revised February 2010

IMPORTANT REMINDERS:

PLEASE WRITE IN **CAPITAL LETTERS** AND **CHECK** THE APPROPRIATE BOXES.
For **local confinement**, this form together with CF2 and other supporting documents should be filed within **60 DAYS** from date of discharge.
For **confinement abroad**, this form together with other supporting documents should be filed within **180 DAYS** from date of discharge.
Only one (1) original copy of this Form is required per claim application/availment.
All information required in this form are necessary and 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 and PATIENT INFORMATION

(Member/Representative to fill out all items with the assistance of the Health Care Provider)

1. PhilHealth Identification No. (PIN): 01 - 246174118736

2. Member Category:
☐ Employed ☐ Government ☐ Private ☐ Sponsored ☐ OFW ☐ Individually Paying ☐ Lifetime

3. Name of Member
OBRERO NANCY REYES
Last Name / First Name / Middle Name (example: Dela Cruz, Juan Jr., Sipag)

4. Mailing Address:
LAC PINAS
(House Number & Name of Street) (Barangay)
(City / Municipality) (Province) (ZIP Code)

5. Date of Birth:
(Month) - (Day) - (Year)

6. Contact Information (if available):
E-mail Address: _____ Mobile No.: _____ Landline No.: _____

7. Name of Patient:
OBRERO JOHN REYES
Last Name / First Name / Middle Name (example: Dela Cruz, Juan Jr., Sipag)

8. ☐ Patient is the Member
☐ Patient is a Dependent
☐ Child ☐ Parent ☐ Spouse

9. CERTIFICATION OF MEMBER:

I hereby certify that the herein information are true and correct and may be used for any legal purpose.

Nancy Obrero
Signature Over Printed Name of Member

Signature Over Printed Name of Member's Representative

Date Signed (month-day-year)

Date Signed (month-day-year)

10. Relationship of the Representative to the Member:
☐ Child ☐ Parent ☐ Spouse ☐ Guardian / Next of Kin

11. Reason for Signing on Behalf of the Member:
☐ Member is Abroad / Out-of-Town ☐ Member is Incapacitated ☐ Other Reasons: _____

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

1. PhilHealth Employer No. (PEN): ___ - _____ - ___ 2. Contact No.: _____

3. Business Name and Official Address:
(Business Name of Employer)
(Building Number and Street Name)
(City / Municipality) (Province) (ZIP Code)

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)

(For PhilHealth use only)

Series # _____
(For PhilHealth use only)

IMPORTANT REMINDERS:

PLEASE WRITE IN CAPITAL **LETTERS** AND **CHECK** THE APPROPRIATE BOXES.
For **local confinement**, this form together with CF1 and other supporting documents should be filed within **60 DAYS** from date of discharge.
All information required in this form are necessary and 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 - PROVIDER INFORMATION (Institutional Health Care Provider to fill out items 1 to 13)

1. Name of Facility: ST. JAMES HOSPITAL

2. Address: LTC PINAS

3. PhilHealth Accreditation No. (PAN): 0 0 4 7 8 1 5 6 6
(Institutional Health Care Provider)

5. PhilHealth Identification No. (PIN): 0 1 - 2 4 6 7 4 1 8 7 3 - 6
(Member)

4. Category of Facility:
☐ T-L4 /L3 ☐ ASC ☐ RHU
☐ S-L2 ☐ FDC ☐ TB DOTS
☐ P-L1 ☐ MCP ☐ _____ (OTHERS)

6. Name of Patient
OBRERO JOHN REYES
Last Name First Name Middle Name (example: Dela Cruz, Juan Jr., Sipag)

7. Date of Birth __ - __ - ____ (month-day-year) 8. Age ____ Year/s ☐ Month/s ☐ Day/s ☐ 9. Sex ☐ Male ☐ Female

10. Confinement Period

a. Date Admitted: 05 - 04 - 2011 (month-day-year) b. Time Admitted: ____ AM ____ PM e. No.of Days Claimed ____

c. Date Discharged: 05 - 06 - 2011 (month-day-year) d. Time Discharged: ____ AM ____ PM f. In case of Death, specify date __ - __ - ____ (month-day-year)

