Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

PHILHEALTH CIRCULAR
No. 2021 - 0007

TO : ALL FILIPINOS, PHILHEALTH REGIONAL OFFICES, BRANCHES, LOCAL HEALTH INSURANCE OFFICES, AND ALL OTHERS CONCERNED

SUBJECT : **Implementing Guidelines on the Coverage of COVID-19 Vaccine Injury due to Serious Adverse Effects (SAEs) Following Immunization Resulting in Hospitalization, Permanent Disability, or Death under the COVID-19 National Vaccine Indemnity Fund (The COVID-19 Vaccine Injury Compensation Package)**

I. RATIONALE

MASTER COPY DC: 1145 Date: 6/17/2021

Section 10 of Republic Act (RA) No. 11525 or the COVID-19 Vaccination Program Act of 2021 provides for the creation of the COVID-19 National Vaccine Indemnity Fund to provide coverage for Serious Adverse Effects (SAEs) following immunization. Further, the same section assigns PhilHealth as the fund administrator and authorizes the Corporation to pay compensation from the indemnity fund for cases of hospitalization, permanent disability, or death due to SAEs to any person inoculated through the Philippine COVID-19 Vaccination Program. In fulfilling its duty as the fund administrator of the COVID-19 National Vaccine Indemnity Fund, PhilHealth is further enjoined to, upon consultation with the Department of Health (DOH), the Department of Finance (DOF), the Department of Budget Management (DBM), and the National Task Force for COVID -19 (NTF), develop "the guidelines for the planning, administration, and monitoring of the utilization of the fund, including the determination of its sufficiency". In fulfillment of the Law and in recognition of its expanded role, PhilHealth Board issued PhilHealth Board Resolution No. 2603 s.2021, creating a compensation package covering hospitalization, permanent disability, and death due to SAEs following immunization for COVID-19.

II. OBJECTIVES

This PhilHealth Circular aims to provide compensation, for any vaccines administered through the COVID-19 Vaccination Program, in case of hospital confinement, permanent disability, or death due to SAEs. This shall be valid until terminated by the President of the Philippines based on the recommendation of the Permanent Committee, for a span of five (5) years or until the completion of the Philippine COVID-19 vaccination program, whichever comes earlier, as specified under Sec. 10, Par. 3 and 4 of RA No. 11525.

III. SCOPE

This PhilHealth Circular shall apply to claims for hospital confinement, permanent disability, or death due to SAEs from COVID-19 vaccines, administered through the COVID-19 Vaccination Program for cases with established causality for individuals inoculated, from March 3, 2021 to March 2, 2026 or until the completion of the COVID-19 vaccination program, whichever comes earlier. This does not apply to claims already compensated or subject for compensation through the COVAX no-fault compensation program (COVAX-NFCP).

IV. DEFINITION OF TERMS

A. **45-day Benefit Limit Rule** refers to a rule of PhilHealth where members are entitled to maximum of 45 days confinement per calendar year and where their qualified dependents share a maximum of 45 days confinement per calendar year.

B. **Beneficiary** refers to the person entitled to compensation from the benefit.

C. **Causality assessments** refers to assessments conducted by an expert or a pool of experts, recognized by PhilHealth, which determines the causal link between the injury and the vaccination.

D. **Claimant** refers to the person filing the claim, whether they are the principal, their duly appointed representative, or their next of kin.

E. **No-fault indemnity compensation** refers to the condition where an insurer is required to pay a third party who was injured or had died without the necessity of proving fault or negligence on the part of the insured.

F. **Out-of-Pocket payments** refer to payment made by a beneficiary on top of what is covered by insurances.

G. **Primary Beneficiary** refers to person who is first in line to receive compensation after a claim has been approved for payment. This often refers to the principal or their next of kin such as legal spouse until he or she remarries; and legitimate, legitimated, or acknowledged illegitimate children.

H. **Secondary Beneficiary** refers to person who is eligible to receive compensation after a claim has been approved for payment if a principal beneficiary is not able to file a claim. This includes legitimate parents.

