PHILHEALTH

CLAIM FORM 4

April 2003

MATERNITY CARE PACKAGE

(DATE RECEIVED)

NOTE: THIS FORM TOGETHER WITH CLAIM FORM 1 SHOULD BE FILED WITH PHILHEALTH WITHIN 60 CALENDAR DAYS FROM DATE OF DISCHARGE.

PART I - FACILITY DATA AND CHARGES (Facility to Fill in All Items)

1. PhilHealth Accreditation No.

2. Accreditation Category ☐ Primary ☐ Secondary ☐ Tertiary
☐ Non-Hospital Facilities (Lying-in clinics,Midwife-managed clinics, Birthing Homes,Ambulatory Surgical Clinics)

3. Name of Facility

4. Address of Facility
No., Street | Barangay
Municipality/City | Province | Zip Code

5. Name of Member and Identification
Last Name | First Name
Middle Name | PhilHealth Identification No.

6. Address of Member
No., Street | Barangay
Municipality/City | Province | Zip Code

7. Name of Patient
Last Name
First Name
Middle Name

8. Age

9. Admission Diagnosis

10. Confinement Period
a. Date Admitted m m d d y y y y
b. Date Discharged m m d d y y y y
c. Total No.of Days
d. Date of Death (If Applicable) m m d d y y y y

11. Facility Services	ACTUAL FACILITY CHARGES	BENEFIT CLAIM		REDUCTION CODE
		FACILITY	PATIENT	
TOTAL				
Medicines & Supplies bought & laboratory performed outside facility during confinement period				

12. CERTIFICATION of FACILITY: I certify that the services rendered are duly recorded in the patient's chart and that the information given in this form are true and correct.

Signature Over Printed Name of Authorized Representative | Date Signed | Official Capacity

PART II - PROFESSIONAL DATA AND CHARGES (Provider/s to Fill in Respective Portions)

13. Complete Final Diagnosis

14. ICD-10 Code:

FOR PHILHEALTH USE
RVS Code
Illness Code
Reduction Code

15. Name of Provider | Signature & Date Signed

16.PHIC Accreditation No.

17. BIR/TIN No. - -

18. Services Performed

19. Actual Professional Charges	Benefit Claim	
	Provider	Patient
P	P	P

NOTE: ANYONE WHO SUPPLIES FALSE OR INCORRECT INFORMATION REQUESTED BY THIS OR A RELATED FORM OR COMMITS MISREPRESENTATION SHALL BE SUBJECT TO CRIMINAL, CIVIL OR ADMINISTRATIVE PROSECUTION UNDER THE LAW. ALL DATA REQUIRED ON THIS FORM ARE NECESSARY FOR ADJUDICATION OF THE CLAIM. PHILHEALTH WILL NOT ADJUDICATE ANY CLAIM WHERE FORMS ARE NOT PROPERLY OR COMPLETELY ACCOMPLISHED.

PHILHEALTH

CLAIM FORM 4A

MATERNITY CARE PACKAGE

April 2003

NOTE: THIS FORM TOGETHER WITH CLAIM FORM 4 SHOULD BE FILED WITH PHILHEALTH WITHIN 60 CALENDAR DAYS FROM DATE OF DISCHARGE.

Name of Physician/Midwife: _____

Name of Facility: _____

Address of Facility: _____

Name of Patient: _____

PART I - PRENATAL

INITIAL PRENATAL CONSULTATION (date: ___/___/___)

A. Clinical History and Physical Examination

1. Vital signs are normal ☐
2. Menstrual History ☐ LMP : _____ Menarche: _____
4. Obstetric History ☐ G_____ P_____ (_____ ,_____ ,_____ ,_____)
5. Ascertain 1st Pregnancy was Low-Risk ☐
6. Obstetric risk factors
   - a. Multiple pregnancy ☐
   - b. Ovarian cyst ☐
   - c. Myoma uteri ☐
   - d. Placenta previa ☐
   - e. History of 3 miscarriages ☐
   - f. History of stillbirth ☐
   - g. History of pre-eclampsia ☐
   - h. History of eclampsia ☐
   - i. Premature contraction ☐
7. Medical/Surgical Risk Factors
   - a. Hypertension ☐
   - b. heart disease ☐
   - c. Diabetes ☐
   - d. Thyroid disorders ☐
   - e. Obesity ☐
   - f. Moderate to severe asthma ☐
   - g. Epilepsy ☐
   - h. Renal disease ☐
   - I. Bleeding disorders ☐
   - j. History of previous cesarean section ☐
   - k. History of uterine myomectomy ☐
8. Determine pertinent abdominal examinations
   - a. Abdomen
     - normoactive bowel sound ☐
     - non-tender ☐
     - active fetal movements ☐
     - fundic ht= _____
     - estimated fetal wt: _____
     - FHT= _____
     - Leopold's Maneuver L1: _____ L3: _____
     - L2: _____ L4: _____
     - presentation: _____
   - b. Speculum Exam
     - parous vagina
     - cervix smooth, closed
   - c. Internal Exam
     - uterus enlarged to AOG
     - adnexal masses
9. Give complete diagnosis: _____

