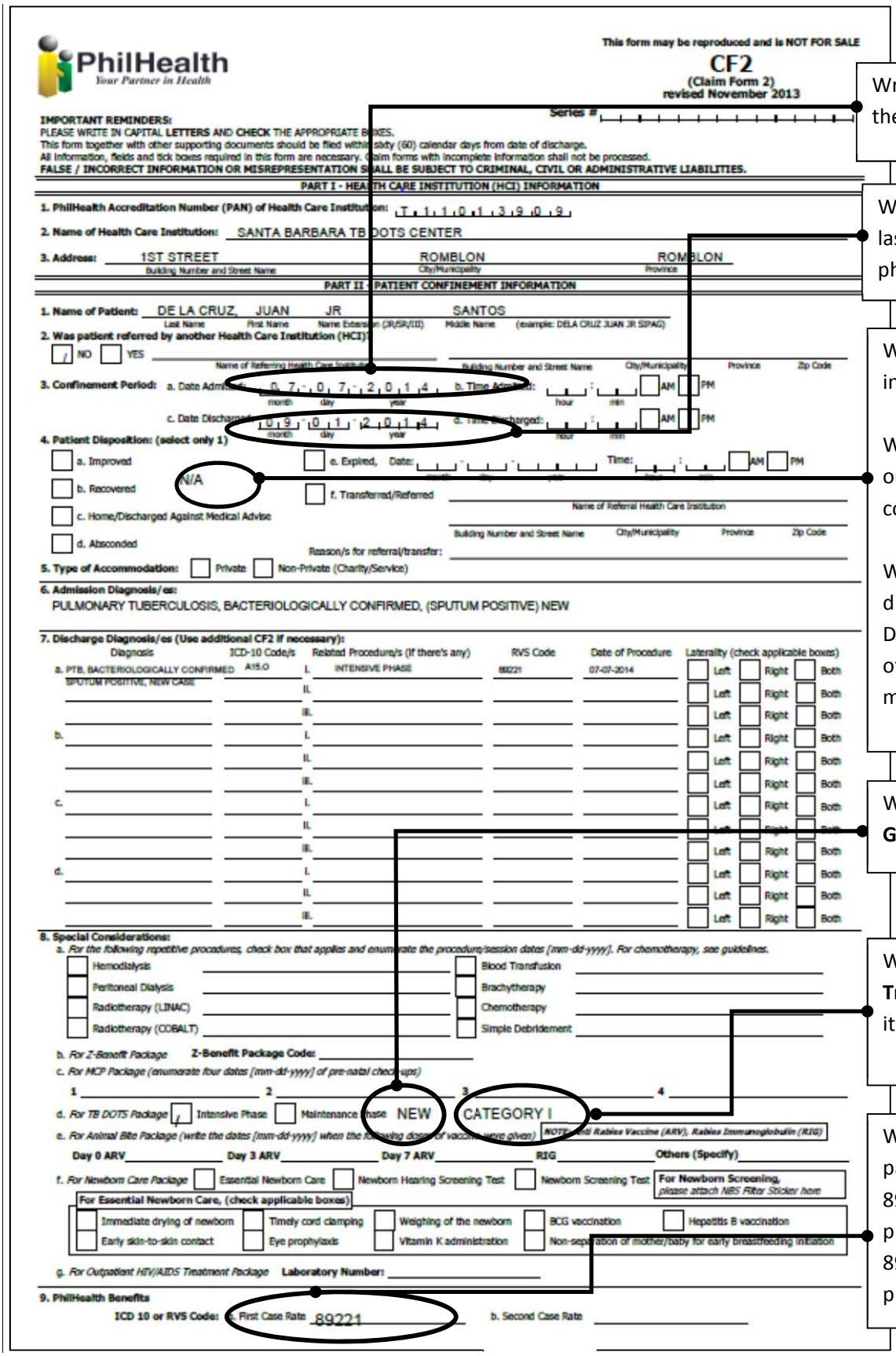
ANNEX 4 - SAMPLE CLAIM FORM 2



PhilHealth
Your Partner in Health

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CF2
(Claim Form 2)
revised November 2013

Series #

IMPORTANT REMINDERS:
PLEASE WRITE IN CAPITAL **LETTERS** AND **CHECK** THE APPROPRIATE BOXES.
This form together with other supporting documents should be filed within sixty (60) calendar days from date of discharge.
All information, fields and tick boxes required in this form are necessary. 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 - HEALTH CARE INSTITUTION (HCI) INFORMATION

