GUIDELINES ON THE PROPER ACCOMPLISHMENT OF PHILHEALTH CLAIM FORM 2 (November 2013)

I. General Guidelines applicable to all Claim Forms:

1. Claim Form 2 (CF2) shall be accomplished and submitted for ALL claim applications except for confinement abroad.
2. CF2 shall be accomplished using capital letters and by checking the appropriate boxes. All items should be marked legibly by using ballpen only.
3. CF2 with incomplete information shall not be processed and shall be returned to sender for compliance.
4. Names should be written starting with last name, first name, name extension and middle name. 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* *Name Extension* *Middle Name*
5. All dates should be filled out following this format: MONTH-DAY-YEAR (MM-DD-YYYY).

   Illustration: December 25, 2013 should be written as ***12 - 25 - 2013***
6. 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.*** *Nine fifteen in the evening should be written as* ***09:15 PM not*** **21:15.**
7. PhilHealth Identification No. (PIN) and PhilHealth Employer No. (PEN) should be filled out following the 2-9-1 format.

   Illustration: ***12-123456789-1***
8. 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***
   FDC - D12345

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

II. Specific Guidelines:

A. Claim Form 2 (CF2)

CF2 is divided into four (4) parts:

Part I – Health Care Institution (HCI) Information

This portion contains the following information:

1. PhilHealth Accreditation Number (PAN)
2. Name of HCI
3. Address

Part II – Patient Confinement Information

This portion contains the following information:

1. Name of patient
2. Referral of patient by another HCI
3. Confinement Period
4. Patient Disposition
5. Type of Accommodation
6. Admission Diagnosis/es
7. Discharge Diagnosis/es
8. Special Considerations
9. PhilHealth Benefits
10. Professional Fees/Charges

Part III – Certification of Consumption of Benefits and Consent to Access Patient Record/s

A. Certification of Consumption of Benefits

This ascertains the following:

1. PhilHealth benefit is enough to cover HCI and PF charges. No purchases of drugs/medicines, supplies, diagnostics, and co-pay for professional fees by the member/patient.
   - **a.** Total HCI Fees
   - **b.** Total PF
   - **c.** Grand Total
2. The benefits of the member/patient was completely consumed prior to co-pay OR the benefit of the member/patient is not completely consumed BUT with purchases/expenses for drugs/medicines, supplies, diagnostics and others.
   a. Total co-pay for the following:
      1) Total Health Care Institution Fees (Total Actual Charges, Amount after Application of Discount [i.e., personal discount, Senior Citizen/PWD], PhilHealth Benefit and Amount after PhilHealth Deduction)
      2) Total Professional Fee/s (for accredited and non-accredited professionals) (Total Actual Charges, Amount after Application of Discount [i.e., personal discount, Senior Citizen/PWD], PhilHealth Benefit and Amount after PhilHealth Deduction)

   b. Purchases/Expenses **NOT** included in the Health Care Institution Charges
      1) Total cost of purchase/s for drugs/medicines and/or medical supplies bought by the patient/member within/outside the HCI during confinement
      2) Total cost of diagnostic/laboratory examinations paid for by the patient/member done within/outside the HCI during confinement

B. Consent to Access Patient Record/s

This ascertains the following:

1. Consent to the examination by PhilHealth of the patient's medical record for the sole purpose of verifying the veracity of the claim and holding PhilHealth or any of its officers, employees and/or representatives free from any and all liabilities relative the herein mentioned consent which the patients have voluntarily and willingly given in connection with the claim for reimbursement before PhilHealth.
2. Conforme through signature of member/patient/authorized representative.
3. Date Signed
4. Relationship of the representative to the member/patient and reason for signing on behalf of the member/patient.
5. Space for thumbmark (for patient/representative who is unable to write)

Part IV – Certification of Health Care Institution

The tables below explain the proper way of accomplishing CF2:

Part I – Health Care Institution (HCI) Information
Health Care Institution to fill out items 1 to 3

Item	Description and Instruction
1	**PhilHealth Accreditation No. (PAN) of Health Care Institution** Write the current accreditation number of the facility. For multiple accreditations, 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.

Item	Description and Instruction
2	**Name of Health Care Institution** Write the complete name of HCI in capital letters as indicated in the accreditation certificate.
3	**Address** Write the complete address of the HCI.

