others who attended and provided services to the patients shall write/affix his/her name and signature with corresponding PhilHealth accreditation number/s in the box/es and line/s provided.**

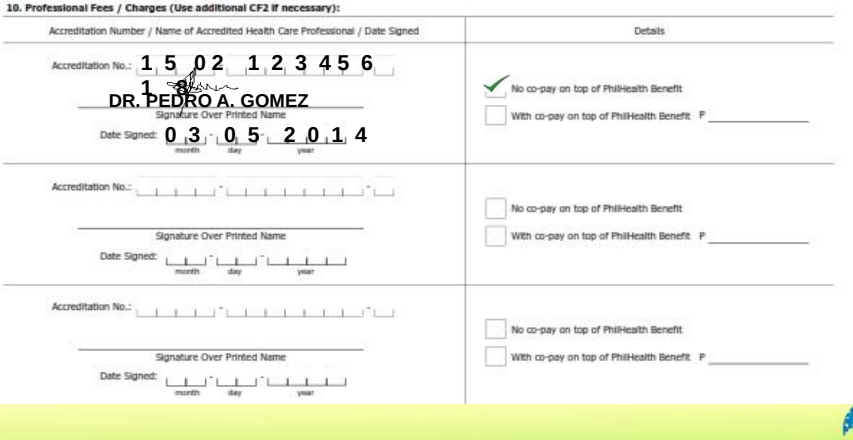
**Write the date of signing following the prescribed format for date.**

**Check the box/es provided if there is no Co-pay on top of PhilHealth Benefit or vice versa (with Co-pay on top of PhilHealth Benefit)**

PhilHealth
Your Partner in Health

33

**EXAMPLE**




PhilHealth
Your Partner in Health

34

**PART III - CERTIFICATION OF CONSUMPTION OF BENEFITS AND CONSENT TO ACCESS PATIENT RECORD/S**

*NOTE: Member/Patient should sign only after the applicable charges have been filled-out*

**A. CERTIFICATION OF CONSUMPTION OF BENEFITS**

☑ PhilHealth benefit is enough to cover HCI and PF charges.
No purchases of drugs/medicines, supplies, diagnostics, and co-pay for professional fees by the member/patient.

| | Total Actual Charges* |
|---|---|
| Total Health Care Institution Fees | **P2,500** |
| Total Professional Fees | |
| Grand Total | **P 2,500** |

☐ The benefit of the member/patient was completely consumed prior to co-pay OR the benefit of the member/patient is not completely consumed BUT with purchases/expenses for drugs/medicines, supplies, diagnostics and others.

a.) The total co-pay for the following are:

| | Total Actual Charges* | Amount after Application of Discount (i.e., personal discount, Senior Citizen/PWD | PhilHealth Benefit | Amount after PhilHealth Deduction |
|---|---|---|---|---|
| Total Health Care Institution Fees | | | | Amount P _____<br>Paid by *(Check all that applies)*:<br>☐ Member/Patient ☐ HMO<br>☐ Others (i.e., PCSO, Promissory note, etc.) |
| Total Professional Fees *(for accredited and non-accredited professionals)* | | | | Amount P _____<br>Paid by *(Check all that applies)*:<br>☐ Member/Patient ☐ HMO<br>☐ Others (i.e., PCSO, Promissory note, etc.) |

b.) Purchases/Expenses **NOT** included in the Health Care Institution Charges

| | |
|---|---|
| Total cost of purchase/s for drugs/medicines and/or medical supplies bought by the patient/member within/outside the HCI during confinement | ☐ None ☐ Total Amount P _____ |
| Total cost of diagnostic/laboratory examinations paid for by the patient/member done within/outside the HCI during confinement | ☐ None ☐ Total Amount P _____ |

**NOTE: Total Actual Charges should be based on Statement of Account (SoA)*

PhilHealth
*Your Partner in Health*

35

**B. CONSENT TO ACCESS PATIENT RECORD/S**

I hereby consent to the examination by PhilHealth of the patient's medical records for the purpose of verifying the veracity of this claim.
I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim for reimbursement before PhilHealth.

