

CF2

(Claim Form) revised February 2010

Series #													ĺ
(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 M	1ISREPRI	ESENTATION SHALL E	BE SUBJECT TO	CRIMINAL, CIVIL (OR ADMINISTRAT	VE LIABILITIES.	
PART I - PRO	VIDER	INFORMATION (Ir	nstitutional He	alth Care Provide	er to fill out item	s 1 to 13)	
1. Name of Facility:							
2. Address:							
3. PhilHealth Accreditation No. (PAN): (Institutional Health Care Provider) 5. PhilHealth Identification No. (PIN):]-[]]			4. Category of Faci T-L4 /L3 S-L2	ility: ASC FDC	RHU TB DOTS
(Member) 6. Name of Patient					P-L1	MCP	
Last Name First Name	Mid	dle Name (exam	nple: Dela Cruz,	Juan Ir Sinad			(OTHERS)
7. Date of Birth		8. Age	Year/s		ay/s 9.	Sex Male	Female
10. Confinement Period							
a. Date Admitted:		b. Time Admitt		AM PM	e. No.of Days (f. In case of De specify o	eath, L	— onth-day-year)
11. Health Care Provider Services		Actual Charg	es	PhilHealth I	Benefit		ealth Use Only nts / Remarks)
a. Room and Board Private Ward							
b. Drugs and Medicines (Part II for details)							
c. X-ray/Lab./Supplies & Others (Part III for de	etails)						
d. Operating Room Fee							
TOTAL							
e. Benefit Package							
12. Case Type* A B C D *This is only applicable for claims with fee for		13. Complete ICD- payment mechanism	10 Code/s				
(Professional Health Care Providers to	fill out	items 14 to 16) 15. Complete Final Dia	agnosis				
14. Admission Diagnosis		15. Complete Final Dia	agnosis				
16. Professional Fees / Charges	le Numbe	er of Visits / RVS Code			a Amount paid by	h Signaturo	1
Name of Professional D. PhilHealth Accreditation No.		ive Dates (mm-dd-yyyy)	e. Total Actua PF Charges		g. Amount paid by members	i. Date Signed	For PhilHealth Use Only

PART II -	DRUGS AND MEDICINE	S (use addition	nal sheet if necessa	-y)			
Generic/Brand name	Preparation (dose/ cap/ syrup/ injectible /tab with ml/mg/gm content)	Qty	Unit Price	Actual Charges	PhilHealth Benefit		
			TOTAL				
PART III - X-RAY, LAB	ORATORIES, SUPPLIES	AND OTHE		heet if necessary)			
Particulars	<u> </u>	Qty	Unit Price	Actual Charges	PhilHealth Benefit		
A. X-Ray (Imaging)							
3. Laboratories/Diagnostics							
C. Supplies and Others							
o. Supplies and Suicis							
			TOTAL				
Official receipts for drugs and medicine outside the hospital which are necessa	ry for the confinement are at	tached to this	clairr		ocedures done		
	RTIFICATION OF INSTITU						
I certify that services rendered were recorded in The foregoing items and charges are in complia				ormation given are t	rue ana correct.		
the joing tions and charges are in company	tee want the applicable saws,	Tures and regu					
Signature Over Printed Name of Authorized Represer	al Capacity / Des	Capacity / Designation Date Signed (month-day-year)					
PAF	RT V - CONSENT TO ACC	ESS PATIEN	NT RECORD/S				
hereby consent to the examination by PhilHead	th of the patient's medical re	cords for the s	ole purpose of veri	fying the veracity of t	his claim.		
hereby hold PhilHealth or any of its officers, e consent which I have voluntarily and willingly					in-mentioned		
Signature Over Printed Name of Patient	Signature Over Printed Name of Pa	ntient's Represent	tative Relatio	onship of the Representa	tive to the Patient:		
Date Signed (month-day-year)	Date Signed (month-da	ıy-year)	Spouse	Child Pare	Guardian/ Nex of Kin		
Reason	for Signing on Behalf of the Patier	nt:					
	Patient is Incapacitated	Other Rea	asons:				