Part II – Patient Confinement Information

Item	Description and Instruction
1	**Name of Patient** Write the complete name of the member starting with last name, first name, name extension and middle name. 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*** (*Last name*) ***JUAN*** (*First Name*) ***JR.*** (*Name Extension*) ***SIPAG*** (*Middle*)
2	**Patient was referred by another HCI** Check the box provided if the patient is referred by another HCI or not. Fill out the following information: ☐ Name of the referring HCI ☐ Building Number ☐ Street Name ☐ City/Municipality ☐ Province ☐ Zip Code
3	**Confinement Period** a. Date Admitted b. Time Admitted c. Date Discharged d. Time Discharged Write the confinement period to include the date and time of admission and discharge following the prescribed formats for date and time. Check the appropriate box whether the time admitted/discharged is AM or PM.
4	**Patient Disposition** Check the appropriate box (select only one) if patient's disposition was improved, recovered, home/discharged against medical advise, absconded, expired (specify the date, time of death and check the appropriate box whether the patient's time of expiration is AM or PM) and transferred/referred. Check the box and fill out the following information if the patient was transferred/referred to another HCI. ☐ Name of the referring HCI ☐ Building Number ☐ Street Name ☐ City/Municipality ☐ Province ☐ Zip Code ☐ Reason/s for referral/transfer

Item	Description and Instruction
5	**Type of Accommodation** Check appropriate box whether patient's type of accommodation is Private or Non-private (charity/service) Definition: □ Private – refers to a single occupancy room or with less than three beds per room divided by either a permanent or semi-permanent partition. □ Non-private (charity/service/ward) – refers to a room with three or more beds.
6	**Admission Diagnosis/es** Write the admission diagnosis/es
7	**Discharge Diagnosis/es** Write the complete diagnosis/es of patient's illness/injuries including the ICD-10 code/s, related procedure/s (if there's any), RVS code and date of procedure. Check the boxes provided for the appropriate laterality of said procedure/s (left, right or both).
8	**Special Considerations** a. Check the box provided if the claim is based on the following repetitive procedures: □ Hemodialysis □ Peritoneal Dialysis □ Radiotherapy (LINAC/COBALT) □ Blood Transfusion □ Brachytherapy □ Chemotherapy □ Simple Debridement Enumerate in the line provided the procedure and session dates. b. For Z benefit package, write the applicable Z benefit package code as the basis for benefit reimbursement.

Instructions for Selected Benefits

a. Maternity Care Package

CF2 Parts/Items	Description of items	What to write
Part II, item 2	Referred by another HCI	Tick "YES" if referred from another institution (BHS, RHU 1 etc). Write the name of referring institution.
Part II, item 3a/3b	Date/Time Admitted	Date and time of admission.
Part II, item 3c/3d	Date discharged/Time Discharged	Date and time of discharge
Part II, Item 6	Admission diagnosis/es	Diagnosis/es including other conditions
Part II, Item 7	Discharge diagnosis/es	Write the complete diagnosis/es including other medical conditions, previous procedures/surgery (s/p).

CF2 Parts/Items	Description of items	What to write
Part II, Item 8 (item c)	Special Considerations	Write the dates of all four (4) pre natal check-ups If more than four check-ups, write at least four with the 1st one the earliest and the last, the latest.

b. TB DOTS Package:

CF2 Parts/Items	Description of items	What to write
Part II, item 2	Referred by another HCI	Tick "YES" if referred from another institution. Write the name of referring TB DOTS Center.
Part II, item 3a	Date Admitted	Date when the patient started treatment (not the date when the NTP card was opened.) Leave the time admitted blank.
Part II, item 3c	Date Discharged	Date when the patient finished treatment. In case of claim for intensive phase, write the date when the last dose of intensive phase was given.
Part II, Item 6	Admission Diagnosis/es	Write diagnosis including the classification (pulmonary and extrapulmonary) and type of patient (new, RAD, retreatment etc)
Part II, Item 7	Discharge Diagnosis/es	Diagnosis and the outcome of treatment (cured, defaulted, completed treatment)
Part II, Item 8 (item d)	Special Considerations	Tick if claim is for intensive or for maintenance phase
Part II, Item 9	PhilHealth Benefits	Write the appropriate package code. No claim for second case rate

c. Animal Bite Treatment Package

CF2 Parts/Items	Description of items	What to write
Part II, item 2	Referred by another HCI	Tick "YES" if referred from another institution. Write the name of referring institution.
Part II, item 3a/3b	Date/Time Admitted	Date and time of 1st visit.
Part II, item 3c/3d	Date discharged/Time Discharged	Date and time of last visit.
Part II, Item 6	Admission diagnosis/es.	Write the admission diagnosis/es including the category of bite.
Part II, Item 7	Discharge diagnosis/es	Write the discharge diagnosis/es including the category of bite.
Part II, Item 8 (item e)	Special Considerations	Write the dates when the following doses were given (Day 0 ARV, Day 3 ARV, Day 7, RIG and Others).