11. Health Care Provider Services	Actual Charges	PhilHealth Benefit	For PhilHealth Use Only (Adjustments / Remarks)
a. Room and Board Private ☒ Ward ☐	7,077.-	5700.-	
b. Drugs and Medicines (Part II for details)	1,587.-	1367.-	
c. X-ray/Lab./Supplies & Others (Part III for details)	482.-	570.-	
d. Operating Room Fee			
TOTAL	9069.-	6867.-	
e. Benefit Package			

12. Case Type* ☐A ☐B ☐C ☐D 13. Complete ICD-10 Code/s _____
*This is only applicable for claims with fee for service payment mechanism

(Professional Health Care Providers to fill out items 14 to 16)

14. Admission Diagnosis	15. Complete Final Diagnosis

16. Professional Fees / Charges

a. Name of Professional b. PhilHealth Accreditation No.	c. Number of Visits / RVS Code d. Inclusive Dates (mm-dd-yyyy)	e. Total Actual PF Charges	f. PhilHealth Benefit	g. Amount paid by members	h. Signature i. Date Signed	For PhilHealth Use Only
____ - ____ - ☐						
____ - ____ - ☐						
____ - ____ - ☐						

Generic/Brand name	(dose/ cap/ syrup/ injectible /tab with ml/mg/gm content)	Qty	Unit Price	Charges	Benefit
			TOTAL		

PART III - X-RAY, LABORATORIES, SUPPLIES AND OTHERS (use additional sheet if necessary)

Particulars	Qty	Unit Price	Actual Charges	PhilHealth Benefit
A. X-Ray (Imaging)				
B. Laboratories/Diagnostics				
C. Supplies and Others				
		TOTAL		

☐ Official receipts for drugs and medicines / supplies purchased by member from external sources as well as laboratory procedures done outside the hospital which are necessary for the confinement are attached to this claim

PART IV - CERTIFICATION OF INSTITUTIONAL HEALTH CARE PROVIDER

I certify that services rendered were recorded in the patient's chart and hospital records and that the herein information given are true and correct.

The foregoing items and charges are in compliance with the applicable laws, rules and regulations.

Signature Over Printed Name of Authorized Representative

Official Capacity / Designation

Date Signed (month-day-year)

PART V - CONSENT TO ACCESS PATIENT RECORD/S

I hereby consent to the examination by PhilHealth of the patient's medical records for the sole 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.

Signature Over Printed Name of Patient

Date Signed (month-day-year)

Signature Over Printed Name of Patient's Representative

Date Signed (month-day-year)

Relationship of the Representative to the Patient:

☐ Spouse ☐ Child ☐ Parent ☐ Guardian/ Next of Kin

Reason for Signing on Behalf of the Patient:

☐ Patient is Incapacitated ☐ Other Reasons: _____

Your Partner in Health

(Claim Form)
revised February 2010

IMPORTANT REMINDERS:
THIS FORM SHOULD BE FILED TOGETHER WITH PHILHEALTH CLAIM FORMS 1 AND 2 WITHIN **60 CALENDAR DAYS** FROM DATE OF DISCHARGE.
FOR LEVEL 1 *FACILITY*, THIS FORM SHALL BE REQUIRED FOR ALL BENEFIT CLAIMS.
FOR LEVELS 2, 3 AND 4 FACILITIES, THIS FORM IS REQUIRED IN CASES OF: 1) EMERGENCY/TRANSFERRED 2) LESS THAN 24 HOURS ADMISSION 3) CASE TYPE 'D' DIAGNOSIS.
THIS FORM SHALL BE REQUIRED FOR ALL CLAIMS ON MATERNITY CARE PACKAGE.

