Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Call Center: (02) 8441-7442 | Trunkline: (02) 8441-7444
www.philhealth.gov.ph

UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Annex D: COVID-19 Vaccine Injury Claim Form

Series #

IMPORTANT REMINDERS IN FILLING OUT THE FORM:
1. Please write in CAPITAL LETTERS and Check [✔] the appropriate boxes.
2. Please ensure that you submit this form along with the other required supporting documents.
3. All information required in this form are necessary.
4. Claim forms with incomplete information shall not be processed.
5. False/incorrect information or misrepresentation shall be subject to criminal, civil or administrative liabilities.

PART I - PRINCIPAL INFORMATION

1. PhilHealth Identification Number (PIN) of Principal: - - 2. Date of Birth: month - date - year

3. Name of Principal:
Last Name (ex. DELA CRUZ) | First Name (ex. Juan) | Middle Name (ex. SIPAG) | Suffix

4. Mailing Address
Unit/Room No./Floor | Building Name | Lot/Blk/House/Bldg. No. | Street
Subdivision/Village | Barangay | City/Municipality
Province | Country | Zip Code

5. Contact Information:
Landline No. Area Code - Number
Mobile No. + Country Code - Number (ex.91XXXXXXXX)
Email Address @

5. Sex: ☐ Male ☐ Female

7. Principal is the Claimant? ☐ Yes (Skip Part II, proceed to Part III) ☐ No (Fillout Part II)
8. What benefit are you claiming for? ☐ Hospitalization ☐ Permanent Disability or Death

PART II - BENEFICIARY INFORMATION (To be filled-out only if the claimant is a primary or secondary beneficiary filing the claim in behalf of the principal)

1. PhilHealth Identification Number (PIN) of Beneficiary: - - 2. Date of Birth: month - date - year

3. Name of Beneficiary:
Last Name (ex. DELA CRUZ) | First Name (ex. Juan) | Middle Name (ex. SIPAG) | Suffix

4. Mailing Address
Unit/Room No./Floor | Building Name | Lot/Blk/House/Bldg. No. | Street
Subdivision/Village | Barangay | City/Municipality
Province | Country | Zip Code

5. Contact Information:
Landline No. Area Code - Number
Mobile No. + Country Code - Number (ex.91XXXXXXXX)
Email Address @

5. Sex: ☐ Male ☐ Female

PART III - PRINCIPAL/BENEFICIARY CERTIFICATION and CONSENT TO ACCESS PATIENT RECORD/S

I hereby consent to the submission and examination of the patient's pertinent medical records for the purpose of verifying the veracity of this claim to effect efficient processing of compensation payment. PhilHealth may share this data and authentic records and documents to the Department of Health and other government agencies pursuant to its statutory functions.
I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all legal liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim for reimbursement before PhilHealth.
Under the penalty of law, I attest that the information I provided in this Form are true and accurate to the best of my knowledge.

Signature over Printed Name of Principal
Date Signed month - date - year

or

Signature over Printed Name of Beneficiary
Date Signed month - date - year

If member/representative is unable to write, put right thumbmark. Member/Representative should be assisted by an HCI representative.
Check the appropriate box.
☐ Principal ☐ Beneficiary

Relationship to the Principal: ☐ Spouse ☐ Children ☐ Parent ☐ Sibling ☐ Other, Specify _____

PART IV - FOR PHILHEALTH USE ONLY

Date Received month - date - year

Received by:
Signature over Printed Name of Recipient