**ROMULO DELA CRUZ JR.**
Signature Over Printed Name of Member/Patient/Authorized Representative

**IN CASE PATIENT IS UNABLE TO SIGN**

Date Signed: 03 (month) - 05 (day) - 2014 (year)

Relationship of the representative to the member/patient: ☑ Spouse ☐ Child ☐ Parent ☐ Sibling ☐ Others, Specify _____

Reason for signing on behalf of the member/patient: ☐ Patient is Incapacitated ☑ Other Reasons: **WEAK**

If patient/representative is unable to write, put right thumbmark. Patient/representative should be assisted by an HCI representative. Check the appropriate box: ☐ Patient ☐ Representative

**PART IV - CERTIFICATION OF HEALTH CARE INSTITUTION**

***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.***

**MA. SONIA M. GOMEZ**
Signature Over Printed Name of Authorized HCI Representative

**PHILHEALTH OFFICER**
Official Capacity / Designation

Date Signed: 03 (month) - 05 (day) - 2014 (year)

PhilHealth
*Your Partner in Health*

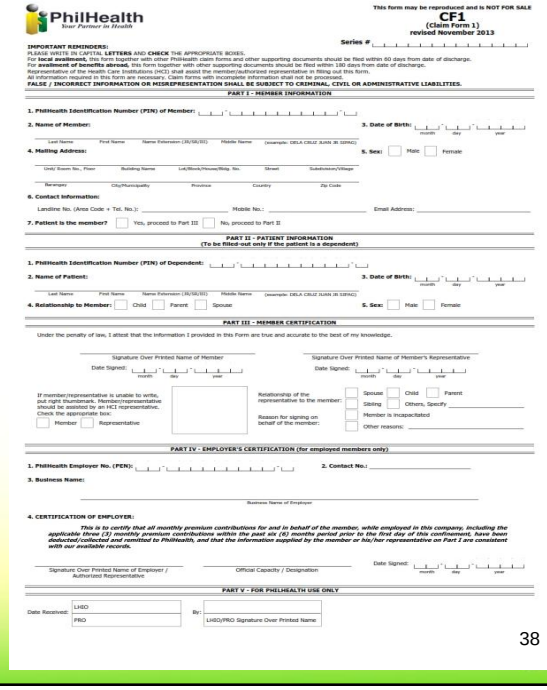
36

# ACCOMPLISHMENT OF NEW PHILHEALTH CLAIM FORM 1

PhilHealth
Your Partner in Health



**PHILHEALTH CLAIM FORM 1**



PhilHealth
Your Partner in Health

This form may be reproduced and is NOT FOR SALE

**CF1**
(Claim Form 1)
revised November 2013

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.
**ANY 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) (example: DELA CRUZ JUAN JR. SERVO)
3. Date of Birth: (month, day, year)
4. Mailing Address: (Unit/ Room No., Floor, Building Name, Lot/Block/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) (example: DELA CRUZ JUAN JR. SERVO)
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)
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 IV - EMPLOYER'S CERTIFICATION (for employed members only)**

1. PhilHealth Employer No. (PEN):
2. Contact No.:
3. Business Name: (Business Name of Employer)
4. CERTIFICATION OF EMPLOYER:

*This is to certify that all monthly premium contributions for and in behalf of the member, while employed in this company, including the applicable three (3) monthly premium contributions within the past six (6) months period prior to the first day of this confinement, have been deducted/collected and remitted to PhilHealth, and that 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 / PRO — By: LHIO/PRO Signature Over Printed Name

PhilHealth
Your Partner in Health

PhilHealth
Your Partner in Health

This form may be reproduced and is NOT FOR SALE

**CF1**
(Claim Form 1)
revised November 2013

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 345678910 1

2. Name of Member: DELA CRUZ, JUAN SR. SIPAG
(Last Name / First Name / Name Extension (JR/SR/III) / Middle Name — example: DELA CRUZ JUAN JR SIPAG)