1. **PhilHealth Accreditation Number (PAN) of Health Care Institution:** 1 1 0 1 3 9 0 9
2. **Name of Health Care Institution:** SANTA BARBARA TB DOTS CENTER
3. **Address:** 1ST STREET (Building Number and Street Name) ROMBLON (City/Municipality) ROMBLON (Province)

PART II - PATIENT CONFINEMENT INFORMATION

1. **Name of Patient:** DE LA CRUZ (Last Name) JUAN (First Name) JR (Name Extension (JR/SR/III)) SANTOS (Middle Name) (example: DELA CRUZ JUAN JR SIPAG)
2. **Was patient referred by another Health Care Institution (HCI)?** / NO ☐ YES (Name of Referring Health Care Institution) (Building Number and Street Name) (City/Municipality) (Province) (Zip Code)
3. **Confinement Period:** a. Date Admitted: 0 7 (month) - 0 7 (day) - 2 0 1 4 (year) b. Time Admitted: (hour) : (min) ☐ AM ☐ PM
   c. Date Discharged: 0 9 (month) - 0 1 (day) - 2 0 1 4 (year) d. Time Discharged: (hour) : (min) ☐ AM ☐ PM
4. **Patient Disposition: (select only 1)**
   ☐ a. Improved ☐ e. Expired, Date: (month) - (day) - (year) Time: : ☐ AM ☐ PM
   ☐ b. Recovered N/A ☐ f. Transferred/Referred (Name of Referral Health Care Institution)
   ☐ c. Home/Discharged Against Medical Advise (Building Number and Street Name) (City/Municipality) (Province) (Zip Code)
   ☐ d. Absconded Reason/s for referral/transfer:
5. **Type of Accommodation:** ☐ Private ☐ Non-Private (Charity/Service)
6. **Admission Diagnosis/es:**
   PULMONARY TUBERCULOSIS, BACTERIOLOGICALLY CONFIRMED, (SPUTUM POSITIVE) NEW
7. **Discharge Diagnosis/es (Use additional CF2 if necessary):**

	Diagnosis	ICD-10 Code/s	Related Procedure/s (If there's any)	RVS Code	Date of Procedure	Laterality (check applicable boxes)
a.	PTB, BACTERIOLOGICALLY CONFIRMED SPUTUM POSITIVE, NEW CASE	A15.0	I. INTENSIVE PHASE	89221	07-07-2014	☐ Left ☐ Right ☐ Both
			II.			☐ Left ☐ Right ☐ Both
			III.			☐ Left ☐ Right ☐ Both
b.			I.			☐ Left ☐ Right ☐ Both
			II.			☐ Left ☐ Right ☐ Both
			III.			☐ Left ☐ Right ☐ Both
c.			I.			☐ Left ☐ Right ☐ Both
			II.			☐ Left ☐ Right ☐ Both
			III.			☐ Left ☐ Right ☐ Both
d.			I.			☐ Left ☐ Right ☐ Both
			II.			☐ Left ☐ Right ☐ Both
			III.			☐ Left ☐ Right ☐ Both

8. **Special Considerations:**
   a. *For the following repetitive procedures, check box that applies and enumerate the procedure/session dates (mm-dd-yyyy). For chemotherapy, see guidelines.*
   ☐ Hemodialysis ☐ Blood Transfusion
   ☐ Peritoneal Dialysis ☐ Brachytherapy
   ☐ Radiotherapy (LINAC) ☐ Chemotherapy
   ☐ Radiotherapy (COBALT) ☐ Simple Debridement
   b. *For Z-Benefit Package* **Z-Benefit Package Code:**
   c. *For MCP Package (enumerate four dates [mm-dd-yyyy] of pre-natal check-ups)*
   1 2 3 4
   d. *For TB DOTS Package* / Intensive Phase ☐ Maintenance Phase NEW CATEGORY I
   e. *For Animal Bite Package (write the dates [mm-dd-yyyy] when the following dose of vaccine were given)* *NOTE: Anti Rabies Vaccine (ARV), Rabies Immunoglobulin (RIG)*
   Day 0 ARV **Day 3 ARV** **Day 7 ARV** **RIG** **Others (Specify)**
   f. *For Newborn Care Package* ☐ Essential Newborn Care ☐ Newborn Hearing Screening Test ☐ Newborn Screening Test **For Newborn Screening,** *please attach NBS Filter Sticker here*
   For Essential Newborn Care, (check applicable boxes)
   ☐ Immediate drying of newborn ☐ Early skin-to-skin contact ☐ Timely cord clamping ☐ Eye prophylaxis ☐ Weighing of the newborn ☐ Vitamin K administration ☐ BCG vaccination ☐ Non-separation of mother/baby for early breastfeeding initiation ☐ Hepatitis B vaccination
   g. *For Outpatient HIV/AIDS Treatment Package* **Laboratory Number:**
9. **PhilHealth Benefits**
   ICD 10 or RVS Code: a. First Case Rate 89221 b. Second Case Rate

