PHILIPPINE HEALTH INSURANCE CORPORATION
City State Centre Bldg., 709 Shaw Blvd., Pasig City
Tel. 637-9999, 627-9852 to 81

May 29, 2000

PHILHEALTH CIRCULAR
No. 044, s-2000

TO All Accredited Professional and Institutional Health Care Providers, Members of the National Health Insurance Program, Employers in the Private and Government Sectors, Regional Health Insurance Offices, Claims Processing Departments in the Central Office and All Concerned

SUBJECT Revised PhilHealth Claim Forms 1,2 and 3

EFFECTIVE immediately, claims for Medicare benefit refunds should be made using the new set of PhilHealth Claim Forms 1,2 and 3 which were revised in May 2000 to accommodate changes in policies and procedures.

The new forms now include Part V in Form 2 which requires members to certify whether or not Medicare benefits were deducted from their hospital charges and from professional fees of doctors. Hospitals are urged to ensure compliance with the use of new forms and of the new procedures.

All hospitals are required to submit Claim Forms 1 and 2 for each qualified member availing of Medicare benefits. Primary category hospitals are also required to submit Form 3, although Secondary and Tertiary category hospitals may be required to submit the same form on a case-to-case basis, especially if data in Forms 1 and 2 are insufficient.

While some portions / spaces in the new forms may not necessarily reflect the existing coding numbers such as accreditation numbers and ID numbers, all concerned are encouraged to indicate the current numbers as deemed appropriate.

All accredited health care providers are given up to July 31, 2000 to adjust their computer systems' programs, consume existing forms and familiarize themselves with the new forms. Claims with admission date from August 1, 2000 not written in the new forms and received by this office and its branches nationwide will be denied.

Specific instructions on how Forms 1, 2 and 3 will be filled out are found in Annex "A.". We enjoin everyone to adopt the new PhilHealth Claim Forms 1,2 and 3 and ensure that Medicare benefits are properly availed of by members.

For strict implementation.

ENRIQUE M. ZALAMEA
President and CEO

PHILHEALTH

CLAIM FORM 1

Revised May 2000

Note: This form together with Claim Form 2 should be filed with PhilHealth within 60 calendar days from date of discharge.

(DATE RECEIVED)

PART I - MEMBER'S CERTIFICATION (Member to Fill in All Items/Indigent to be Assisted by Hospital Representative)

1. Type of Membership ☐ Employed:[ ]Private Sector [ ]Gov't. Sector ☐ Individually paying: [ ]Self-employed [ ]OFW [ ]Others [ ]OWWA
☐ Indigent ☐ Retiree/Pensioner: [ ]SSS [ ]GSIS [ ]Military [ ]Judiciary

Identification No.

2. Name of Member
Last Name
First Name
Middle Name

3. Date of Birth
m m d d y y y y

4. Civil Status
☐ Single ☐ Separated
☐ Married ☐ Widow/er

5. Sex
☐ Male
☐ Female

6. Address of Member
No., Street
Barangay
Municipality/City
Province
Zip Code

7. Name of Spouse
Last Name
First Name
Middle Name
☐ Not Applicable

8. Name of Patient ☐ Patient is the Member
Last Name
First Name
Middle Name

9. Date of Birth
m m d d y y y y

10. Age

11. Sex
☐ Male
☐ Female

12. Relationship of Patient to Member (Check applicable box if patient is a dependent)
☐ Legitimate spouse who is not an NHIP Member.
☐ Unmarried and unemployed, legitimate, legitimated, acknowledged and illegitimate or legally adopted/step child, below 21 years old.
☐ Parent who is 60 years old and above, not an NHIP member/retiree/pensioner and wholly dependent on me for support.
☐ Unmarried child 21 years old & above with physical/ mental disability, congenital or acquired and wholly dependent on me for support.

13. CERTIFICATION of MEMBER: I certify that the foregoing information are true and correct and that the three(3) applicable monthly contributions had been paid within six(6) month prior to the month of this confinement.

