Annex 1

Waiver Form for Directly Filed Claims (revised May 2014)

_____
(Date)

To Whom It May Concern:

This is to certify that based on our record, _____ ,
(Name of Patient)

who was confined/admitted at _____
(Name of Health Care Institution)

from _____ to _____ had no PhilHealth deductions for health care
(Date of Admission) *(Date of Discharge)*

institution charges (HCI) and professional fees upon discharge. All HCI charges and professional

fees to the amount of _____
(Amount in words)

(Php _____) were fully paid by the patient/member under Official Receipt Nos.

_____.

PhilHealth benefits were not deducted prior to discharge because of the following reason/s:

_____

_____
(reason)

This waiver is being issued upon the request of _____ for
(Name of Patient/Member)

whatever legal purpose it may serve.

_____
(Printed Name and Signature of Authorized HCI Representative)

_____
(Printed Name and Signature of Attending Health Care Professional)

_____
(Designation of Authorized HCI Representative)

Conforme:

_____
(Printed Name and Signature of Patient/Member/Authorized Representative)