Write the start date of the treatment phase

Write the date of the last day of treatment phase

Write NA if still intensive phase

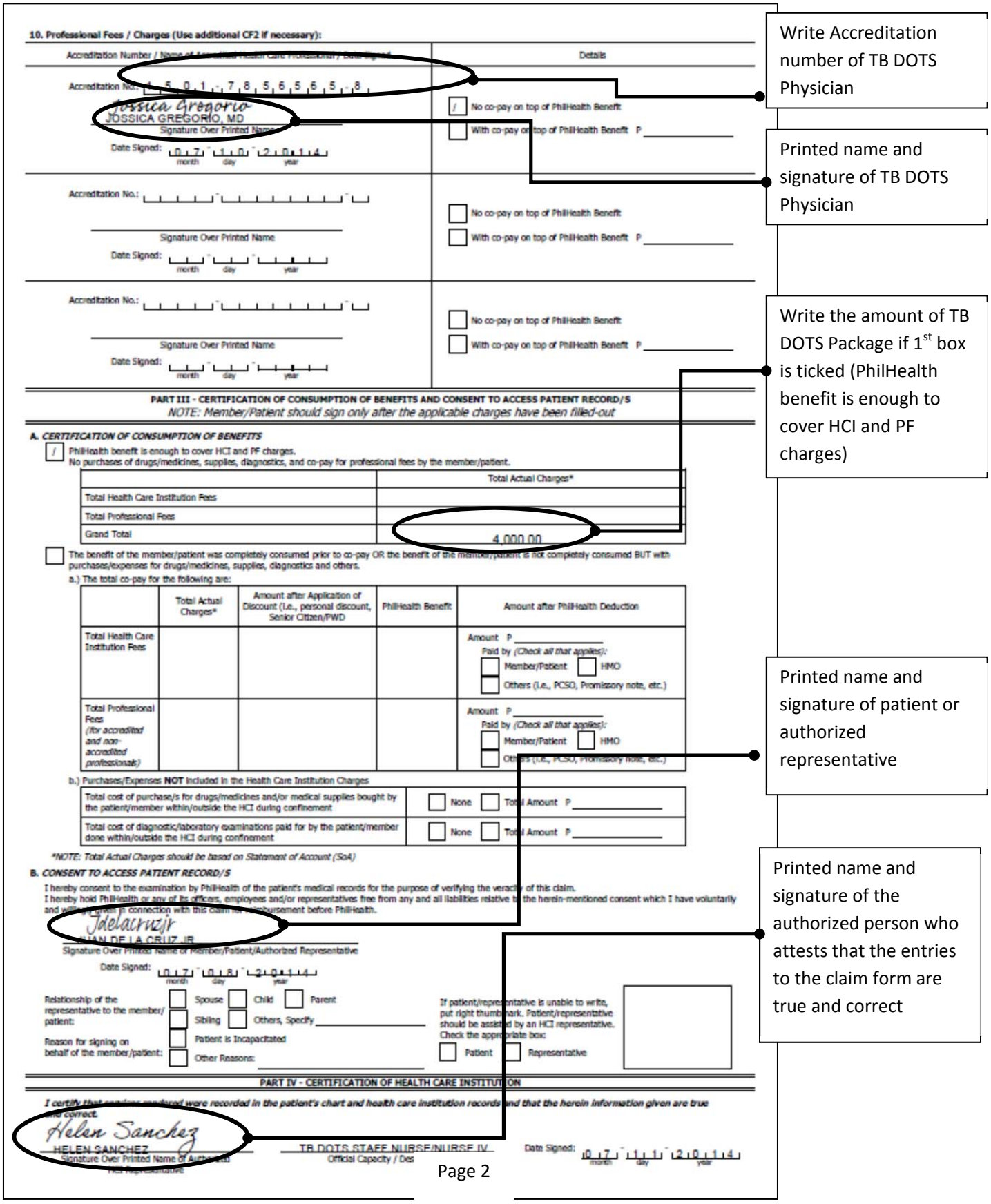
Write the treatment outcome if in continuation phase