Signature of Member

If unable to write, affix **Right** thumbmark

Printed Name & Signature of Witness to Thumbmark

PART II - EMPLOYER'S CERTIFICATION (For employed members only)

14. Registered Name of Employer
Identification No. of Employer

15. Address of Employer (No., Street, Barangay/Municipality/City, Province, Zip Code)
No., Street
Barangay
Municipality/City
Province
Zip Code

16. CERTIFICATION of EMPLOYER: This is to certify that three(3) applicable monthly contributions were collected during the six(6) month period prior to the month of this confinement and that the ***data supplied by the member on Part I are true and conform with our available records.***

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

cut here

Member's Copy

This portion should be completely filled up, detached by the hospital and given to member

ACKNOWLEDGEMENT RECEIPT

Name of Member :
Name of Patient :
Name of Hospital :
Address of Hospital :

SSS/GSIS/MEC/PhilHealth No. :
Confinement Period :
PhilHealth Forms Received by :
Date :

PHILHEALTH

CLAIM FORM 2

Revised May 2000

Note: This form together with Claim Form 1 should be filed with PhilHealth within 60 calendar days from date of discharge.

HEALTH CARE PROVIDER'S CERTIFICATION

(DATE RECEIVED)

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

1. PhilHealth Accreditation No.
2. Accreditation Category ☐ Primary ☐ Secondary ☐ Tertiary ☐ Ambulatory
3. Name of Hospital/Ambulatory Clinic
4. Address of Hospital/Ambulatory Clinic
   No., Street | Barangay
   Municipality/City | Province | Zip Code
5. Name of Member and Identification
   Last Name | First Name
   Middle Name | Identification No.
6. Address of Member
   No., Street | Barangay
   Municipality/City | Province | Zip Code
7. Name of Patient
   Last Name
   First Name
   Middle Name
8. Age
9. Sex ☐ M ☐ F
10. Admission Diagnosis
11. Confinement Period
    a. Date Admitted (m m d d y y y y) | c. Date Discharged (m m d d y y y y) | e. Claimed No.of Days
    b. Time Admitted (AM/PM) | d. Time Discharged (AM/PM) | f. Date of Death (If Applicable) (m m d d y y y y)

12. Hospital/Ambulatory Services	ACTUAL HOSPITAL/ AMBULATORY CHARGES	BENEFIT CLAIM HOSPITAL	BENEFIT CLAIM PATIENT	REDUCTION CODE
a. Room and Board				
b. Drugs and Medicines (Part III for details)				
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

FOR PHILHEALTH USE
Relative Unit Value
Illness Code
Reduction Code

15. Case Type ☐ Ordinary ☐ Intensive ☐ Catastrophic
16. Name of Attending Physician — Signature & Date Signed
17. PHIC Accreditation No.
18. BIR/TIN No.
19. Services Performed
20. Actual Professional Charges — Benefit Claim: Physician | Patient
P | P | P

21. Name of Surgeon — Signature & Date Signed
22. PHIC Accreditation No.
23. BIR/TIN No.
24. Services Performed
Date of Operation
25. Actual Professional Charges — Benefit Claim: Surgeon | Patient
P | P | P

26. Name of Anesthesiologist — Signature & Date Signed
27. PHIC Accreditation No.
28. BIR/TIN No.
29. Services Performed
30. Actual Professional Charges — Benefit Claim: Physician | Patient
P | 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.

PHILHEALTH

(DATE RECEIVED)

CLAIM FORM 3

PATIENT'S CLINICAL RECORD

Revised May 2000

Note: This form should be filed with PhilHealth within 60 calendar days from date of discharge.

Case No.: _____

Admission:

Date: m m d d y y y y Time: : AM/PM

Name of Hospital/Ambulatory Clinic: Accreditation No.:

Address of Hospital/Ambulatory Clinic:

No., Street Barangay

Municipality/City Province Zip Code

PATIENT'S CLINICAL RECORD

1. Patient Name
   Last Name
   First Name
   Middle Name

2. Age

3. Sex
   ☐ Male
   ☐ Female

4. _____
   Printed Name & Signature of Admitting Officer

5. Admitting Diagnosis:

6. Chief Complaint:

7. Reason for Admission:

8. Brief History of Present Illness/OB History:

9. Physical Examination (Pertinent Findings per System)

General Survey:

Vital Signs: BP: _____ HR: _____ RR: _____ Temperature: _____

HEENT:

Chest/Lungs:

CVS:

Abdomen:

GU (IE):

