Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre Building, 709 Shaw Blvd., Pasig City
Healthline 637-99-99 *www.philhealth.gov.ph*

PHILHEALTH CIRCULAR
No. 12 s.2010
July

TO : ALL ACCREDITED HEALTH CARE PROVIDERS (INSTITUTIONS AND PROFESSIONALS), ALL MEMBERS AND EMPLOYERS, ALL PHILHEALTH OFFICES AND ALL OTHERS CONCERNED

SUBJECT : ENHANCED PHILHEALTH CLAIM FORMS

For operational efficiency and to reduce administrative cost for both the Corporation and its partner stakeholders, the herein attached enhanced PhilHealth Claim Forms 1, 2 and 3 are issued. These forms shall be used for all types of claims to include confinements, packages and out-patient services.

For verification purposes, National Tuberculosis Program (NTP) card are still required for all TB-DOTS package claims. Providers are also advised to fill-out Part II of Claim Form 3 for Maternity Care Package (MCP) claims.

In order to give ample time to prepare and consume old forms, these forms shall be used for all types of reimbursements effective admission date September 1, 2010.

The new forms to include the guidelines on proper filling-out may be downloaded from the official Corporate website (www.philhealth.gov.ph)

All issuances inconsistent hereof are hereby effectively repealed accordingly.

For strict compliance.

DR. REY B. AQUINO
President and CEO

Date signed: 26 July 10

PHILHEALTH
MA. TERESA A. QUIAOIT
A.O. IV, Chief, RELMS
Date: 4/14/10
CERTIFIED TRUE COPY

PhilHealth
Your Partner in Health
10033012:40
OP-S10-29609

PhilHealth
Your Partner in Health

CF1

(Claim Form)
revised February 2010

IMPORTANT REMINDERS:

PLEASE WRITE IN **CAPITAL LETTERS** AND **CHECK** THE APPROPRIATE BOXES.
For **local confinement**, this form together with CF2 and other supporting documents should be filed within **60 DAYS** from date of discharge.
For **confinement abroad**, this form together with other supporting documents should be filed within **180 DAYS** from date of discharge.
Only one (1) original copy of this Form is required per claim application/availment.
All information required in this form are necessary and 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 - MEMBER and PATIENT INFORMATION

(Member/Representative to fill out all items with the assistance of the Health Care Provider)

1. PhilHealth Identification No. (PIN): ☐☐ – ☐☐☐☐☐☐☐☐☐ – ☐

2. Member Category:
☐ Employed ☐ Government ☐ Private
☐ Sponsored
☐ OFW
☐ Individually Paying
☐ Lifetime

3. Name of Member
Last Name First Name Middle Name (**example**: Dela Cruz, Juan Jr., Sipag)

4. Mailing Address:
(House Number & Name of Street) (Barangay)
(City / Municipality) (Province) (ZIP Code)

5. Date of Birth:
☐☐ – ☐☐ – ☐☐☐☐
(Month) (Day) (Year)

6. Contact Information (if available):
E-mail Address: _____ Mobile No.: _____ Landline No.: _____

7. Name of Patient:
Last Name First Name Middle Name (**example**: Dela Cruz, Juan Jr., Sipag)

8. ☐ Patient is the Member
☐ Patient is a Dependent
☐ Child ☐ Parent
☐ Spouse

9. CERTIFICATION OF MEMBER:

I hereby certify that the herein information are true and correct and may be used for any legal purpose.

Signature Over Printed Name of Member
☐☐ – ☐☐ – ☐☐☐☐
Date Signed (month-day-year)

Signature Over Printed Name of Member's Representative
☐☐ – ☐☐ – ☐☐☐☐
Date Signed (month-day-year)

10. Relationship of the Representative to the Member:
☐ Child ☐ Parent
☐ Spouse ☐ Guardian / Next of Kin

11. Reason for Signing on Behalf of the Member:
☐ Member is Abroad / Out-of-Town ☐ Member is Incapacitated ☐ Other Reasons: _____

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

1. PhilHealth Employer No. (PEN): ☐☐ – ☐☐☐☐☐☐☐☐☐ – ☐ 2. Contact No.: _____

3. Business Name and Official Address:
(Business Name of Employer)
(Building Number and Street Name)
(City / Municipality) (Province) (ZIP Code)

4. CERTIFICATION OF EMPLOYER:

This is to certify that all monthly premium contributions for and in behalf of the member, while employed in this company, including the applicable three (3) monthly premium contributions within the past six (6) months period prior to the first day of this confinement, have been deducted/collected and remitted to PhilHealth, and that the information supplied by the member or his/her representative on Part I are consistent with our available records.