Write DRTB if diagnosed to have DRTB during the course of treatment before 5th month of treatment

Write the **Registration Group i**n Part II, item 8d

Write the **Category of Treatment** in Part II, item 8d

Write the appropriate package code
89221 for intensive phase
89222 for continuation phase



10. Professional Fees / Charges (Use additional CF2 if necessary):

Accreditation Number / Name of Accredited Health Care Professional / Date Signed	Details
Accreditation No.: 1501-785656-8 Jessica Gregorio JOSSICA GREGORIO, MD Signature Over Printed Name Date Signed: 07 / 10 / 2014 (month / day / year)	[/] No co-pay on top of PhilHealth Benefit [ ] With co-pay on top of PhilHealth Benefit P _____
Accreditation No.: _____ Signature Over Printed Name Date Signed: ___ / ___ / ___ (month / day / year)	[ ] No co-pay on top of PhilHealth Benefit [ ] With co-pay on top of PhilHealth Benefit P _____
Accreditation No.: _____ Signature Over Printed Name Date Signed: ___ / ___ / ___ (month / day / year)	[ ] No co-pay on top of PhilHealth Benefit [ ] With co-pay on top of PhilHealth Benefit P _____

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*

[/] 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.

	Total Actual Charges*
Total Health Care Institution Fees	
Total Professional Fees	
Grand Total	4,000.00

[ ] 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.

a.) The total co-pay for the following are:

	Total Actual Charges*	Amount after Application of Discount (i.e., personal discount, Senior Citizen/PWD	PhilHealth Benefit	Amount after PhilHealth Deduction
Total Health Care Institution Fees				Amount P _____ Paid by *(Check all that applies)*: [ ] Member/Patient [ ] HMO [ ] Others (i.e., PCSO, Promissory note, etc.)
Total Professional Fees *(for accredited and non-accredited professionals)*				Amount P _____ Paid by *(Check all that applies)*: [ ] Member/Patient [ ] HMO [ ] Others (i.e., PCSO, Promissory note, etc.)

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	[ ] None [ ] Total Amount P _____
Total cost of diagnostic/laboratory examinations paid for by the patient/member done within/outside the HCI during confinement	[ ] None [ ] Total Amount P _____

**NOTE: Total Actual Charges should be based on Statement of Account (SoA)*

B. *CONSENT TO ACCESS PATIENT RECORD/S*

I hereby consent to the examination by PhilHealth of the patient's medical records for the 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.

Jdelacruzjr
JUAN DE LA CRUZ JR.
Signature Over Printed Name of Member/Patient/Authorized Representative

Date Signed: 07 / 08 / 2014 (month / day / year)

Relationship of the representative to the member/patient: [ ] Spouse [ ] Child [ ] Parent [ ] Sibling [ ] Others, Specify _____

Reason for signing on behalf of the member/patient: [ ] Patient is Incapacitated [ ] Other Reasons: _____

If patient/representative is unable to write, put right thumbmark. Patient/representative should be assisted by an HCI representative. Check the appropriate box: [ ] Patient [ ] Representative

PART IV - CERTIFICATION OF HEALTH CARE INSTITUTION

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

Helen Sanchez
HELEN SANCHEZ
Signature Over Printed Name of Authorized Representative

TB DOTS STAFF NURSE/NURSE IV
Official Capacity / Designation

Date Signed: 07 / 11 / 2014 (month / day / year)

Write Accreditation number of TB DOTS Physician

Printed name and signature of TB DOTS Physician

Write the amount of TB DOTS Package if 1st box is ticked (PhilHealth benefit is enough to cover HCI and PF charges)

Printed name and signature of patient or authorized representative

Printed name and signature of the authorized person who attests that the entries to the claim form are true and correct