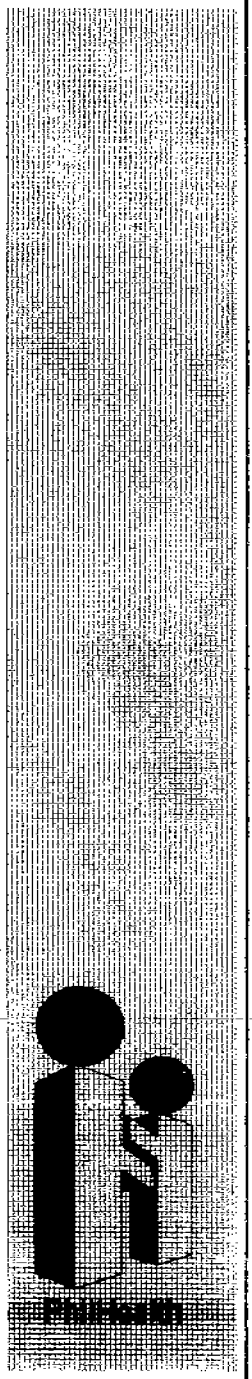
Skin/Extremities:

Neuro Examination:

Guidelines in Accomplishing the Revised PhilHealth Claim Forms

Annex to PhilHealth Circular No. 011 s. 2000

May 2000



Produced by the
Corporate Communications Office
for the
CLAIMS PROCESSING GROUP
Philippine Health Insurance Corporation
City State Centre Building, Shaw Blvd., Pasig City
NCR - 637-2677, 637-2679, P.O. Box 767 Manila CPO
Central Regions - 637-2874, 637-2879, P.O. Box 768 Manila CPO
or visit us at www.philhealth.gov.ph

Item No.	Instruction
	d. **Condition on Discharge** : indicate whether patient was discharged fully recovered, improved, unimproved or expired. Indicate also if the patient was transferred to another hospital or discharged against medical advice (AMA). e. **Signature of Attending Physician**: affix signature over printed or typewritten name. **Surgeon** to sign over printed or typewritten name in cases where surgical procedure was done on the patient. **Anesthesiologist** likewise to affix signature over printed or typewritten name.
14	Patient or his/her representative to affix signature or right thumbprint (in case both could not write) In case of thumprint, a witness must affix signature attesting to the thumbprint.

Patient's Clinical Record

Item No.	Instruction
1	Write the name of the patient starting with last (surname), first (given) and middle name.
2	Indicate the age of the patient at the time of admission.
3	Check appropriate box whether patient is male or female.
4	Admitting officer should sign over printed or typewritten name.
5	Indicate initial diagnosis of attending physician at the time of admission.
6	Indicate patient's primary symptom/s for seeking consultation.
7	State immediate indication/justification for admitting the patient. (Ex: for observation; for surgery; for further work-up; etc.)
8	Describe the chronologic development of symptoms including positives & negatives, prompting consultation as relayed by the patient or informant/guardian. For pregnant patients, include the complete obstetrical history and scoring.
9	Describe the signs including pertinent negative findings per organ system elicited during the conduct of physical examination.
10	Describe significant changes/developments in the patient condition on a day-to-day basis during the confinement.
11	Indicate pertinent/significant laboratory and diagnostic results. The temperature chart should also be attached.
12	Specify the exact procedure done including site and/or location & laterality. Indicate also the date & time the procedure or surgery was performed, and the type of anesthesia used on the patient, if any.
13	**Discharge data:** a. **Date:** indicate the month, day & year patient was discharged b. **Time:** indicate the exact time of discharge c. **Final Diagnosis:** indicate the final diagnosis relative to the history, clinical and laboratory findings.

GUIDELINES IN ACCOMPLISHING THE REVISED PHILHEALTH CLAIM FORMS

PHILHEALTH CLAIM FORM 1

One original duly accomplished copy should be submitted.

Part I: Member's Certification

This portion is to be filled up by the member. In case of indigent members, hospital representatives are requested to assist them in filling-out this form.

Item No.	Procedure
1	Check the appropriate box for the type of membership and write the corresponding ID number or PhilHealth number (including dash) appearing on the PhilHealth number/member card on the space provided for.
2	Write the name of the member starting with the last (surname), first (given name) and then middle name.
3	Enter date of birth of member indicating the exact month, day, and year.
4	Check appropriate box for civil status of the member at the time of patient's admission. "Separated" here means "legally separated".
5	Check the appropriate box whether member is male or female.
6	Write the complete home address of the member, indicating the house number, Street, Barangay, Municipality or City, Province & zip code.
7	For married member, write the name of the spouse (husband or wife) starting with the last, first and then middle names. For unmarried members, tick the "not applicable" box.
8	Write the name of patient if the patient is a dependent of the member. If the member is the patient, tick the box for "Patient is the member".
9	Enter patient's date of birth indicating the month (01 for January, 02 for February & so on), day & year.
10	Indicate the age of patient at the time of admission.
11	Check the appropriate box whether patient is male or female.
12	Check appropriate relationship of the patient to the member. This applies only to dependent-patients.