I. **Serious adverse effect** (SAE) refers to serious adverse event following immunization that upon causality assessment, is classified as "vaccine product-related reaction" or "vaccine quality defect-related reaction", arising from the use of COVID-19 vaccine. Serious adverse event following immunization (AEFI) is a medical occurrence that 1) result to any of the following outcomes – death, hospitalization, or prolongation of

existing hospitalization, persistent or significant disability or incapacity, and congenital anomaly or birth defects; 2) may be severe, critical, or life-threatening; 3) require intervention to prevent any of the above-mentioned outcomes; or 4) classified by the Department of Health as a medically important event or reaction.[1]

J. **Single Period of Confinement** refers to a rule of PhilHealth where admissions and re-admissions due to the same illness or procedure within a 90-calendar day period shall only be compensated with one (1) case rate benefit. Therefore, availment of benefit for the same illness or procedure that is not separated from each other by more than 90 calendar days will not be provided with a new benefit, until after the 90-calendar day period reckoned from the date of admission.

V. POLICY STATEMENTS

A. COVID-19 Vaccine Injury Compensation Package

1. The compensation package covering incidents of hospitalization, permanent disability, and death due to SAEs following COVID-19 immunization hereto shall be referred to as the "COVID-19 Vaccine Injury Compensation Package". These incidents are due to "vaccine product-related reaction" or "vaccine quality-defect reaction" from the use of COVID-19 vaccines.

2. The COVID-19 Vaccine Injury Compensation Package shall provide no-fault indemnity compensation for patients vaccinated through the Philippine COVID-19 Vaccination Program for any cases of hospitalization, permanent disability, or death determined to have been caused by SAEs due to COVID-19 Vaccines.

3. Beneficiaries requiring coverage for hospitalization shall be afforded coverage for all direct healthcare costs adjudicated by PhilHealth to be essential in managing the SAE, including ambulance services for transport, transfer, and referral, provided that:

   a. The claim corresponds to remaining charges on top of PhilHealth benefits and other health benefits provided by private health insurances (PHIs) and Health Management Organizations (HMOs); and,

   b. It does not exceed the pre-set compensation cap per beneficiary (Annex A: Package Rates and Compensation for the COVID-19 Vaccine Injury Package).

4. Beneficiaries are entitled to compensation for either permanent disability or death due to SAEs following immunization and shall receive lump sum compensation, paid only once per beneficiary (Annex A).

[1] DOH-NTF JAO No. 2021-0001 Implementing Rules and Regulations of the Republic Act No. 11525 known as "An Act Establishing the Coronavirus Disease 2019 (COVID-19) Vaccination Program Expediting the Vaccine Procurement and Administration Process, Providing Funds Therefor, and For Other Purposes

B. Claimable Cases

1. Only serious cases identified by PhilHealth (Annex B: List of Conditions that may be Claimed from COVID-19 Vaccine Injury Package) and assessed to be "vaccine product-related reaction" or "vaccine quality-defect reaction" due to COVID-19 vaccines by causality assessment shall be claimable. The Cases eligible for compensation shall include the following:

   a. Hospitalization due to Anaphylaxis, Guillain-Barre Syndrome (GBS), blood clots leading to Stroke and other diseases, and other such cases that may be determined by PhilHealth based on prevailing evidence;
   b. Permanent disability resulting from the loss of sight for both eyes; loss of any two limbs at or above the ankle or wrists; or permanent complete paralysis of any two limbs; brain injury resulting in incurable imbecility or insanity; and other such cases that may be determined by PhilHealth based on prevailing evidence; and,
   c. Death

2. Claim submissions for cases with manifestations outside those explicitly stated in this policy shall be subject to extensive review by PhilHealth.

3. Subsequent inclusions and exclusions in the list of claimable cases shall only be approved by PhilHealth if it has determined that the available literature, research, global data, and other resources collectively establish a preponderance of evidence in support of or against the notion that there is a causal link between the specific COVID vaccine in question and the SAEs observed.

4. PhilHealth shall, for this purpose, reserve the right to secure the opinion of experts from a PhilHealth-recognized expert pool or committee, engage firms or institutions to gather and process available evidence establishing causality, and/or commission studies as they see fit which shall serve as part of its review and adjudication processes.

