

Annex C



PhilHealth Konsulta Registration Form

To be filled-out by the Beneficiary

Name: _____

PIN: _____

Member: ____ Dependent: ____ (please check)

Contact No: _____

Email Address (if applicable): _____

Preferred PhilHealth Konsulta Facility and Address
(Municipality/Town/City/Province):

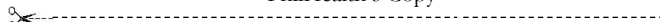
1st choice: _____

2nd choice: _____

3rd choice: _____

(Signature over printed name)

PhilHealth's Copy



PhilHealth Konsulta Registration Confirmation Slip

To be filled-out by the Authorized personnel

Registration No.: _____

Date registered: _____

Name: _____

PIN: _____

PhilHealth Konsulta Facility: _____

PhilHealth Konsulta Facility Address: _____

(Signature over printed name of Authorized Personnel)

Beneficiary's Copy

(to be printed at the back)

Instructions:

1. All information should be written in UPPER CASE/CAPITAL LETTERS.
2. All fields are mandatory.
3. If the beneficiary is dependent, use the dependent PIN.
4. If the beneficiary is below 21 years old, the signatory should be the parent/guardian.