Item No.	Procedure
13	**Certification of Member that:** All information entered in Part I are true & correct. Three (3) applicable monthly contributions have been paid within the immediate six (6) month period prior to confinement. **Note:** *Member to affix thumbprint in case he/she could not sign due to illiteracy or physical disability. In case of thumbprint, a witness must affix signature printed/ typewritten name attesting to the thumbprint.*

Part II: Employer's Certification

This portion is to be filled up by employer if member is employed.

Item No.	Procedure
14	Write the complete registered name of employer and employer ID number.
15	Write the complete address of employer.
16	**Certification of Employer that:** Three (3) monthly contributions were collected and remitted during the immediate six (6) month period prior to the month of confinement. All information supplied by the member in Part I are true and conform with available records. **Important:** Employer's authorized representative must affix his signature over printed/typewritten name together with exact date (month, day & year) of certification and the official capacity of the authorized signatory.

Part III: Acknowledgement Receipt

Hospital representative should accomplish and detach this portion to be given to the member. This serves as proof that PhilHealth Claim Form 1 has been submitted to and received by the hospital.

The healthcare provider and the member should both be guided by the important provision at the back of Claim Form 1.

Column	Procedure
Actual Charges	Enter actual total amount per item (in the **Particulars** column) incurred by the patient during confinement.
Benefit claim there are two sub-columns under this item:	**Hospital** Enter PhilHealth/Medicare benefits deducted from the patient. **Patient** Enter net amount paid (per item) by the patient. These include all applicable X-ray and laboratories done and supplies used (including those performed and bought outside the hospital) during the confinement. **Important:** *All corresponding original official receipts of drugs & medicines, laboratory procedures done & supply bought outside the hospital should be attached to the claim.* **Note:** The provider may submit computer generated formats for Parts III & IV provided they conform with the information required by this form.

Part V : Patient/Member's Certification

The patient/member should tick appropriate box whether PhilHealth benefits were deducted from the actual hospital charges and professional services charges. The corresponding amount deducted should be accurately indicated. This portion should be signed by the patient/member after the settlement of the bill. The patient/member should affix signature over his/her printed name at the bottom right hand corner.

PHILHEALTH FORM 3 : PATIENT'S CLINICAL RECORD

One copy should be accomplished & submitted by Primary Category hospitals only. Secondary & tertiary hospitals may be required submission on a case to case basis.

Upper Right Hand Corner:

Indicate the case number of the patient based on hospital record.

Write the date (month, day & year) and time of admission.

Write the current hospital accreditation number.

Write the name of the hospital on the space provided for together with the complete mailing address.

Part III: Drugs & Medicines

Itemize all applicable drugs and medicines consumed during confinement. Use additional sheet if necessary.

Column	Procedure
Generic name	List the generic names of drugs and medicines used/consumed by the patient during confinement.
Brand	Write corresponding brand names of the drugs listed in the "generic name" column if applicable.
Preparations	Indicate corresponding preparation (capsule/syrup/tablet/ampule/vial with mg/ml content).
Quantity	Indicate total units consumed for each drug/medicine.
Unit price	Indicate cost per unit/piece for individual drug/medicine.
Actual Charges	Enter actual total amount per item (in the Generic column) incurred by the patient.
Benefit Claim there are two sub-columns under this item:	**Hospital** Enter PhilHealth/Medicare benefits deducted (per item in generic column) from actual total amount. **Patient** Enter net amount paid (per item) by the patient. Include all drugs & medicines bought outside the hospital if any.

Part IV : X-ray, Laboratories and Others

Use additional sheet if necessary

Column	Procedure
Particulars under this column are three (3) separate items	A. **X-ray/Laboratories**- list all X-ray and laboratory procedures performed on the patient including those done outside the hospital. B. **Supplies** - itemize all supplies used by the patient during confinement. C. **Others** - itemize other services or procedures done for the patient.
Quantity	Indicate corresponding frequency/number/units used per item listed in the **Particulars** column.
Unit Price	Indicate cost of each procedure done or item/piece used.