5. Cases determined to be unrelated to COVID-19 vaccination at the point of review shall not be compensable, provided however that denied claims for cases which, based on new, emerging evidence, could have been caused by the COVID-19 vaccine, can be refiled by beneficiaries following applicable processes in filing for motions for reconsideration (MR) and/or appeals, and shall have to be reviewed by PhilHealth.

C. Eligibility of Claimants

1. Claimants for the COVID-19 Vaccine Injury Compensation Package shall be limited to primary and secondary beneficiaries, ranked accordingly in precedence.

2. Claims from the person vaccinated, hereto referred to as the "principal", shall hold precedence over all other claimants filing claims on their behalf. However, should the principal be unable to file for their own benefit, in the advent of death or permanent disability, their legal spouse until he or she remarries, or in the absence of a spouse,

any of their legitimate, legitimated, or acknowledged illegitimate children shall be allowed to file a claim. The share of illegitimate children shall only be 50% of the share of legitimate children.

3. Should there be no primary beneficiaries, secondary beneficiaries such as legitimate parents can file the claim on behalf of the principal.

4. Any disputes relating to having multiple claims filed on behalf of the principal from different claimants shall be adjudicated by PhilHealth, provided that the dispute was raised prior the release of any payment.

5. Should there be a dispute on who is eligible to receive compensation on behalf of the principal after payment has already been made, the concerned parties will have to settle the dispute through other avenues afforded to them by law.

D. Eligible Claims

1. Claims shall be eligible for compensation only if:
   a. At least one of the vaccine doses received by the patient was procured and administered through the Philippine COVID-19 Vaccine Program;
   b. The vaccine in question has not been granted a Certificate of Product Registration (CPR) by the Food and Drug Authority (FDA) upon administration;
   c. The beneficiary has not received nor plan to receive compensation through the COVAX-NFCP, where if the beneficiary has filed for compensation to the COVAX-NFCP, they are deemed to have expressed intent in forfeiting their right to file for compensation from the COVID-19 National Vaccine Indemnity Fund, until such that their case has been denied for acceptance or payment by the COVAX-NFCP for any reason other than failing to establish causality between the vaccine and the observed SAEs;
   d. The claim is for SAEs that upon causality assessment was determined to be "vaccine product-related reaction" or "vaccine quality defect-related reaction", arising from the use of COVID-19 vaccine; and,
   e. That the claim was submitted with proof of hospitalization, permanent disability, or death.
   f. Filed between March 3, 2021 to March 2, 2026 or until completion of the COVID-19 Vaccination Program whichever comes earlier.

2. Beneficiaries can file for more than one claim for hospitalization, without regard to single-period-confinement rule and the 45-day rule, which will be eligible for compensation, provided that:
   a. The beneficiary was confined for at least 24 hours;
   b. The services performed were not exclusively provided in the Emergency Room (ER) or did not just involve ER consultations;
   c. The services performed were not provided on an outpatient basis;
   d. The commodities provided were not for outpatient use;
   e. The services and commodities provided were deemed to be in accordance with current clinical practice guidelines and pathways in managing complications following the SAEs, based on the medical evaluation of PhilHealth; and,

f. The maximum capped amount has not already been exhausted through previous claims.

3. Claims for hospitalization that do not meet all the listed requirements identified in the provisions above shall not be reimbursable except in special cases where either:
   a. The beneficiary died in the ER prior admission to the healthcare facility (HCF);
   b. The services and commodities being claimed were provided in the ER where the beneficiary was kept in the ER for more than or equal to 24 hours due to insufficient bed capacity;
   c. The beneficiary died within 24 hours following admission to an HCF; or,
   d. Any other such cases determined by PhilHealth to be reasonable and just.

4. Any claim for hospitalization made for an amount in excess of the compensation cap shall not be reimbursable.

5. Claims for beneficiaries who died or became permanently disabled due to SAEs following immunization against COVID-19 during or after hospitalization are eligible to reimbursements for both the hospitalization and the permanent disability or death.