3. Date of Birth: 05 01 1980 (month / day / year)

4. Mailing Address: 143 MASINOP ST., BGY. LINGAP QUEZON CITY
(Unit/ Room No. / Floor No. / Name of Building / House No./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.): 441-1234 Mobile No.: 0913-123-4567 Email Address: juandelacruz@yahoo.com

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: DELA CRUZ, RONILA RENTA
(Last Name / First Name / Name Extension (JR/SR/III) / Middle Name — example: DELA CRUZ JUAN JR SIPAG)

3. Date of Birth: 08 26 1981 (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.

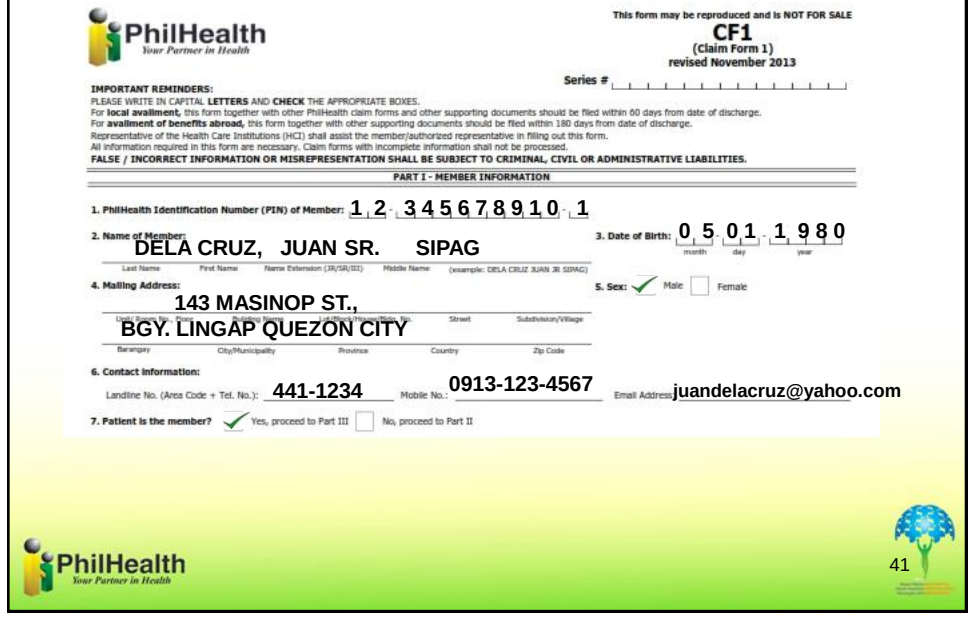
Signature Over Printed Name of Member
Date Signed: ____ (month / day / year)

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: ____



PhilHealth
Your Partner in Health

This form may be reproduced and is NOT FOR SALE

**CF1**
(Claim Form 1)
revised November 2013

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: 12-345678910-1

2. Name of Member: DELA CRUZ, JUAN SR. SIPAG
(Last Name / First Name / Name Extension (JR/SR/III) / Middle Name — example: DELA CRUZ JUAN JR SIPAG)

3. Date of Birth: 05-01-1980 (month-day-year)

4. Mailing Address: 143 MASINOP ST., BGY. LINGAP QUEZON CITY
(House/Bldg. No. / Street / Subdivision/Village / Barangay / City/Municipality / Province / Country / Zip Code)

