

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION

Citystate Centre Building, 709 Shaw Boulevard, Pasig City
Healthline 441-7444 www.philhealth.gov.ph



PHILHEALTH CIRCULAR

No. 006, s-2013

TO : ACCREDITED HEALTH CARE PROVIDERS (AHCPs), INDIVIDUALLY PAYING MEMBERS (IPMs), OVERSEAS FILIPINO WORKERS (OFWs), EMPLOYERS FROM THE PRIVATE AND GOVERNMENT SECTOR, SPONSORS, PHILHEALTH REGIONAL/BRANCH/ LOCAL HEALTH INSURANCE OFFICES, AND ALL OTHERS CONCERNED

SUBJECT : PNB stamped Allied Bank Bills Payment Slip as proof of PhilHealth premium payment

Relative to the merger of the Philippine National Bank (PNB) and Allied Banking Corporation, PhilHealth paying members are advised that premium contributions remitted at Allied Bank branches will be acknowledged with a ***“PNB stamped” Allied Bank bills payment slip*** effective **09 February 2013**.

As such, the PNB stamped Allied Bank bills payment slip shall be recognized as proof of PhilHealth premium payments when ***duly validated*** with the required payment information as prescribed in PhilHealth Circular No. 08,s.2011 (please see Annex A for the sample PhilHealth Premium Payment Slip (PPPS) and validated PNB stamped Allied Bank bills payment slip for reference).

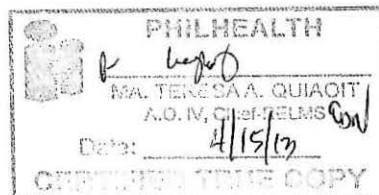
Please be guided accordingly.

ENRIQUE T. ONA, M.D.


Secretary of Health/Chairman of the Board and
OIC, President and CEO

4/11/13

Date signed



Annex A Figure 1: "PhilHealth Premium Payment Slip (PPPS)"

PHILHEALTH PREMIUM PAYMENT SLIP  *Your Partner In Health*


PIN/ PEN/ POGN:

BUSINESS/AGENCY NAME: _____


MEMBER'S NAME: (SURNAME) (GIVEN NAME) (MIDDLE NAME)

MEMBER TYPE
 Voluntary OFW Secured Private Government

APPLICABLE PERIOD
 FROM TO

AMOUNT PAID 

Annex A Figure 2: "PNB stamped" Allied Bank Bills Payment Slip



Transaction Date →

Member/Employer Name →

PIN/PEN →

Amount Paid →

Applicable Period →

→

→

→

THIS PAYMENT IS FOR
 PESO BILLING DOLLAR BILLING DATE _____

COMPANY NAME _____

CARDING/SUBSCRIBER'S NO./ POLICY/PLAN/REF NUMBER _____

PAYOR'S NAME _____

MODE OF PAYMENT:
 CASH ON US LOCAL REGIONAL DEBIT ACCOUNT

BANK/INITIALS/BRANCH	CHECK NUMBER	AMOUNT	TYPE

PLEASE INDICATE CASH BREAKDOWN AT THE BACK

DEBIT MY ACCOUNT NO.

AMOUNT IN WORDS _____

ACCOUNT HOLDER'S SIGNATURE: _____

POSTED BY	APPROVED BY	Teller	Supervisor

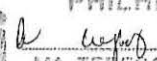
PAYMENT SLIP

RECEIVED BY TELLER

TRANSACTION/RECEIPT NO. →

MEMBER TYPE →

PHILHEALTH


 MA. TERESA A. QUIAOIT
 A.O. IV, Chief-RELMS

Date: 4/15/13

FOR THE TRUE COPY