SAMPLE CLAIM FORM 2 FOR SPECIALTY MH PACKAGE (TRANCHE 2)

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 • Trunkline (02) 441-7444
www.philhealth.gov.ph
email: actioncenter@philhealth.gov.ph

PhilHealth
Your Partner in Health

CF-2
(Claim Form 2)
Revised September 2018

Series # _____

IMPORTANT REMINDERS:
PLEASE WRITE IN CAPITAL **LETTERS** AND **CHECK** THE APPROPRIATE BOXES.
This form together with other supporting documents should be filed within sixty (60) calendar days from date of discharge.
All information, fields and trick boxes required in this form are necessary. 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 - HEALTH CARE INSTITUTION (HCI) INFORMATION

1. **PhilHealth Accreditation Number (PAN) of Health Care Institution:** H 9 3 0 0 X X X X
2. **Name of Health Care Institution:** ABC Mental and Wellness Hospital
3. **Address:** SHAW BLVD (Building Number and Street Name) | PASIG CITY (City/Municipality) | _____ (Province)

PART II - PATIENT CONFINEMENT INFORMATION

1. **Name of Patient:** DELA CRUZ (Last Name) | JUAN (First Name) | III (Name Extension (JR/SR/II)) | MAPAGPALA (Middle Name (ex: DELA CRUZ JUAN JR SIPAG))

2. **Was patient referred by another Health Care Institution (HCI)?**
☑ NO ☐ YES
Name of referring Health Care Institution | Building Number and Street Name | City/Municipality | Province | Zip code

3. **Confinement Period:**
a. Date Admitted 01 (month) - 05 (day) - 2024 (year) b. Time Admitted ____ (hour) : ____ (min) ☐ AM ☐ PM
c. Date Discharge 04 (month) - 05 (day) - 2024 (year) d. Time Discharge ____ (hour) : ____ (min) ☐ AM ☐ PM

OUTPATIENT

4. **Patient Disposition:** (select only 1)
☑ a. Improved
☐ b. Recovered
☐ c. Home/Discharged Against Medical Advise
☐ d. Absconded
☐ e. Expired ____ (month) - ____ (day) - ____ (year) Time: ____ (hour) : ____ (min) ☐ AM ☐ PM
☐ f. Transferred/Referred _____ (Name of Referral Health Care Institution)
Building Number and Street Name | City/Municipality | Province | Zip code
Reason/s for referral/transfer: _____

5. **Type of Accomodation:** ☐ Private ☐ Non-Private (Charity/Service)

6. **Admission Diagnosis/es:** Epilepsy

7. **Discharge Diagnosis/es** (Use additional CF2 if necessary):

	Diagnosis	ICD-10 Code/s	Related Procedure/s (if there's any)	RVS Code	Date of Procedure	Laterality (check applicable box)
a.	Epilepsy		i.			left right both
			ii.			left right both
			iii.			left right both
b.			i.			left right both
			ii.			left right both
			iii.			left right both

8. **Special Considerations:**
a. For the following repetitive procedures, check box that applies and enumerate the procedure/sessions dates [mm-dd-yyyy]. For chemotherapy, see guidelines.
☐ Hemodialysis _____ ☐ Blood Transfusion _____
☐ Peritoneal Dialysis _____ ☐ Brachytherapy _____
☐ Radiotherapy (LINAC) _____ ☐ Chemotherapy _____
☐ Radiotherapy (COBALT) _____ ☐ Simple Debridement _____
b. For Z-Benefit Package **Z-Benefit Package Code:** MHS2
c. For MCP Package (enumerate four dates [mm-dd-year] of pre-natal check-ups)
1 _____ 2 _____ 3 _____ 4 _____
d. For TB DOTS Package ☐ Intensive Phase ☐ Maintenance Phase
e. For Animal Bite Package (write the dates [mm-dd-year] when the following doses of vaccine were given) **Note: Anti Rabies Vaccine (ARV), Rabies Immunoglobulin (RIG)**
Day 0 ARV _____ **Day 3 ARV** _____ **Day 7 ARV** _____ **RIG** _____ **Others (Specify)** _____
f. For Newborn Care Package ☐ Essential Newborn Care ☐ Newborn Hearing Screening Test ☐ Newborn Screening Test
For Newborn Screening, *please attach NBS Filter Sitcker here*
For Essential Newborn Care (check applicable boxes)
☐ Immediate drying of newborn ☐ Timely cord clamping ☐ Weighing of the newborn ☐ BCG vaccination ☐ Hepatitis B vaccination
☐ Early skin-to-skin contact ☐ Eye Prophylaxis ☐ Vitamin K administration ☐ Non-separation of mother/baby for early breastfeeding initiation
g. For Outpatient HIV/AIDS Treatment Package **Laboratory Number:** _____

