Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8441-7442 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

RESEARCH DATA REQUEST FORM

A. REQUESTING PARTY

NAME		DATE
AGENCY/INSTITUTION		ADDRESS
TELEPHONE/FAX	MOBILE	EMAIL

B. RESEARCH DETAILS

TITLE OF THE STUDY		
OBJECTIVES OF THE STUDY		
DATA REQUEST (You may attach a dummy table or use a separate sheet.)		
Particulars	Applicable Period	Level of Disaggregation

Acknowledgement and Declaration

I declare that the information I have given on this form is true and correct in all regards. Any data received will be used only for the purpose for which it was disclosed and will be accessed only by those authorized to use it. I also agree to provide *Philippine Health Insurance Corporation (PhilHealth)* through its Corporate Planning Department copies (printed and e-copy) of my research study once completed.

_____
Name & Signature of Applicant

FOR PHILHEALTH USE:

Data Requested	Date Forwarded to Processing Unit	Date Received from Processing Unit	Date Released to Requesting Party
☐ Received copies of the research study.	Date Received	Date Appraised	Date Archived