PHILHEALTH CLAIM FORM 2: Health Care Providers' Certification

One copy will be filled-up by the hospital and submitted together with PhilHealth Claim Form 1 and other supporting documents (as required) within sixty (60) calendar days from discharge of the patient.

Part I: Hospital Data and Charges

Hospital representatives must supply the necessary data including charges incurred by the patient during the confinement period.

Item No.	Procedure
1	Enter the hospital's current accreditation number.
2	Check appropriate box for the hospital accreditation category whether Primary (P), Secondary (S), Tertiary (T), or Ambulatory (A).
3	Write the official name of the hospital appearing in PhilHealth Accreditation Certificate.
4	Write the complete postal address of the hospital indicating the number, street, barangay, municipality or city, province and zip code.
5	Write the name of member starting with the last, first, and middle name and the identification number.
6	Write complete mailing address of member indicating the house number, street, barangay, municipality or city, province and zip code.
7	Write the full name of the patient starting with the last, first, and then middle name.
8	Write the age of the patient at the time of admission.
9	Check the appropriate box whether the patient is male or female.
10	Enter the physician's diagnosis of the patient's condition at the time of admission.
11	**Confinement period** - properly fill-in the following blanks: a. Month, day and year patient was admitted in the hospital b. Time of admission c. Month, day and year patient was discharged from the hospital d. Time the patient was discharged from the hospital e. Total number of confinement days being claimed f. Date of death in case the patient died during confinement

Item No.	Procedure
12	**Hospital/Ambulatory Services:** **Actual Hospital/Ambulatory Charges Column** Enter the actual total amount incurred by the patient during confinement per item of hospital charges (room & board, medicines, etc.). **Benefit Claim** There are two sub-columns under this item: **Hospital** Enter Medicare benefits deducted from the patient's actual charges (estimated to be equivalent to the amount that PhilHealth shall reimburse to the hospital). **Patient** Enter net amount per item paid (per item) by the patient including applicable medicines and supplies bought outside the hospital during confinement. *In cases where the patient paid the total actual amount, and direct reimbursement is requested, attach all applicable official receipts and/or hospital waiver.* ***All benefit claims should therefore, be reflected under the patient column.*** *The hospital column should be left blank.*
13	**Certification of hospital/Ambulatory Clinic:** Hospital's authorized representative shall affix his signature over printed name certifying that all information entered in the form and the services rendered are duly recorded in the patient's chart. Indicate also the official capacity of the signatory.

Part II: Professional Data and Charges

To be filled-out by respective doctors.

Item No.	Procedure
14	Enter complete final diagnosis of the patient's illness/injuries.
15	Check appropriate box indicating the case-type of the illness/injury whether ordinary, intensive or catastrophic.
16	Attending physician should affix his signature after the printed or typewritten name and indicate the date (month, day & year) of signing.

Item No.	Procedure
17	Enter the current PhilHealth Accreditation number.
18	Enter the BIR Taxpayer's Identification Number (TIN).
19	Write all applicable services performed on the patient. Use additional sheet if necessary.
20	There are two main columns under this item: **Actual Professional Charges** Enter actual total amount (professional fee) charged by the doctor for services rendered during confinement period. **Benefit Claim:** **Physician** - enter the Medicare benefits deducted from the total amount charged to the patient **Patient** - enter net amount paid by the patient for services rendered. ***If the patient paid the actual total amount of professional fee, the total payment should be reflected under the patient column.***
21	Surgeon should affix his signature after the printed or typewritten name. Indicate the date (month, day & year) of signing.
22	Enter the current PhilHealth Accreditation number.
23	Enter the BIR Taxpayer's Identification Number (TIN).
24	Write all applicable services performed on the patient. Use additional sheet if necessary.
25	Follow similar procedure as in item number 20 of this form.
26	Anesthesiologist should affix his signature after the printed or typewritten name. Indicate the date (month, day & year) of signing.
27	Enter the current PhilHealth Accreditation number.
28	Enter the BIR Taxpayer's Identification Number (TIN).
29	Write all applicable services performed on the patient. Use additional sheet if necessary.
30	Follow similar procedure as in item number 20 of this form.