PART I - PATIENT'S CLINICAL RECORD

1. PhilHealth Accreditation No. (PAN) - Institutional Health Care Provider: 010417811516

2. Name of Patient

OBRERO JOHN REYES
Last Name, First Name, Middle Name (example: Dela Cruz, Juan Jr., Sipag)

3. Chief Complaint / Reason for Admission:

4. Date Admitted: 05 - 04 - 2011 (Month - Day - Year) Time Admitted: ___ AM ___ PM (hh-mm)

5. Date Discharged: 05 - 06 - 2011 (Month - Day - Year) Time Discharged: ___ AM ___ PM (hh-mm)

6. Brief History of Present Illness / OB History:

7. Physical Examination (Pertinent Findings per System)

General Survey:

Vital Signs : BP: _____ CR: _____ RR: _____ Temperature: _____

HEENT :

Chest/Lungs :

CVS :

Abdomen :

GU (IE) :

Skin/Extremities :

Neuro Examination :

8. Course in the Wards (attach additional sheets if necessary):

9. Pertinent Laboratory and Diagnostic Findings: (CBC, Urinalysis, Fecalysis, X-ray, Biopsy, etc.)

PRENATAL CONSULTATION

1. Initial Prenatal Consultation ☐☐ - ☐☐ - ☐☐☐☐ (Month - Day - Year)

2. Clinical History and Physical Examination

a. Vital signs are normal ☐ c. Menstrual History LMP ☐☐ - ☐☐ - ☐☐☐☐ (Month - Day - Year) Age of Menarche _____

b. Ascertain the present Pregnancy is low-Risk ☐ d. Obstetric History G _____ P _____ (___, ___, ___, ___) (T, P, A, L)

3. Obstetric risk factors

a. Multiple pregnancy	☐	d. Placenta previa	☐	g. History of pre-eclampsia	☐
b. Ovarian cyst	☐	e. History of 3 miscarriages	☐	h. History of eclampsia	☐
c. Myoma uteri	☐	f. History of stillbirth	☐	i. Premature contraction	☐

4. Medical/Surgical risk factors

a. Hypertension	☐	d. Thyroid Disorder	☐	g. Epilepsy	☐	j. History of previous cesarian section	☐
b. Heart Disease	☐	e. Obesity	☐	h. Renal disease	☐	k. History of uterine myomectomy	☐
c. Diabetes	☐	f. Moderate to severe asthma	☐	i. Bleeding disorders	☐		

5. Admitting Diagnosis _____

6. Delivery Plan

a. Orientation to MCP/Availment of Benefits ☐ yes ☐ no b. Expected date of delivery ☐☐ - ☐☐ - ☐☐☐☐ (Month - Day - Year)

7. Follow-up Prenatal Consultation

	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th
a. Prenatal Consultation No											
b. Date of visit (mm/ dd/ yy)											
c. AOG in weeks											
d. Weight & Vital signs:											
d.1. Weight											
d.2. Cardiac Rate											
d.3. Respiratory Rate											
d.4. Blood Pressure											
d.5. Temperature											

DELIVERY OUTCOME

8. Date and Time of Delivery Date ☐☐ - ☐☐ - ☐☐☐☐ (Month - Day - Year) Time ☐ AM ☐ PM (hh-mm)

9. Maternal Outcome: _____ Pregnancy Uterine, _____ _____ _____
(Obstetric Index; AOG by LMP; Manner of Delivery; Presentation)

10. Birth Outcome: _____ _____ _____ _____
(Fetal Outcome; Sex; Birth Weight (grm); APGAR Score)

11. Scheduled Postpartum follow-up consultation 1 week after delivery ☐☐ - ☐☐ - ☐☐☐☐ (Month - Day - Year)

12. Date and Time of Discharge Date ☐☐ - ☐☐ - ☐☐☐☐ (Month - Day - Year) Time ☐ AM ☐ PM (hh-mm)

POSTPARTUM CARE

	done	Remarks
13. Perineal wound care	☐	
14. Signs of Maternal Postpartum Complications	☐	
15. Counselling and Education		
a. Breastfeeding and Nutrition	☐	
b. Family Planning	☐	
16. Provided family planning service to patient (as requested by patient)	☐	
17. Referred to partner physician for Voluntary Surgical Sterilization (as requested by pt.)	☐	
18. Schedule the next postpartum follow-up	☐	

19. Certification of Attending Physician/Midwife:

I certify that the above information given in this form are true and correct.