Signature Over Printed Name of Employer / Authorized Representative | Official Capacity / Designation | ☐☐ – ☐☐ – ☐☐☐☐ Date Signed (month-day-year)

(For PhilHealth use only)

PhilHealth
Your Partner in Health

CF2

(Claim Form)
revised February 2010

Series # _____
(For PhilHealth use only)

IMPORTANT REMINDERS:

PLEASE WRITE IN CAPITAL **LETTERS** AND **CHECK** THE APPROPRIATE BOXES.
For **local confinement**, this form together with CF1 and other supporting documents should be filed within **60 DAYS** from date of discharge.
All information required in this form are necessary and 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 - PROVIDER INFORMATION (Institutional Health Care Provider to fill out items 1 to 13)

1. Name of Facility: _____

2. Address: _____

3. PhilHealth Accreditation No. **(PAN)**: _____
(Institutional Health Care Provider)

5. PhilHealth Identification No. **(PIN)**: _____ - _____ - _____
(Member)

4. Category of Facility:
☐ T-L4 /L3 ☐ ASC ☐ RHU
☐ S-L2 ☐ FDC ☐ TB DOTS
☐ P-L1 ☐ MCP ☐ _____ (OTHERS)

6. Name of Patient

Last Name First Name Middle Name (example: Dela Cruz, Juan Jr., Sipag)

7. Date of Birth ___ - ___ - _____ (month-day-year) 8. Age ____ Year/s ☐ Month/s ☐ Day/s ☐ 9. Sex ☐ Male ☐ Female

10. Confinement Period

a. Date Admitted: ___ - ___ - _____ (month-day-year)
b. Time Admitted: ____ AM ____ PM
e. No.of Days Claimed ____
c. Date Discharged: ___ - ___ - _____ (month-day-year)
d. Time Discharged: ____ AM ____ PM
f. In case of Death, specify date ___ - ___ - _____ (month-day-year)

11. Health Care Provider Services	Actual Charges	PhilHealth Benefit	For PhilHealth Use Only (Adjustments / Remarks)
a. Room and Board Private ☐ Ward ☐			
b. Drugs and Medicines (Part II for details)			
c. X-ray/Lab./Supplies & Others (Part III for details)			
d. Operating Room Fee			
TOTAL			
e. Benefit Package			

12. Case Type* ☐A ☐B ☐C ☐D
13. Complete ICD-10 Code/s _____
*This is only applicable for claims with fee for service payment mechanism

(Professional Health Care Providers to fill out items 14 to 16)

14. Admission Diagnosis	15. Complete Final Diagnosis

16. Professional Fees / Charges

a. Name of Professional b. PhilHealth Accreditation No.	c. Number of Visits / RVS Code d. Inclusive Dates (mm-dd-yyyy)	e. Total Actual PF Charges	f. PhilHealth Benefit	g. Amount paid by members	h. Signature i. Date Signed	For PhilHealth Use Only
_____ ___ - _____ - ___	_____ _____					
_____ ___ - _____ - ___	_____ _____					
_____ ___ - _____ - ___	_____ _____					
_____ ___ - _____ - ___	_____ _____					

Generic/Brand name	Preparation (dose/ cap/ syrup/ injectible /tab with ml/mg/gm content)	Qty	Unit Price	Actual Charges	PhilHealth Benefit
			TOTAL		

PART III - X-RAY, LABORATORIES, SUPPLIES AND OTHERS (use additional sheet if necessary)

Particulars	Qty	Unit Price	Actual Charges	PhilHealth Benefit
A. X-Ray (Imaging)				
B. Laboratories/Diagnostics				
C. Supplies and Others				
		TOTAL		

☐ Official receipts for drugs and medicines / supplies purchased by member from external sources as well as laboratory procedures done outside the hospital which are necessary for the confinement are attached to this claim.

PART IV - CERTIFICATION OF INSTITUTIONAL HEALTH CARE PROVIDER

I certify that services rendered were recorded in the patient's chart and hospital records and that the herein information given are true and correct.

The foregoing items and charges are in compliance with the applicable laws, rules and regulations.

Signature Over Printed Name of Authorized Representative

Official Capacity / Designation

Date Signed (month-day-year)

PART V - CONSENT TO ACCESS PATIENT RECORD/S

I hereby consent to the examination by PhilHealth of the patient's medical records for the sole purpose of verifying the veracity of this claim.

I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim for reimbursement before PhilHealth.

Signature Over Printed Name of Patient

Date Signed (month-day-year)

Signature Over Printed Name of Patient's Representative

Date Signed (month-day-year)

Relationship of the Representative to the Patient:

☐ Spouse ☐ Child ☐ Parent ☐ Guardian/ Next of Kin

Reason for Signing on Behalf of the Patient:

☐ Patient is Incapacitated ☐ Other Reasons: _____

PhilHealth
Your Partner in Health

CF3

(Claim Form)
revised February 2010

IMPORTANT REMINDERS:
THIS FORM SHOULD BE FILED TOGETHER WITH PHILHEALTH CLAIM FORMS 1 AND 2 WITHIN **60 CALENDAR DAYS** FROM DATE OF DISCHARGE.
FOR LEVEL 1 FACILITY, THIS FORM SHALL BE REQUIRED FOR ALL BENEFIT CLAIMS.
FOR LEVELS 2, 3 AND 4 FACILITIES, THIS FORM IS REQUIRED IN CASES OF: 1) EMERGENCY/TRANSFERRED 2) LESS THAN 24 HOURS ADMISSION 3) CASE TYPE 'D' DIAGNOSIS.
THIS FORM SHALL BE REQUIRED FOR ALL CLAIMS ON MATERNITY CARE PACKAGE.

