PhilHealth
Your Partner in Health

CSF
(Claim SIgnature Form)

IMPORTANT REMINDERS:

PLEASE WRITE IN CAPITAL **LETTERS** AND **CHECK** THE APPROPRIATE BOXES.

Series # ☐☐☐☐☐☐☐☐☐☐☐☐☐

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 AND CERTIFICATION

1. PhilHealth Identification Number (PIN) of Member: __ - __________ - _
2. Name of Member:

Last Name   First Name   Middle Name   (**example**: Dela Cruz, Juan Jr., Sipag)

3. Member Date of Birth: __ - __ - ____ (month-day-year)

4. PhilHealth Identification Number (PIN) of Dependent: __ __________ _
5. Name of Patient:

Last Name   First Name   Middle Name   (**example**: Dela Cruz, Juan Jr., Sipag)

6. Relationship to Member: ☐ Child ☐ Parent ☐ Spouse

7. Confinement Period

a. Date Admitted: __ - __ - ____ (month-day-year)   c. Date Discharged: __ - __ - ____ (month-day-year)

8. Patient Date of Birth: __ - __ - ____ (month-day-year)

9. CERTIFICATION OF MEMBER:

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 II - 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 III - 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.

Signature Over Printed Name of Member/ Patient/ Authorized Representative
__ - __ - ____
(Date Signed (month-day-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 ______________

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 - HEALTH CARE PROFESSIONAL INFORMATION

Accreditation No. ____ - _______ - _
Signature Over Printed Name
__ - __ - ____
Date Signed (month-day-year)

Accreditation No. ____ - _______ - _
Signature Over Printed Name
__ - __ - ____
Date Signed (month-day-year)

Accreditation No. ____ - _______ - _
Signature Over Printed Name
__ - __ - ____
Date Signed (month-day-year)

Accreditation No. ____ - _______ - _
Signature Over Printed Name
__ - __ - ____
Date Signed (month-day-year)

PART V - PROVIDER INFORMATION AND CERTIFICATION

1. PhilHealth Benefits

ICD 10 or RVS Code   **a. First Case Rate** ____________   **b. Second Case Rate** ____________

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.

Signature Over Printed Name Authorized HCI Representative   Official Capacity / Designation   __ __ ____ Date Signed (month-day-year)