6. Claims for permanent disability or death shall only be compensated once. Any claim for death following permanent disability shall be denied, provided that initial compensation has already been paid on behalf of the beneficiary. Retroactive claims for permanent disability following the death of a beneficiary shall likewise not be reimbursable, provided that compensation for the death has already been paid.

E. Claims Filing Requirements

1. Claimants shall have to file for a vaccine injury claim directly to PhilHealth (Annex C: Claims Filing, Motion for Reconsideration, and Appeals Process for the COVID-19 Vaccine Injury Package).

2. Claimants, in filing for any compensation under the package, shall have to submit a duly accomplished claim form (Annex D: COVID-19 Vaccine Injury Claim Form).

3. For hospitalization claims, principals shall append the following documents to their claim (Annex E: List of Documentary Requirements when filing for a Claim for the COVID-19 Vaccine Injury Package):
   a. Proof of COVID-19 Vaccination (i.e., vaccine card or slip);
   b. Vaccine Injury Assessment Survey (Annex F: Vaccine Injury Assessment Survey);
   c. Statement of Account (SOA) per admission;
   d. Medical Certificate; and,
   e. Official Receipt indicating deductions from PhilHealth benefits, private insurers, and/or HMOs, and Out-of-Pocket (OOP) payments for hospital bills.

4. For permanent disability claims, principals shall append the following documents to their claim:

a. Medical Certificate;
b. Vaccine Injury Assessment Survey (Annex F) duly accomplished by the attending physician; and,
c. Other documents that may be required to support the disability claim which can include a physical examination report describing the disabling manifestation and signed by a duly licensed physician.

5. For survivorship claims in cases of death, the claimant shall append following documents to their claim:
   a. Vaccine Injury Assessment Survey (Annex F) duly accomplished by the attending physician; and,
   b. Certified True Copy (CTC) of the principal's Death Certificate.

6. If the beneficiary or the claimant is not registered to PhilHealth, they shall have to append a duly filled-out PhilHealth Membership Registration Form (PMRF) (Annex G: PhilHealth Membership Registration Form).

7. The Vaccine Injury Assessment Survey shall serve as the primary document that PhilHealth will use in approximating the injury incurred, the extent of the disability of the patient, the nature of the SAE in determining the compensability of a case, and the compensable amount.

8. PhilHealth reserves to right to request for additional evidence and documents from the claimant to facilitate adjudication. These can include proofs of relationship, an autopsy report signed by the medical examiner, and/or an autopsy consent form authorizing an autopsy, among others.

9. PhilHealth shall provide notice to the claimant of any deficiencies in their claim submission or for any additional documentary requirements the claimant will have to submit whereby the claimant shall have sixty (60) working days to comply. Incomplete claim submissions will be denied once the sixty (60) day period has lapsed.

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10. For each initial claim filed by or on behalf of the beneficiary, a causality assessment shall be conducted to serve as evidence that there is a causal link between the injury being claimed and the COVID-19 vaccine used. Only causality assessments from a PhilHealth-recognized expert or pool of experts shall be accepted as evidence in adjudicating a claim.

11. PhilHealth shall keep a record of all causality assessments conducted for each claim submitted for compensation.

12. If the beneficiary has a copy of their causality assessment from a PhilHealth-recognized expert or pool of experts, the beneficiary can append a copy of the causality assessment to their claim subject to validation of its authenticity.

13. PhilHealth shall not charge any fee for any claims for the package.

F. Rules on Adjudication

1. PhilHealth, upon receipt of a fully accomplished and complete claim, shall process the claim within sixty (60) working days, provided that:
   a. A causality assessment has already been conducted; and,
   b. The causality assessment has definitively indicated that the injury observed was caused by the COVID-19 vaccine.

2. Should there be no causality assessment that definitively identifies evidence that there is a causal link, the indicated turn-around-time in processing the claim will exclude the time needed to properly investigate the case to which PhilHealth shall have to gather further evidence and conduct inquiry either in its own capacity or through commissioned investigators and experts.

3. The period required to properly conduct these investigations shall vary depending on the case, the nature of the claim, and on the process required in determining causality.