d. Newborn Care Package

CF2 Parts/Items	Description of items	What to write
Part II, item 2	Referred by another HCI	Tick "YES" if referred from another institution (BHS, RHU 1 etc). Write the name of referring institution.
Part II, item 3a/3b	Date/Time Admitted	Date and time of admission.
Part II, item 3c/3d	Date discharged/Time Discharged	Date and time of discharge
Part II, Item 6	Admission diagnosis/es	Write the admission diagnosis/es.
Part II, Item 7	Discharge diagnosis/es	Write the complete diagnosis/es.
Part II, Item 8 (item f)	Special Considerations	Tick the services given Definition: The four time-bound interventions of essential newborn care refer to the following: 1. Immediate drying of the newborn 2. Early skin to skin contact 3. Timely cord clamping 4. Non-separation of the mother and baby for initiation of breastfeeding

e. Outpatient HIV/AIDS Treatment Package: Write the required Laboratory Number in the line provided.

f. Chemotherapy: A cycle is a course of treatment wherein medications are administered followed by a rest period. It varies based on type of cancer, drugs used, and patient's response to treatment. Examples of cycles are:

Day 1 every 21 days
Days 1-3 every 14 days
Day 1 every 14 days
Days 1-5 every 28 days
Day 1, Day 8 every 21 days
Day 1, Day 8 every 28 days
Day 1, Day 8, Day 15 every 28 days

In CF2, under Item 8a, the cycle number and the dates covering the chemotherapy cycle should be written on the blank. For example, Patient A is scheduled for chemotherapy using the 'day 1, day 8 every 28 days' cycle, with day 1 on January 1, 2014.

First chemotherapy claim of Patient A:

☑ Chemotherapy cycle 1: 01-01-2014, 01-08-2014

Second chemotherapy claim of Patient A:

☑ Chemotherapy cycle 2: 01-29-2014, 02-05-2014

Items no. 9 and 10 below are the continuation of Part II (Patient Confinement Information)

Item	Description and Instruction
9	**PhilHealth Benefits** Write the ICD-10 or RVS code of the 1st and 2nd case rate.
10	**Professional Fees/Charges (use additional CF2 if necessary)** **Accreditation Number, Name of Accredited Health Care Professional, Date Signed and Details** The primary attending professional health care provider and among others who attended and provided services to the patients shall write/affix his/her name and signature with corresponding PhilHealth accreditation number/s in the box/es and line/s provided. **Date Signed** Write the date of signing following the prescribed format for date. **Details** Check the box/es provided if there is no Co-pay on top of PhilHealth Benefit or vice versa (with Co-pay on top of PhilHealth Benefit)

Part III - Certification of Consumption of Benefits and Consent to Access Patient Record/s

NOTE: Member/Patient should sign only after the applicable charges have been filled-out

A. Certification of Consumption of Benefits

1. Check the applicable box/es and fill out the table provided if:
   - PhilHealth benefit is enough to cover HCI and PF charges. No purchases of drugs/medicines, supplies, diagnostics, and co-pay for professional fees by the member/ patient. Fill out the following fields in the table provided:
     - Total Actual Charges*****: Total Health Care Institution Fees, Total Professional Fees and Grand Total
   - The benefit of the member/patient was completely consumed prior to co-pay OR the benefit of the member/patient is not completely consumed BUT with purchases/expenses for drugs/medicines, supplies, diagnostics and others. Fill out the following fields in the table provided:

   a. The total co-pay for the following are:
      - Total Health Care Institution Fees (Total Actual Charges*****, Amount after application of discount [i.e., personal discount, Senior Citizen/PWD], PhilHealth Benefit and Amount after PhilHealth Deduction).
      - Total Professional Fee/s (for accredited and non-accredited professionals) (Total Actual Charges*****, Amount after Application of Discount [i.e., personal discount, Senior Citizen/PWD], PhilHealth Benefit and Amount after PhilHealth Deduction)

*****NOTE: *Total Actual Charges Should be based on Statement of Account (SOA)*

b. Purchases/Expenses **NOT** included in the Health Care Institution Charges:
   - Total cost of purchase/s for drugs/medicines and/or medical supplies bought by the patient/member within/outside the HCI during confinement.
   - Total cost of diagnostic/laboratory examinations paid for by the patient/member done within/outside the HCI during confinement.

B. Consent to Access Patient Record/s

1. Signature Over Printed Name of Member/Patient/Authorized Representative)
   Write the signature over printed name of member/patient/authorized representative.
2. Date Signed
   Write the date of signing following the prescribed format for date.
3. Check the applicable box/line provided for the relationship of the representative to the member/patient and reason for signing on behalf of the member/patient. Please specify the other reasons in the line provided.
4. Check the appropriate box provided. If the patient/representative is unable to write, put right thumbmark on the space provided (Patient/Representative should be assisted by an HCI representative)

Part IV- Certification of Health Care Institution

Signature Over Printed Name of Authorized HCI 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 health care institution records and the 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.