PART I - PATIENT'S CLINICAL RECORD

1. PhilHealth Accreditation No. (PAN) - Institutional Health Care Provider: |_|_|_|_|_|_|_|_|_|_|_|_|

2. Name of Patient

Last Name, First Name, Middle Name (example: Dela Cruz, Juan Jr., Sipag)

3. Chief Complaint / Reason for Admission:

4. Date Admitted: |_|_| – |_|_| – |_|_|_|_| (Month – Day – Year) Time Admitted: |_|_| AM |_|_| PM (hh-mm)

5. Date Discharged: |_|_| – |_|_| – |_|_|_|_| (Month – Day – Year) Time Discharged: |_|_| AM |_|_| PM (hh-mm)

6. Brief History of Present Illness / OB History:

7. Physical Examination (Pertinent Findings per System)

General Survey:

Vital Signs : BP: _____ CR: _____ RR: _____ Temperature: _____

HEENT :

Chest/Lungs :

CVS :

Abdomen :

GU (IE) :

Skin/Extremities :

Neuro Examination :

8. Course in the Wards (attach additional sheets if necessary):

9. Pertinent Laboratory and Diagnostic Findings: (CBC, Urinalysis, Fecalysis, X-ray, Biopsy, etc.)

10. Disposition on Discharge: ☐ Improved ☐ Transferred ☐ HAMA ☐ Absconded ☐ Expired

PART II- MATERNITY CARE PACKAGE

PRENATAL CONSULTATION

1. Initial Prenatal Consultation ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year)

2. Clinical History and Physical Examination

a. Vital signs are normal ☐

c. Menstrual History LMP ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year) Age of Menarche _____

b. Ascertain the present Pregnancy is low-Risk ☐

d. Obstetric History G _____ P _____ (_____, _____, _____, _____) (T, P, A, L)

3. Obstetric risk factors

a. Multiple pregnancy	☐	d. Placenta previa	☐	g. History of pre-eclampsia	☐
b. Ovarian cyst	☐	e. History of 3 miscarriages	☐	h. History of eclampsia	☐
c. Myoma uteri	☐	f. History of stillbirth	☐	i. Premature contraction	☐

4. Medical/Surgical risk factors

a. Hypertension	☐	d. Thyroid Disorder	☐	g. Epilepsy	☐	j. History of previous cesarian section	☐
b. Heart Disease	☐	e. Obesity	☐	h. Renal disease	☐	k. History of uterine myomectomy	☐
c. Diabetes	☐	f. Moderate to severe asthma	☐	i. Bleeding disorders	☐		

5. Admitting Diagnosis _____

6. Delivery Plan

a. Orientation to MCP/Availment of Benefits ☐ yes ☐ no

b. Expected date of delivery ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year)

7. Follow-up Prenatal Consultation

a. Prenatal Consultation No.	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th
b. Date of visit (mm/ dd/ yy)											
c. AOG in weeks											
d. Weight & Vital signs:											
d.1. Weight											
d.2. Cardiac Rate											
d.3. Respiratory Rate											
d.4 Blood Pressure											
d.5. Temperature											

DELIVERY OUTCOME

8. Date and Time of Delivery Date ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year) Time ☐☐ AM ☐☐ PM (hh-mm)

9. Maternal Outcome: _____ Obstetric Index; Pregnancy Uterine, _____ AOG by LMP; _____ Manner of Delivery; _____ Presentation

10. Birth Outcome: _____ Fetal Outcome; _____ Sex; _____ Birth Weight (grm); _____ APGAR Score

11. Scheduled Postpartum follow-up consultation 1 week after delivery ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year)

12. Date and Time of Discharge Date ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year) Time ☐☐ AM ☐☐ PM (hh-mm)

POSTPARTUM CARE

	done	Remarks
13. Perineal wound care	☐	
14. Signs of Maternal Postpartum Complications	☐	
15. Counselling and Education		
a. Breastfeeding and Nutrition	☐	
b. Family Planning	☐	
16. Provided family planning service to patient (as requested by patient)	☐	
17. Referred to partner physician for Voluntary Surgical Sterilization (as requested by pt.)	☐	
18. Schedule the next postpartum follow-up	☐	

19. Certification of Attending Physician/Midwife:

I certify that the above information given in this form are true and correct.

_____
Signature Over Printed Name of Attending Physician/Midwife

☐☐ ☐☐ ☐☐☐☐
Date Signed (Month / Day / Year)

GUIDELINES ON THE PROPER ACCOMPLISHMENT OF REVISED PHILHEALTH CLAIM FORMS 1, 2, & 3

I. General Guidelines applicable to all Claim Forms:

1. Claim Form 1 (CF1) and Claim Form 2 (CF2) shall be accomplished and submitted for ALL claim applications except for confinement abroad.
2. All CF shall be accomplished using capital letters and by checking the appropriate boxes. All items should be marked legibly by using ballpen or sign pen only.
3. Names should be written starting with last, first and middle name and should be separated by a comma. Extensions such as (but not limited to the following) Jr., Sr., III should be indicated after the first name.