B. Write Delivery Plan indicating:

1. Orientation to LRMC Package/Availment of Benefits
2. Schedule of prenatal examinations Date: ___/___/___ Place: _____
3. Expected date and venue of delivery

FOLLOW-UP PRENATAL CONSULTATION (date: ___/___/___)

Visit No.	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th
Date of visit											
A. Determine AOG in weeks											
B. Obtain vital signs											
a. Wt											
b. HR											
c. RR											
d. BP											
e. T											

PART II - NORMAL BIRTH (date:__/__/__)

DONE

A. Perform complete Physical Examination (VS)

1. Determine AOG ☐ AOG: _____ LMP: _____
2. Obtain Vital Signs ☐ HR: _____ RR: _____ BP: _____ T: ____
3. Perform pertinent physical examination

a. HEENT
- anicteric sclerae (+) (-)
- pink palpebral conjunctiva (+) (-)
- REMARKS _____

b. Heart/Lungs
- clear breath sounds (+) (-)
- sinus rhythm (+) (-)
- REMARKS _____

c. Skin/Extremities
- full pulses (+) (-)
- bipedal edema (+) (-)
- REMARKS _____

4. Determine pertinent abdominal examinations

regular uterine contractions **(+)** **(-)** FHT= _____

bloody show **(+)** **(-)** fundic ht= _____

active fetal movements **(+)** **(-)** estimated fetal wt: _____

5. Perform IE

BOW:_____ Cervical Effacement: _____ Presentation: _____

Cervical dilatation: _____ Station: _____

B. Ascertain that patient is in true active labor ☐ Time of start of labor: _____

C. Admit and obtain informed consent ☐ Time of Admission: _____

D. Monitor course of labor, accomplish partogram ☐ _____

E. Prepare Delivery Room ☐ _____

F. Attend to Delivery of Baby ☐ Time of delivery of newborn: _____

G. Get APGAR score of Newborn ☐ APGAR : _____

H. Routine Newborn Care ☐ _____

I. Perform Delivery of Placenta ☐ Time of delivery of placenta: _____

J. Check if placenta is complete ☐ _____

K. Ensure good uterine contraction ☐ _____

L. Inspect for perineal and vaginal lacerations ☐ _____

M. Explain to patient the procedure of perineal repair ☐ _____

N. Suture perineal laceration under Local Anesthesia ☐ _____

O. Check repair and ensure hemostasis ☐ _____

P. Transfer patient to recovery area ☐ _____

Q. Monitor during Immediate Postpartum Period ☐ BP: ____ HR: ____ RR: ____ T: ____

R. Discharge Clearance (D/C IE) ☐ Vagina: _____

Cervix: _____

Uterus: _____

S. Give Complete Diagnosis

OB Score : G ____ P ____ (____ , ____ , ____ , ____)

Maternal Outcome: _____ , _____ , _____ , _____

Pregnancy Uterine | AOG by LMP | Manner of Delivery | Presentation

Birth Outcome: _____ , _____ , _____ , _____

Live | Sex | Birthweight | APGAR Score

T. Accomplish documents for PHIC Reimbursement _____

U. Schedule Postpartum and Newborn Care follow-up Date: _____

consult - 1 week after delivery ☐

V. Discharge Patient ☐ Date and Time of Discharge: _____

I hereby certify that I received the services indicated above.

_____

Signature of Patient

I hereby certify that I delivered the services indicated above.

_____

Signature of Physician/Midwife

PHILHEALTH

CLAIM FORM 4B
April 2003

MATERNITY CARE PACKAGE

NOTE: THIS FORM TOGETHER WITH CLAIM FORM 4 SHOULD BE FILED WITH PHILHEALTH WITHIN 90 CALENDAR DAYS FROM DATE OF DISCHARGE.

Name of Physician/Midwife: _____
Name of Facility: _____
Address of Facility: _____
Name of Patient: _____

POST-PARTUM CARE (date:__/__/__)

	DONE	REMARKS
A. Check perineal wound healing	☐	_____
B. Check for signs of Maternal Postpartum complications	☐	_____
C. Check for signs of Newborn complications	☐	_____
D. Counselling and Education		
1. Newborn Care	☐	_____
2. Breastfeeding and Nutrition	☐	_____
3. Newborn Immunization	☐	_____
4. Family Planning	☐	_____
E. Provide family planning service to patient if requested	☐	_____
F. Refer to Partner Physician for Voluntary Surgical Sterilization, if requested by patient		_____
G. Schedule postpartum visit 6 weeks postpartum	☐	_____

I hereby certify that I received the services indicated above.

_____
Signature of Patient

I hereby certify that I delivered the services indicated above.

_____
Signature of Physician/Midwife