4. In adjudicating claims for vaccine injury from COVID-19 vaccines, PhilHealth shall conduct medical evaluation and review all the documentary submissions provided to determine:
   a. Whether the claim is covered based on prevailing issuances;
   b. Whether the claimant is eligible to receive the payment; and,
   c. The amount subject for reimbursement.

5. Claims determined to be ineligible for payment due to non-compliance to the rules and guidelines expressly determined in this PhilHealth Circular shall be denied.

6. PhilHealth shall provide feedback to the claimant on the status of their claim.

G. Rules on Motions for Reconsideration (MR), Appeals, and Refiling of Claims

1. Claimants reserve the right to file for an MR (Annex H: Sample Motion for Reconsideration/Appeal), subject to the following conditions:
   a. The MR concerns a claim that has been denied for whatever reason; or,
   b. The MR concerns the amount of the approved reimbursement scheduled to be paid or have already been paid to the claimant.

2. MRs shall be submitted to PhilHealth within fifteen (15) calendar days upon receiving notice of the decision which can be extended an additional fifteen working days during fortuitous events. Failure to submit an MR within the prescribed period shall imply that the claimant has accepted the decision, rendering the decision to be final and executory.

3. MRs for denied claims due to non-compliance to the documentary requirements within the indicated grace period can be refiled by the claimant provided that the MR includes all documentary requirements previously requested by PhilHealth.

4. MRs for denied claims due to a lack of evidence definitively establishing causality shall have to provide a second opinion that the observed SAE is COVID-19 vaccine related. The second opinion shall have to be signed by a government physician recognized by PhilHealth to have sufficient capacity in conducting causality assessments. In the absence of a PhilHealth-recognized government physician, any government physician with a proven track record and expertise in conducting causality assessments would suffice.

5. PhilHealth shall have to review the case upon receipt of MR and shall inform the claimant of the status.

6. Should the claimant be unsatisfied with the decision of PhilHealth on the MR, the claimant can file an appeal to PhilHealth within 15 days upon receiving the notice of decision which can be extended to another 15 days during fortuitous events. Appeals shall be subject to the existing appeals process of PhilHealth.

H. Rules on Compensation

1. Upon determination that the claim is approved for reimbursement, PhilHealth shall notify the claimant.

2. The beneficiary, in receiving payments through the COVID-19 Vaccine Injury Compensation Package, shall forfeit any right to file suit against public officials and employees, contractors, manufacturers, volunteers, and representatives of duly authorized private entities involved in the administration of the COVID-19 vaccine (Annex D).

3. Any amount received from the fund outside of what is permitted by this PhilHealth Circular, either due to clerical or technical error, misrepresentation on the part of the claimant, or other forms of non-compliance, whether with or without explicit intent to defraud the system shall have to be returned to PhilHealth.

4. Claimants suspected of fraud who received compensation through the fund shall be subject to investigation and further legal action.

5. Claimants proven guilty of fraud in a court of law shall be liable to pay for damages on top of the compensated amount.

I. Fund Management Rules

1. In accordance with the provisions of the law, a Trust Fund shall be set up for PhilHealth equivalent to Php 500 million in the first year of implementation sourced from the FY 2021 contingent fund under the FY 2021 GAA.

2. The value of the Trust Fund shall be transferred to PhilHealth following the submission of a Special Budget Request to DBM, subject to applicable accounting and disbursement guidelines.

3. The schedule of fund releases shall be defined and agreed upon between PhilHealth and the Bureau of Treasury (BTr).

4. PhilHealth shall submit regular financial reports to the DOH, DBM, DOF, NTF, and the Permanent Committee on the status of fund in accordance with existing reporting standards required from Government Owned and Controlled Corporations (GOCCs) and other applicable issuances.

5. At the end of the indemnification period, PhilHealth shall return any amount not scheduled for payment for vaccine injury claims, provided that there are no pending claims for adjudication. The amount to be returned shall be subject to reconciliation following the actuarial assessment of funding required to settle cases under adjudication.