   Illustration:

DELA CRUZ,	*JUAN JR.,*	*SIPAG*
Last name	*First Name*	*Middle Name*

4. All dates should be filled out following this format:

   MONTH-DAY-YEAR (MM-DD-YYYY).

   Illustration:

   July 27, 2010 should be written as ***07/27/2010***

5. Time should be filled out using this format: HOUR: MINUTE (HH:MM) following the 12-hour convention. It should be indicated in the appropriate box whether AM (morning) or PM (afternoon and evening).

   Illustration:

   Nine fifteen in the morning should be written as ***09:15 AM***

6. PhilHealth Identification No. (PIN) and PhilHealth Employer No. (PEN) should be filled out following the 2-9-1 format.

   Illustration: ***12-123456789-1***

7. PhilHealth Accreditation No. (PAN) for institutions and professionals should be filled out following the prescribed formats.

   Illustration for institutions:

   Hospitals -H12345678, ASC– A12345678, MCP-M12345,

   TB DOTS - T12345 and FDC- D12345

   Illustration for professionals: ***1234-1234567-1***

8. For local confinement, supporting documents together with CF1 and CF2 should be filed with PhilHealth within 60 days from date of discharge, e.g.,:

   - Member Data Record
   - MI5 (for individually paying members)
   - PhilHealth ID (for OFW, Lifetime Member and Sponsored Program Member)

II. Specific Guidelines:

A. Claim Form 1 (CF1)

CF1 is divided into two parts:

Part I - Member and Patient Information requires information about the member and patient to ascertain the identity of the member/patient/dependent for eligibility to PhilHealth benefits.

Part II - Employer's Certification (for employed members' only) provides the basic information about the employer and contains the certification of qualifying contributions and correctness of the information supplied by the member.

The tables below explain the proper way of accomplishing CF1:

Part I - Member and Patient Information (Member/ Representative to fill out items 1 to 11)

Item No.	Description and Instruction
1	**PhilHealth Identification Number (PIN)** Write the member's PhilHealth Identification Number (PIN), a 12 digit number, as reflected in the PhilHealth Number Card/Identification Card/Member Data Record (MDR). *Illustration:* *07-123456789-1* In case the PIN is not known, the member is advised to: a. Inquire from any PhilHealth office; or b. Seek information from employer (for employed members)
2	**Member Category** Check the appropriate box for the current membership category whether: Employed (government/private), Individually Paying; Sponsored; OFW & Lifetime.
3	**Name of Member** Write the complete name of the member starting with last, first and middle name. It should be separated by a comma. Extensions such as (but not limited to the following) Jr., Sr., III should be indicated after the first name. *Illustration:* *Name with Suffix:* *The name Juan Sipag Dela Cruz, Jr. should be written as* *DELA CRUZ, JUAN JR., SIPAG* *Last name / First Name / Middle Name* In case the name is different from what is registered with PhilHealth (per MDR) the member is advised to attach supporting documents (birth certificate or marriage contract as applicable) for updating of MDR.
4	**Mailing Address** *(This is the address where the Benefit Payment Notice [BPN] will be mailed to)* Write the complete address of the member, indicating the house number, name of street, barangay, municipality or city, province and zip code.
5	**Date of Birth** Write the date of birth of member following the prescribed format for date.
6	**Contact Information** Write the member's contact information such as email address, mobile number and landline number, if available.

7	**Name of Patient** Write the complete name of the patient starting with last, first and middle name. It should be separated by a comma. Extensions such as (but not limited to the following) Jr., Sr., III should be indicated after the first name.
8	**Patient is the Member** If patient is the member, check the appropriate box and then proceed to item 9. **Patient is a Dependent** If patient is a dependent (to be filled out if patient is dependent) Check the appropriate box if patient is a child, spouse or parent of the member. Reminder: If patient is legal dependent of the member, the patient's name should appear in the MDR. If not, attach applicable supporting documents as proof of dependency.
9	**Certification of Member** **Signature over printed name of member** The member affixes his/her signature over printed name certifying that all information supplied in Part I are true and correct and granting consent to PhilHealth to use the supplied information for any legal purpose. In case the member is a minor or a survivor-child, a representative (legal guardian) will also countersign using the member representative portion. If the legal guardian is not duly indicated in the MDR, a copy of a judicial order shall be attached to the claim. **Date signed** The member indicates the date when he/she signed the certificate following the prescribed format for date. **Signature over printed name of member's representative** An authorized representative of the member may sign on his/her behalf. **Date signed** The authorized representative of the patient indicates the date when he/she signed on behalf of the patient following the prescribed format for date.
10	**Relationship of the Representative to the member** Check the appropriate box whether the representative of the member is his/her child (must be 18 years old and above), spouse, parent and guardian/next of kin.
11	**Reason for signing on behalf of the member** Indicate the reason for signing on behalf of the member such as: (1) Member is Abroad / Out-of-Town; (2) Member is incapacitated and (3) Other reasons. For other reasons, please specify.