9. **PhilHealth Benefits:**
ICD 10 or RVS Code: a. First Case Rate _____ b. Second Case Rate _____

Date of the succeeding follow-up visit with any of the following:
a. Psychiatrist
b. Neurologist
c. Psychologist

(Refer to Annex D: MH passport)

Date of the last follow-up visit with any of the following:
a. Psychiatrist
b. Neurologist
c. Psychologist

(Refer to Annex D: MH passport)

Write OUTPATIENT in lieu of time admitted & discharged

Tick YES if the patient was referred by another HF

This is not required as mental health services provided is an out-patient setting

Indicate the diagnosis

Indicate the appropriate "benefit package code"

This is not required

10. Accreditation Number/Name of Accredited Health Care Professional/Date Signed and Professional Fees/Charges
(Use additional CF2 if necessary):

Accreditation number/Name of Accredited Health Care Professional/Date Signed	Details
Accreditation No.: 1234-5678901-2 JUANA DELA CRUZ, MD Signature Over Printed Name Date Signed: ___-___-___ (month-day-year)	☑ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____
Accreditation No.: ___-___-___ Signature Over Printed Name Date Signed: ___-___-___ (month-day-year)	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____
Accreditation No.: ___-___-___ Signature Over Printed Name Date Signed: ___-___-___ (month-day-year)	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____

Tick this box if patient paid no additional Professional fee

Tick this box if patient paid an additional Professional fee

PART III - CERTIFICATION OF CONSUMPTION OF BENEFITS AND CONSENT TO ACCESS PATIENT RECORD/S

NOTE: Member/Patient should sign only after the applicable charges have been filled-out

A. CERTIFICATION OF CONSUMPTION OF BENEFITS:

☑ PhilHealth benefit is enough to cover HCI and PF Charges.
No purchase of drugs/medicines, supplies, diagnostics, and co-pay for professional fees by the member/patient.

	Total Actual Charges*
Total Health Care Institution Fees	6,400.00
Total Professional Fees	
Grand Total	6,400.00

Tick this box if patient has NO co-payment

☐ The benefit of the member/patient was completely consumed prior to co-pay OR the benefit of the member/patient is not completely consumed BUT with purchases/expenses for drugs/medicines, supplies, diagnostics and others.

a.) The total co-pay for the following are:

	Total Actual Charges*	Amount after Application of Discount (i.e., personal discount, Senior Citizen/PWD)	PhilHealth Benefit	Amount after PhilHealth Deduction
Total Health Care Institution Fees				Amount P _____ Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☐ Others (i.e., PCSO, Promisory note, etc.)
Total Professional Fees (for accredited and non-accredited professionals)				Amount P _____ Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☐ Others (i.e., PCSO, Promisory note, etc.)

Tick this box if patient has a co-payment

b.) Purchases/Expenses **NOT** included in the Health Care Institution Charges

Total cost of purchase/s for drugs/medicines and/or medical supplies bought by the patient/member within/outside the HCI during confinement	☐ None ☐ Total Amount P _____
Total cost of diagnostic/laboratory examinations paid by the patient/member done within/outside the HCI during confinement	☐ None ☐ Total Amount P _____

*** NOTE:** Total Actual Charges should be based on Statement of Account (SOA)

B. CONSENT TO ACCESS PATIENT RECORD/S:

I hereby consent to the submission and examination of the patient's pertinent medical records for the purpose of verifying the veracity of this claim to effect efficient processing of benefit payment.
I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all legal liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim for reimbursement before PhilHealth.

JUAN MAPAGPALA DELA CRUZ, III
Signature Over Printed Name of Member/Patient/Authorized Representative

Affix signature of the patient/parent /authorized representative

Date Signed: 04-05-2024 (month-day-year)

Indicate date signed

If patient/representative is unable to write, put right thumbmark. Patient/ Representative should be assisted by an HCI representative.

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 _____

☐ Patient ☐ Representative

PART IV - CERTIFICATION OF CONSUMPTION OF HEALTH CARE INSTITUTION

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.

CARDING DELOS REYES
Signature Over Printed Name of Authorized HCI Representative

RECORDS OFFICER
Official Capacity/Designation

Date Signed: 04-06-2024 (month-day-year)

Affix signature of HF representative