6. Once all claims have been properly adjudicated and there are no pending MRs or appeals, any remaining amount in the fund not scheduled for payment shall be returned to the BTr.

J. Fund Adjustments

1. PhilHealth shall inform the Permanent Committee once claims scheduled for payment reaches 70% of the total value of the fund or once actuarial projections for potential payments reach 100% of fund, to which all additional claim applications shall be put on hold.

2. PhilHealth shall reimburse claims for as long as the funds are available and replenished. The continuance of payments shall be contingent upon fund adjustments following additional allocations from the National Government as approved by the President of the Philippines following the recommendation of the Permanent Committee.

3. PhilHealth shall conduct a regular review of its package and, once more data on the nature and severity of SAEs following immunization become available, shall adopt changes in the package design, compensation amount, benefit inclusions, and appeals process.

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K. Annexes

1. Annex A: Package Rates and Compensation for the COVID-19 Vaccine Injury Package
2. Annex B: List of Conditions that may be Claimed from COVID-19 Vaccine Injury Package
3. Annex C: Claims Filing, Motion for Reconsideration, and Appeals Process for the COVID-19 Vaccine Injury Package
4. Annex D: COVID-19 Vaccine Injury Claim Form
5. Annex E: List of Documentary Requirements when filing for a Claim for the COVID-19 Vaccine Injury Package
6. Annex F: Vaccine Injury Assessment Survey
7. Annex G: PhilHealth Membership Registration Form (PMRF)
8. Annex H: Sample Motion for Reconsideration/Appeal

VI. PENALTY CLAUSE

Violations of any provision of this PhilHealth Circular shall be penalized under R.A. Nos. 10606, 11223, and 11525, their Implementing Rules and Regulations, and other applicable laws, rules, and regulations.

VII. SEPARABILITY CLAUSE

Should any provision of this PhilHealth Circular be declared invalid, unconstitutional, or unenforceable in whole or part by any competent authority, it shall not affect or invalidate the remaining provisions thereof.

MASTER COPY Date: 6/17/2021 DC: 1445

VIII. DATE OF EFFECTIVITY

This PhilHealth Circular shall be effective immediately upon publication in a newspaper of general circulation or Official Gazette and shall apply to claims for vaccine injury starting March 3. 2021. A copy of the PhilHealth Circular shall be also deposited thereafter with the Office of the National Administrative Register at the University of the Philippine Law Center.

ATTY. DANTE A. GIERRAN, CPA
President and Chief Executive Officer (PCEO)

Date signed: 06/15/2021

Annex A: Package Rates and Benefit Cap for the COVID-19 Vaccine Injury Package

Table 1: Applicable Package Code, Description, and Amount

Package Code	Description	Amount
C19VIH	Hospitalization due to Serious Adverse Effects (SAEs) following COVID-19 immunization	Php 100,000 (max)
C19VID	Death or permanent disability due to Serious Adverse Effects (SAEs) following COVID-19 immunization	Php 100,000 (lump sum)

1. The benefit cap for hospitalization claims under the COVID-19 Vaccine Injury package is **Php 100,000 per beneficiary** and shall be make use of the package code "C19VIH".

2. The lump sum compensation for death or permanent disability under the COVID-19 Vaccine Injury package is **Php 100,000 per beneficiary** and shall be make use of the package code "C19VID".

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Annex B: List of Conditions that may be claimed from COVID-19 Vaccine Injury Compensation Package

Adverse Events of Special Interest

1. Anaphylaxis
2. Thrombocytopenia
3. Generalized convulsion
4. Acute disseminated encephalomyelitis
5. Guillain Barré Syndrome
6. Acute respiratory distress syndrome
7. Multisystem inflammatory syndrome (children & adults)
8. Acute cardiovascular injury
   (Includes: myocarditis/pericarditis, microangiopathy, heart failure, stress cardiomyopathy, coronary artery disease arrhythmia)
9. Coagulation disorder
   (Includes: thrombotic disorders, bleeding disorders)
10. Anosmia, ageusia
11. Chilblain – like lesions
12. Erythema multiforme
13. Single Organ Cutaneous Vasculitis
14. Acute kidney injury
15. Acute liver injury
16. Acute pancreatitis
17. Rhabdomyolysis
18. Subacute thyroiditis
19. Acute aseptic arthritis
20. Aseptic meningitis
21. Encephalitis / Encephalomyelitis
22. Idiopathic Peripheral Facial Nerve Palsy

Source: Brighton Collaboration

Note: Under the COVID-19 Vaccine Injury Compensation Package, it must be established that these conditions are directly caused by COVID -19 vaccines and resulted to hospitalization, death, or permanent disability.