Part II - Employer's Certification (for employed members' only)

1	**PhilHealth Employer No. (PEN)** Write the PhilHealth Employer Number (PEN) as reflected in the Certificate of Registration (CoR).
2	**Contact Number** Write the contact number (landline and/or mobile number) of the employer.
3	**Business Name and Official Address:** Write the Business Name (as reflected in the Certificate of Registration [CoR]) of the employer and the official address starting with building number, street name, city/municipality, province and zip code.
4	**Certification of Employer (for employed members only)** **Signature over printed name of employer/ authorized representative:** The employer or his/her authorized representative shall affix his/her signature certifying that all monthly premium contributions for and in behalf of the member, while employed in their company, including the applicable three (3) monthly premium contributions have been deducted/collected and remitted to PhilHealth during the past six (6) month period prior to the first day of confinement and the information supplied by the member or his/her representative are consistent with their available records. **Official capacity/designation:** The employer or authorized representative shall indicate his/her official capacity/designation. **Date signed:** The employer/authorized representative shall indicate the date when he/she signed the claim form in the following the prescribed format for date.

For PhilHealth use only	**This box/portion shall be for the use of PhilHealth.**

B. Claim Form 2 (CF2)

Part I – Health Care Provider Information

This portion contains the following information:

a. hospital information needed by PhilHealth to ascertain the hospital accreditation
b. patient information
c. confinement period
d. admission diagnosis and complete final diagnosis
e. a summary of health care services with corresponding hospital charges and amount of PhilHealth benefit deducted
f. information on the professional health care provider needed by PhilHealth to ascertain the accreditation status
g. summary of services performed with corresponding RVS codes, inclusive dates, actual professional charges and amount of PhilHealth benefit deducted

Part II - Drugs and Medicines

This contains the detailed list of the medicines and drugs administered to the patient including generic names,preparation, quantity, unit price and corresponding actual charges and amount of PhilHealth benefit deducted.

Part III - X-Ray, Laboratories, Supplies and Others

This contains the details on the imaging services, laboratory procedures done, supplies used with corresponding quantity and actual charges and amount of PhilHealth benefit deducted.

Part IV - Certification of Institutional Health Care Provider

This ascertains that the services rendered to the patient are duly recorded in the patient's chart and hospital records and that all information pertaining to the particular claim are true and correct as certified by the authorized representative.

Part V - Consent to Access Patient Records
This contains the consent voluntarily given by the patient for verification of the veracity of information relative to the evaluation and reimbursement of the claim.

The following tables below explain the proper way of accomplishing CF2:

Part I - HEALTH CARE PROVIDER INFORMATION

Institutional Health Care Provider to fill out items 1 to 13

Item No.	Description and Instruction
1	**Name of Facility** Write the complete name of facility in capital letters as indicated in the accreditation certificate.
2	**Address** Write the complete address of the facility.
3	**PhilHealth Accreditation No. (PAN) (For Institutional Health Care Provider)** Write the current accreditation number of the facility. For multiple accreditation, indicate the accreditation number of the facility applicable to the benefit claim. e.g., Hospital A, a tertiary hospital categorized as accredited hospital and TB DOTS facility, claiming for TB-DOTS package, the PAN for TB-DOTS facility should be written.
4	**Category of Facility** Check the appropriate box for the category of the facility whether: • Tertiary- L4/L3 (T-L4/L3) • Secondary-Level2 (S-L2) • Primary-Level 1 (P-L1) • Ambulatory Surgical Clinic (ASC) • Freestanding Dialysis Clinic (FDC) • Maternity Care Package provider (MCP) • Rural Health Unit (RHU) • TB DOTS • Others (for non-accredited facility) If the facility has multiple accreditations, e.g., accredited hospital and TB DOTS facility, accredited RHU and TB DOTS facility , accredited RHU, TB DOTS facility and MCP (3 in 1 accreditation), check the appropriate box applicable to the benefit claim.
5	**Member's PhilHealth Identification No. (PIN) (for member)** Write the Member's PhilHealth Identification Number (PIN) following the 2-9-1 format.
6	**Name of Patient** Write the complete name of the patient starting with last, first and middle name. It should be separated by a comma. Extensions such as (but not limited to the following) Jr., Sr., III should be indicated after the first name.
7	**Date of Birth** Write the date of birth of patient following the prescribed format.
8	**Age** Write the age of the patient at the time of admission and check appropriate box whether the age is in year/s, month/s or day/s.
9	**Sex** Check appropriate box whether patient is male or female.
10 10a,10b 10c,10d	**Confinement Period** Date Admitted; Time Admitted; Date Discharged; Time Discharged Write the confinement period to include the date and time of admission and discharge following the prescribed formats for date and time. **For TB-DOTS Package:** • For patient on intensive phase, indicate the Registration Date as date admitted (item 10a) following the prescribed format for date. • For patient on maintenance phase, indicate the Start Date of maintenance phase as date admitted (item 10a) following the prescribed format for date. • Write NA (Not Applicable) in time admitted, date and time discharged. **For Outpatient Malaria Package:** • Date admitted corresponds to the date of the start of treatment. • Date discharged corresponds to the date of the last day of treatment. • Write NA (Not Applicable) in time admitted and time discharged.
10e	**No. of Days Claimed** Write the number of days claimed. In computing the number of days claimed exclude the day of admission and include the day of discharge. *Illustration:* <u>For in-patient cases:</u> Admission Date: January 1, 2010 Discharge Date: January 13, 2010 No. of Days Claimed: 12 Days <u>For out-patient cases:</u> Admission Date: January 7, 2010 Discharge Date: January 7, 2010 No. of Days Claimed: 1
10f	**In case of death, specify date** In case of death of patient during confinement period, specify the date of death in the appropriate box following the prescribed format for date.
11	**Health Care Provider Services** Indicate the amount of the following items accordingly: • "Actual charges" refers to the total amount charged by the health care provider (HCP) for every benefit item. • "PhilHealth benefit" refers to the amount that will be reimbursed to the HCP by PhilHealth. The same represents deduction made from the patient's actual charge as member's benefit.
11a	For item 11a **Room** and **Board**, check appropriate box whether private or ward.

