PHILHEALTH

March 2003

TB-DOTS PACKAGE CLAIM FORM 5

(DATE RECEIVED)

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

1. PhilHealth Accreditation No.

2. Name of Hospital/DOTS Center

3. Address of Hospital/DOTS Center

No., Street | Barangay

Municipality/City | Province | Zip Code

4. Name of Member

Last Name | PIN

First Name

Middle Name

5. Address of Member

No., Street | Barangay

Municipality/City | Province | Zip Code

6. Name of Patient

Last Name

First Name

Middle Name

7. Age

8. Sex

☐ M

☐ F

9. Date of Registration Enrollment: _____

Date of Completion: _____

☐ intensive phase ☐ date of death _____

☐ maintenance

10. Diagnosis and ICD-10 Code:

11. CLASSIFICATION OF TB:

☐ Pulmonary

☐ Extra-Pulmonary site: _____

TYPE OF PATIENT:

☐ New ☐ Return After Default (RAD)

☐ Relapse ☐ Failure

☐ Trans. In ☐ Other

12. CATEGORY (tick box):

I. 6-SCC (2HRZE/4HR)

☐ New Case

☐ 1. Smear (+)

☐ 2. Seriously ill

☐ 2.1. Smear (-): MA or FA Radiographic lesion

☐ 2.2. Extra-pulmonary

II. 8-CC (2HRZES/5HRE)

☐ 1.Relapse ☐ 2.Failure

☐ 3. Return After Default (RAD) ☐ 4. Other (smear +)

III. 6-SCC (2HRZ/4HR)

☐ New Case

☐ 1. Smear (-): Minimal

☐ 2. Extra-pulmonary not seriously ill

13.CERTIFICATION of HOSPITAL/DOTS CENTER: I certify that the services rendered are duly recorded in the patient's chart and that the information in this form are true and correct.

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