

PHILHEALTH

CLAIM FORM 2

Revised May 2000

HEALTH CARE PROVIDER'S CERTIFICATION

(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 - HOSPITAL DATA AND CHARGES (Hospital to Fill in All Items)

1. PhilHealth Accreditation No. <input type="text"/>		2. Accreditation Category <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary <input type="checkbox"/> Ambulatory	
3. Name of Hospital/Ambulatory Clinic <input type="text"/>			
4. Address of Hospital/Ambulatory Clinic No., Street <input type="text"/>		Barangay <input type="text"/>	
Municipality/City <input type="text"/>		Province <input type="text"/>	Zip Code <input type="text"/>
5. Name of Member and Identification			
Last Name <input type="text"/>		First Name <input type="text"/>	
Middle Name <input type="text"/>		Identification No. <input type="text"/>	
6. Address of Member			
No., Street <input type="text"/>		Barangay <input type="text"/>	
Municipality/City <input type="text"/>		Province <input type="text"/>	Zip Code <input type="text"/>
7. Name of Patient		8. Age <input type="text"/>	10. Admission Diagnosis
Last Name <input type="text"/>		9. Sex <input type="checkbox"/> M <input type="checkbox"/> F	
First Name <input type="text"/>			
Middle Name <input type="text"/>			
11. Confinement Period		m m d d y y y y	m m d d y y y y
a. Date Admitted <input type="text"/>	c. Date Discharged <input type="text"/>	e. Claimed No. of Days <input type="text"/>	f. Date of Death (If Applicable) m m d d y y y y
b. Time Admitted <input type="text"/> : <input type="text"/> AM/PM	d. Time Discharged <input type="text"/> : <input type="text"/> AM/PM		
12. Hospital/Ambulatory Services		ACTUAL HOSPITAL/ AMBULATORY CHARGES	
		BENEFIT CLAIM	
a. Room and Board		HOSPITAL	PATIENT
b. Drugs and Medicines (Part III for details)			REDUCTION CODE
c. X-ray/Lab. Test/Others (Part IV for details)			
d. Operating Room Fee			
e. Medicines bought & laboratory performed outside hospital during confinement period			
TOTAL			
13. CERTIFICATION of HOSPITAL/AMBULATORY CLINIC: 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 (Doctor/s to Fill in Respective Portions)

14. Complete Final Diagnosis <input type="text"/>		FOR PHILHEALTH USE	
		Relative Unit Value	
15. Case Type <input type="checkbox"/> Ordinary <input type="checkbox"/> Intensive <input type="checkbox"/> Catastrophic			
16. Name of Attending Physician <input type="text"/>		Signature & Date Signed _____	Illness Code
17. PHIC Accreditation No. <input type="text"/>		18. BIR/TIN No. <input type="text"/>	Reduction Code
19. Services Performed		20. Actual Professional Charges	
		Benefit Claim	
		Physician	Patient
		P	P
21. Name of Surgeon <input type="text"/>		Signature & Date Signed _____	Reduction Code
22. PHIC Accreditation No. <input type="text"/>		23. BIR/TIN No. <input type="text"/>	
24. Services Performed		25. Actual Professional Charges	
		Benefit Claim	
		Surgeon	Patient
Date of Operation <input type="text"/>		P	P
26. Name of Anesthesiologist <input type="text"/>		Signature & Date Signed _____	Reduction Code
27. PHIC Accreditation No. <input type="text"/>		28. BIR/TIN No. <input type="text"/>	
29. Services Performed		30. Actual Professional Charges	
		Benefit Claim	
		Physician	Patient
		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.

PART III - DRUGS AND MEDICINES

Generic name	Brand	Preparation (cap/sy/inj/tab with ml/mg/gm content)	Qty.	Unit Price	Actual Charges	Benefit Claim	
						Hospital	Patient
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
TOTAL							

NOTE: OFFICIAL RECEIPTS FOR DRUGS AND MEDICINES PURCHASED BY PATIENT MUST BE ATTACHED TO THIS CLAIM.

PART IV - X-RAY, LABORATORIES AND OTHERS

Particulars	Qty.	Unit Price	Actual Charges	Benefit Claim	
				Hospital	Patient
A. X-ray/Lab.					
1.					
2.					
3.					
4.					
5.					
B. Supplies					
1.					
2.					
3.					
4.					
5.					
C. Others					
1.					
2.					
3.					
4.					
5.					
TOTAL					

NOTE: OFFICIAL RECEIPTS FOR LABORATORY PROCEDURES PERFORMED OUTSIDE THE HOSPITAL DURING CONFINEMENT PERIOD MUST BE ATTACHED TO THIS CLAIM.

PART V - CERTIFICATION of PATIENT/MEMBER

I hereby certify that:

The amount of P _____ was deducted from the hospital charges.

The amount of P _____ was deducted from the professional fee charges.

The amount of P _____ was paid for medicines/lab. acquired outside the hospital during this confinement
(Official Receipts attached).

No deduction was made from the hospital charges.

No deduction was made from the professional fee charges.

_____ Date _____ Signature Over Printed Name of Patient/Member