11e	• Private – refers to a single occupancy room or with less than three beds per room divided by either a permanent or semi-permanent partition. • Ward – refers to a room with three or more beds. For benefit packages not requiring itemization PHIC benefit should be indicated in 11e.
12	**Case Type** Check the appropriate box of the correct illness case type whether A,B,C or D. This is only applicable for claims with fee-for-service payment mechanism.
13	**Complete ICD-10 Codes** Write the complete ICD 10 code/s of the patient's diagnosis. The first code indicated should be the primary illness. The succeeding codes shall represent co-morbidities.

Professional Health Care Provider to fill out items 14 to 16

14	**Admission Diagnosis** Write the admission diagnosis.
15	**Complete Final Diagnosis** Write the complete final diagnosis of patient's illness/injuries including the main diagnosis and other co-morbidities. Provide the following information, as applicable: a The etiologic agent (e.g., Escherichia coli) in diagnosing infections; b For benign and malignant tumors, indicate the site, morphology and behaviour. c. In diagnosing injuries, provide the nature of the injury, and if possible, the place of occurrence and the activity of the one injured during the time of the incident. d. When diagnosing poisoning or adverse reaction cases, specify the offending agent (e.g., drug, chemical). e. Specify if a condition is a late effect or sequelae of another condition (e.g., pulmonary fibrosis sequelae of PTB). For multiple conditions, the main or primary condition must be the first diagnosis that should be written. e.g., Patient X is diagnosed with acute pyelonephritis with concomitant hypertension and diabetes *Complete Final Diagnosis:* acute bacterial pyelonephritis, hypertension controlled, diabetes mellitus controlled
16 16a, 16b	**Professional Fees/Charges** **Name of Accredited Professional and PhilHealth Accreditation No.** Write the name/s of professional health care provider/s who attended and provided services to the patient with corresponding PhilHealth accreditation number/s in the boxes provided.
16c, 16d	**No. of Visits/ RVS Code and Inclusive Dates** Indicate the following services rendered to the patient by the professional Medical Case – • Indicate if daily visits with inclusive dates • Indicate if preoperative inpatient consultation (CP Clearance) inclusive dates
	Surgical case – • Indicate the appropriate RVS code and date of operation/procedure. • Anesthesia services – Indicate the type of anesthesia services given and date of service/ procedure.
	Professional Health Care Services Indicate the amount of the following items accordingly:
16e	• "Total Actual Professional Fee Charges" refers to the total amount of the professional fee charged by the health care professional to the patient before deduction of PhilHealth Benefit.
16f	• "PhilHealth benefit" refers to the amount that will be reimbursed to the professional by PhilHealth. The same represents deduction made from the patient's actual charge as member's benefit.
16g	• "Amount paid by member" refers to the payment made by the member after deduction of PhilHealth benefit. This represents the excess amount shouldered by the member. If full payment was made, indicate the amount equivalent to actual professional charges.
16h/i	**Signature/Date Signed -** • The professional who actually rendered the services shall sign in the box provided and indicate the date of signing following the prescribed format for date.

Part II - Drugs and Medicines
List down drugs and medicines used/consumed during confinement.

- Indicate the generic name and the corresponding brand name of the drug
  Illustration: amoxicillin (Amoxil);
- Indicate corresponding preparation (dose,cap/tab in mg; syrup/suspension in mg/ml; amp/vial in mg/ml);
- Indicate total quantity used (piece, ampule, vial, etc);
- Indicate the amount per unit;
- "Actual charges" refers to the actual amount charged by the facility for every item.
- "PhilHealth benefit" refers to the total amount of benefits for all drugs and medicines.
- Indicate the total amount of actual charges and PhilHealth Benefits for all drugs and medicines
- For benefit packages not requiring itemization, only the total amount of PHIC benefit should be indicated.

