



Republic of the Philippines  
**PHILIPPINE HEALTH INSURANCE CORPORATION**

Citystate Centre Building, 709 Shaw Boulevard, Pasig City  
 Healthline 441-7444 [www.philhealth.gov.ph](http://www.philhealth.gov.ph)



**PHILHEALTH CIRCULAR**

No. ~~0016~~, s-2013

*July*  
 TO

: INDIVIDUALLY PAYING MEMBERS (IPMs), ACCREDITED HEALTH CARE PROVIDERS, PHILHEALTH REGIONAL OFFICES, BRANCHES, AND ALL OTHERS CONCERNED

SUBJECT : Revised Bayad Center Payment Transaction Form as proof of PhilHealth premium payment

Effective **June 1, 2013**, CIS Bayad Center including their affiliates shall acknowledge premium payments from Individually Paying Members (IPM) with PhilHealth Identification Number (PIN) using the *Revised Bayad Center Transaction Form*.

As such, the *Revised Bayad Center Payment Transaction Form* shall be recognized as proof of PhilHealth premium payments when **duly validated** with the required payment information as prescribed in PhilHealth Circular No. 16,s.2010 (please see Annex A for the sample *Revised Bayad Center Payment Transaction Form* for ready reference).

Please be guided accordingly.

**ALEXANDER A. PADILLA**  
 President and CEO

*7/4/13*

Date signed





# TRANSACTION FORM

Please provide all required information below

1 → Account Name (Surname, Given Name, Middle Name)

2 → Present Address

3 ← Contact No.

**TRANSACTION DETAILS**

4 →  Bills Payment  Others

5 → Biller:  Date:  6 ←

Amount Due:  Due Date:

SOA/Invoice No.:  Statement Date:

Account Number:

**FOR GOVERNMENT TRANSACTIONS ONLY**

7 → ID Number:

8 → Payment Type:  Contribution  Short Term Loan  Real Estate

9 → Payor Type:  SE  VM  OFW  Others

Loan Acct No.:  Loan Type:

10 → Applicable Month(s) From  To  Year:

11 → Contribution/Month:  Total Amount:  12 ←

**PAYMENT DETAILS**

Cash  Check  Cash & Check  Credit Card

Cash Pnp:  Check No.:

Check Pnp:  Bank:

Total Pnp:  Branch:

Credit Card No.:  Expiry date:

**DECLARATION:** The information provided above and attachments hereto submitted have been examined and found to be correct to the best of my knowledge, based on my Laws and Regulations applicable. This is declared that this BAYAD CENTER is authorized to accept and process payments and documents submitted through its branches.

Signature over printed name 13 ←

**Machine Validation**  
This will serve as your receipt when machine validated

PhilHealth 183708000000100001 04/04/13 10:30AM  
 PFM000230450903 Applicable Month: Jul 2013 - Jul 2013  
 ESR: 500.00 CMI: 0.00 SVC FEE: 00.00 # irenepatilla/0000 1-000000103000  
 THANK YOU FOR PAYING AT BAYAD CENTER.

# ANNEX A

How to fill-out the Bayad Center Transaction Form:		
Field No.	Field Name	Required Information
1	Account Name	Name of the Individually Paying Member (IPM)
2	Present Address	IPM's present address (Optional)
3	Contact No.	IPM's contact no. (Optional)
4	Type of Transaction	Check ( ) "Bills Payment"
5	Biller	Write "PHILHEALTH"
6	Date	Date of Payment
7	ID Number	IPM's Philhealth Identification Number (PIN)
8	Payment Type	Check ( ) Contribution
9	Payor Type	Check ( ) SE for Self Employed or ( ) VM for Voluntary Member
10	Applicable Month/s and Year	Applicable month/period
11	Contribution/Month	Contribution amount per month (Ex. P150.00/month)
12	Total Amount	Total amount of contribution for payment
13	Signature	Signature of IPM/Authorized representative