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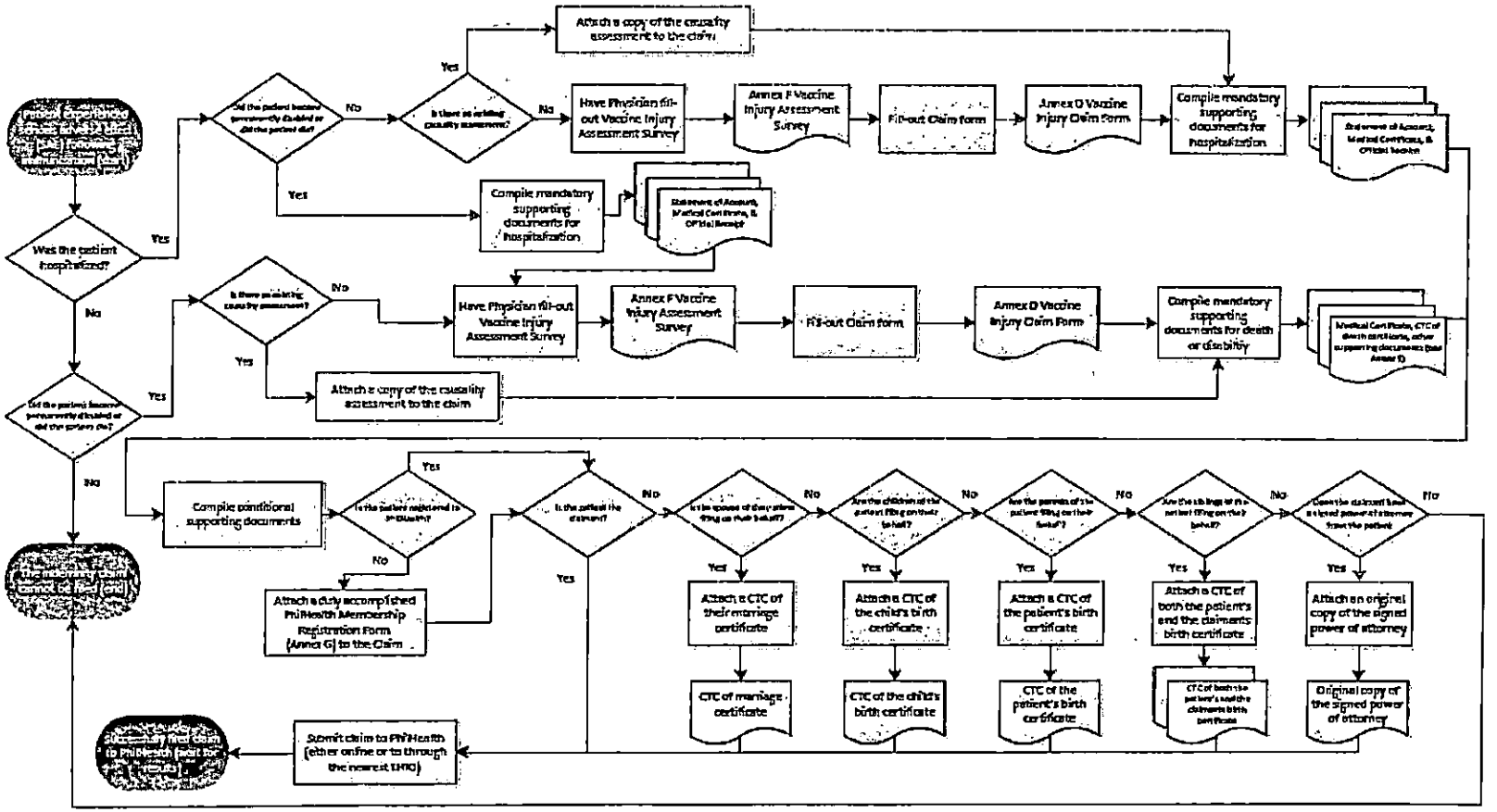
Annex C Claims Filing, Motion for Reconsideration, and Appeals Process for the COVID-19 Vaccine Injury Package