Part III - X-ray, Laboratories, Supplies and Others
Indicate all diagnostic procedures (imaging, laboratory tests, etc.) done and supplies and other items used during confinement.

- Indicate total number of procedures/items.
- Indicate the amount per item;
- "Actual charges" refers to the total amount charged by the facility for every item or service rendered;
- "PhilHealth benefit" refers to the total amount of "benefits for x-ray, laboratories, supplies and others.
- Indicate the total amount for columns Actual Charges and PhilHealth Benefit

Note: Check the box provided if official receipts for drugs and medicines/supplies purchased by member from external sources as well as laboratory procedures done outside the hospital, which are necessary for the confinement, are attached to the claim.

Part IV- Certification of Institutional Health Care Provider

Signature over Printed Name of Authorized Representative

The authorized representative shall write his/her printed name and affix his/her signature certifying that the services rendered were recorded in the patient's chart and hospital records and the given information given are true and correct.

Official capacity/Designation
Write the official capacity/designation of the signatory.

Date signed
Write the date of signing following the prescribed format for date.

Part V - Consent to Access Patient Records
Signature over Printed Name
The patient shall write his/her name and affix his/her signature signifying consent to PhilHealth's verification of the veracity of the information contained in the claim.

Date Signed
Write the date of signing following the prescribed format for date.

Signature Over Printed Name of Patient's Representative
The authorized representative of the patient may sign on behalf of the patient.

Date Signed
Write the date of signing following the prescribed format for date.

Relationship of the Representative to the Patient
Write the relationship of the representative to the patient by checking the appropriate box whether spouse, child for majority age, parent or guardian/next of kin.

Reason for Signing on Behalf of the Patient
Indicate the reason for signing on behalf of the patient whether patient is incapacitated or due to other reasons (specify).

C. Claim Form 3 (CF3) (To be filled out by accredited Health Care Provider)

This claim form will support the information supplied in the Claim Form 2 and shall be used in the evaluation of proper case type determination especially type D cases, emergency cases and less than 24 hour admissions.

This is mandatory in:

- Level 1 facilities;
- Case type D;
- Maternity Care Package;
- Emergency/ Transferred cases, and
- Less than 24-hour confinement

Part I - Patient's Clinical Record
This is the basis of PhilHealth to ascertain the patient's clinical history, pertinent physical examination findings, laboratory & diagnostic findings and disposition upon discharge.

Part II Maternity Care Package
This provides the information about the prenatal consultation, delivery outcome and postpartum care of the patient.

CF3 is not required in other PhilHealth benefit packages such as Newborn Care Package, Voluntary Surgical Contraception, Outpatient Malaria and TB-DOTS, regardless of facility level.

The tables below explain the proper way of accomplishing CF3:

Part I Patient's Clinical Record

Item No.	Description/Procedure
1	**PhilHealth Accreditation Number (PAN)** This refers to the current accreditation number of the institutional health care provider assigned by PhilHealth. For multiple accreditation, indicate the accreditation number of the facility applicable to the benefit claim. Write PAN following the prescribed format.
2	**Name of Patient** Write the complete name of the patient starting with last, first and middle name. It should be separated by a comma. Extensions such as (but not limited to the following) Jr., Sr., III should be indicated after the first name.
3	**Chief Complaint/ Reason for Admission** Indicate patient's chief complaint for seeking consultation and/or reason for admission.
4	**Date Admitted** Write the date when the patient was admitted following the prescribed format for date. **Time Admitted** Write the time when the patient was admitted following the prescribed format for time.
5	**Date Discharged** Write the date when the patient was discharged following the prescribed format for date. **Time Discharged** Indicate the time when the patient was discharged following the prescribed format for time.
6	**Brief History of Present Illness** Indicate the chronological events of present illness including all signs and symptoms, prompting consultation and subsequent confinement as described by the patient /guardian/informant.
7	**Physical Examination** Indicate the objective findings including pertinent negative findings per organ system elicited during the conduct of the physical examination.
8	**Course in the Wards** Indicate significant changes/progress on the patient's condition during confinement. May add additional sheets if necessary.
9	**Pertinent Laboratory and Diagnostic Findings** Indicate all significant laboratory results and diagnostic findings.

10	**Disposition on Discharge** Check the appropriate box for the disposition whether the patient was discharged Improved, Transferred, Home Against Medical Advice (HAMA), Absconded or Expired.

Part II Maternity Care Package (MCP)
CF3 Part II shall be accomplished for MCP claims and must be submitted together with CF1 and CF2.