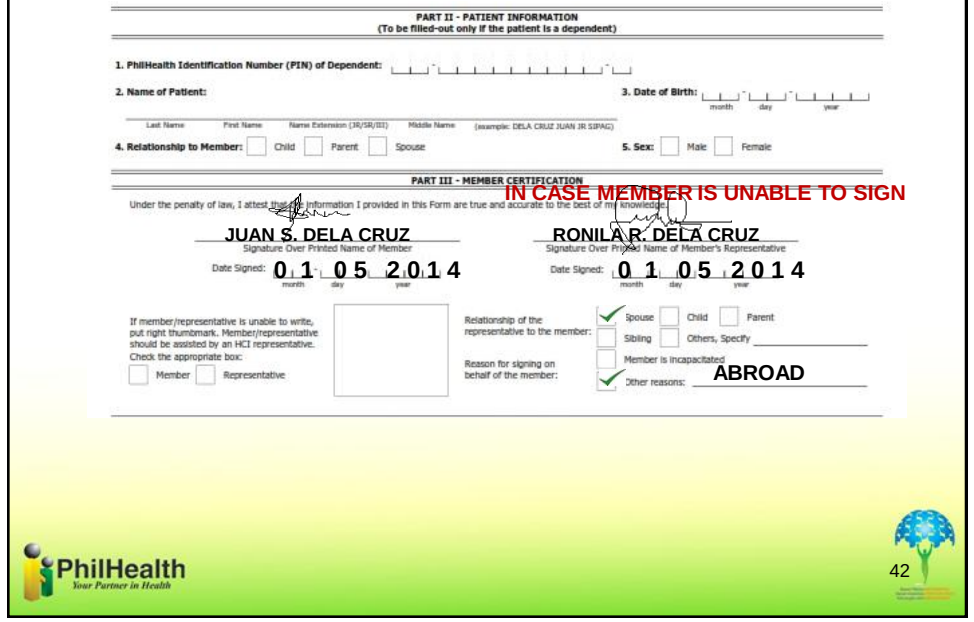
5. Sex: ✓ Male ☐ Female

6. Contact Information:
Landline No. (Area Code + Tel. No.): 441-1234 Mobile No.: 0913-123-4567 Email Address: juandelacruz@yahoo.com

7. Patient is the member? ✓ Yes, proceed to Part III ☐ No, proceed to Part II

PhilHealth
Your Partner in Health

41



**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 — example: 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**

IN CASE MEMBER IS UNABLE TO SIGN

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.

JUAN S. DELA CRUZ
Signature Over Printed Name of Member
Date Signed: 01-05-2014 (month-day-year)

RONILA R. DELA CRUZ
Signature Over Printed Name of Member's Representative
Date Signed: 01-05-2014 (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: ABROAD

PhilHealth
Your Partner in Health

42

PART IV - EMPLOYER'S CERTIFICATION (for employed members only)

1. PhilHealth Employer No. (PEN): 2 0 2 4 6 8 1 0 1 2 1 4 2. Contact No.: 362-369123

3. Business Name:

GHI MANUFACTURING CORP.

Business Name of Employer

4. CERTIFICATION OF EMPLOYER:

*This is to certify that all monthly premium contributions for and in behalf of the member, while employed in this company, including the applicable three (3) monthly premium contributions within the past six (6) months period prior to the first day of this confinement, have been deducted/collected and remitted to PhilHealth, and that the information supplied by the member or his/her representative on Part I are consistent with our available records.*

Ma. Clara Ibarra — Signature Over Printed Name of Employer / Authorized Representative

Manager — Official Capacity / Designation

Date Signed: 0 1 - 0 5 - 2 0 1 4 (month - day - year)

PART V - FOR PHILHEALTH USE ONLY

Date Received: LHIO / PRO

By: LHIO/PRO Signature Over Printed Name

PhilHealth Your Partner in Health

43

# NCR-CENTRAL

## (Quezon City, Marikina, San Juan, Rizal)

- **QUEZON CITY SERVICE OFFICE:**
  - **F.R. Estuar & Associates Bldg., 880 Quezon Ave., Quezon City**
  - **332-1550 / 332-1551**
- **RIZAL SERVICE OFFICE:**
  - **The Brick Road, Sta. Lucia East Grand Mall, Marcos Hiway, Cainta, Rizal**
  - **681-5111 / 681-5499**

PhilHealth Your Partner in Health

45

# THANK YOU!

PhilHealth
Your Partner in Health