Item No.	Description/ Procedure
	PRENATAL
1	**Initial Prenatal Consultation** Write the date of the initial prenatal consultation of the patient following the prescribed format for date.
2 2a	**Clinical History and Physical Examination** **Vital signs are normal** Check the box provided if the vital signs of the patient are normal.
2b	**Ascertain the present pregnancy is low risk** Check the box provided if present pregnancy is low risk.
2c	**Menstrual History** Indicate the date of Last Menstrual Period (LMP) following the prescribed format for date and Age of Menarche.
2d	**Obstetric History** Write the Obstetric Score of the patient by indicating the number of pregnancy/pregnancies (G) and the number of pregnancy/pregnancies that reached viability (P). The next four (4) blanks correspond to pregnancy outcome (*Term, Preterm, Abortion and Living*) *Illustration*: A mother on her third pregnancy has had 2 deliveries to two (2) live, term offspring with no history of abortion. The obstetric score shall be: **G3P2 (2 0 0 2)**
3	**Obstetric Risk Factors** Check the appropriate box if patient has any of the following obstetric risk factors: a. Multiple pregnancy b. Ovarian cyst c. Myoma uteri d. Placenta previa e. History of 3 miscarriages f. History of stillbirth g. History of pre-eclampsia h. History of eclampsia i. Premature contraction
4	**Medical/ Surgical Risk Factors** Check the appropriate box if patient has any of the following medical/surgical risk factors: a. Hypertension b. Heart Disease c. Diabetes d. Thyroid disorder e. Obesity f. Moderate to Severe Asthma g. Epilepsy h. Renal disease i. Bleeding disorders j. History of previous caesarian section k. History of uterine myomectomy
5	**Admitting Diagnosis** Write the admitting diagnosis of the patient.
6 6a 6b	**Delivery Plan** **Orientation to MCP/ Availment of Benefits** Check the appropriate box whether or not orientation on MCP Package /Availment of Benefits was provided to the patient. **Expected date of delivery** Write the expected date of delivery following the prescribed format for date.
7 7a 7b 7c 7d	**Follow-up Prenatal Consultation** **Prenatal Consultation Number** This corresponds to the subsequent prenatal consultations of the patient. **Date of visit (MM/DD/YY)** Write the date of prenatal consultation as MM/DD/YY. *Illustration:* The prenatal visit was done on July 26, 2010; the date should be written as 07/26/10. **Age of Gestation (AOG) in weeks** Compute for age of gestation in weeks and write in the appropriate box corresponding to the date of consultation. **Weight & Vital signs** Write the weight and vital signs such as cardiac rate, respiratory rate, blood pressure and temperature corresponding to the consultation.
	DELIVERY OUTCOME
8	**Date and Time of Delivery** Write the date and time of delivery following the prescribed format for date and time.
9	**Maternal Outcome** Write the maternal outcome as to: • **Obstetric Index**-Indicate the Obstetric Index e.g., G3P3 (3003) • **AOG by LMP**- Indicate the Age of Gestation (AOG) in weeks based on the Last Menstrual Period (LMP). • **Manner of Delivery** – Indicate the manner of delivery (NSD, assisted) • **Presentation**- Indicate the presentation of the fetus (cephalic, breech, compound)
10	**Birth Outcome** Write the birth outcome of the fetus as to: • **Fetal Outcome** – Indicate whether the fetus is alive ("live") or not such as "fetal death" or "stillbirth". • **Sex** – Indicate the sex of the fetus whether female or male • **Birth weight** – Indicate the birth weight of fetus in grams

	• **APGAR Score** – Indicate the APGAR score of the fetus on the first minute and five (5) minutes thereafter as to Appearance, Pulse, Grimace, Activity and Respiration.
11	**Scheduled Postpartum follow-up consultation 1 week after delivery** Write the scheduled postpartum and newborn care follow-up consultation following the prescribed format for date.
12	**Date and Time of Discharge** Write the date and time when patient was discharged following the prescribed formats for date and time.
	POSTPARTUM CARE
13	**Perineal wound care** Check the box provided if perineal wound care was done. Write significant findings, if any, in the remarks.
14	**Signs of Maternal Postpartum complications** Check the box for any sign of maternal postpartum complications. Write significant findings, if any, in the remarks.
15 15a,15b	**Counselling and Education** Breastfeeding and Nutrition; Family Planning Check the box if counselling and education was provided to the patient on Breastfeeding and Nutrition and Family Planning. Use remarks portion, if any.
16	**Family Planning Service to patient (as requested by patient)** Check the box if family planning service was provided to the patient as requested. Use remarks portion, if any.
17	**Referred to partner physician for Voluntary Surgical Sterilization (as requested by patient)** Check the box if patient was referred to partner physician for voluntary surgical sterilization as requested. Use remarks portion, if any.
18	**Schedule the next postpartum follow-up** Check the box if patient was scheduled for the next postpartum follow-up. Use remarks portion, if any.
19	**Certification of Attending Physician/Midwife** **Signature Over Printed Name of Attending Physician/Midwife** The attending physician or midwife writes name and signs certifying that the information provided in the form are true and correct. **Date signed** Write the date of signing following the prescribed format for date.