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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. 9100000000)
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. 9100000000)
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
Relationship to the Principal ☐ Spouse ☐ Children ☐ Parent ☐ Sibling ☐ Other, Specify

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

PART IV - FOR PHILHEALTH USE ONLY

Date Received month - date - year
Received by: Signature over Printed Name of Recipient

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Annex E: List of Documentary Requirements when filing for a Claim for the COVID-19 Vaccine Injury Compensation Package

Type of Claim	Documentary Requirements	
	Mandatory	**Conditional**
Hospitalization	1. Proof of COVID-19 Vaccination (i.e., vaccine card or slip) 2. Vaccine Injury Claim Form (AnnexD) 3. Vaccine Injury Assessment Survey (Annex F) 4. Statement of Account (SOA) per admission 5. Medical Certificate 6. Official Receipt (indicating deductionsfrom PhilHealth benefits, private insurers, and/or HMOs, and Out-of- Pocket payments for hospital bills.)	If the principal and beneficiary is not registered to PhilHealth: 1. duly filled-out PhilHealth Member Registration Form(PMRF) (Annex G) If the claim is filed on behalf of theprincipal: 1. CTC of Marriage Certificate (ifclaimant is the spouse) 2. CTC of Birth Certificate of Beneficiary/Claimant (if claimant is the principal's children) 3. CTC of Birth Certificate of thePrincipal (if claimant is the principal's parent or siblings) 4. CTC of Birth Certificate of claimant/beneficiary (if claimant is the principal's siblings) 5. Special Power of Attorney (SPA) signed by the principal If there is a need for additionalevidence: 1. Consent form authorizingautopsy 2. Autopsy report (if available) 3. Others
Permanent Disability	1. Proof of COVID-19 Vaccination (i.e., vaccine card or slip) 2. Vaccine Injury Claim Form (AnnexD) 3. Medical Certificate 4. Vaccine Injury Assessment Survey (Annex F) 5. Other documents that may be required to support the disability claim which can include a physical examination report describing the disabling manifestation and signed by a duly licensed physician.	
Death	1. Proof of COVID-19 Vaccination (i.e., vaccine card or slip) 2. Vaccine Injury Claim Form (AnnexD) 3. Vaccine Injury Assessment Survey (Annex F) 4. Certified True Copy (CTC) of the principal's Death Certificate.	

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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
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UNIVERSAL HEALTH CARE

Annex F: COVID-19 Vaccine Injury Survey

IMPORTANT REMINDERS IN FILLING OUT THE FORM:
1. Please append with this Survey any supporting documents to provide medical evidence of the responses captured in this survey.
2. Do not accomplish this survey by yourself, the form is designed to be accomplished by duly licensed physicians.
3. The survey needs to be signed and confirmed by at least one duly licensed physician.
4. Please provide as much detail as possible in filling out the survey.
5. All information required in this survey are necessary.
6. False/incorrect information or misrepresentation shall be subject to criminal, civil or administrative liabilities.

Special Note: The COVID-19 Vaccine Injury Survey was patterned from the WHO COVAX Supporting Evidence Form

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.9100000000))
Email Address @

5. Sex: ☐ Male ☐ Female

7. Principal is the Claimant? ☐ Yes (Skip Part II, proceed to Part III) ☐ No (Fillout Part II)

PART II - HEALTH PROFESSIONAL INFORMATION

1. Name of Licensed Physician 1:
Last Name (ex. DELA CRUZ) | First Name (ex. Juan) | Middle Name (ex. SIPAG) | Suffix

Professional Regulatory Commission (PRC) License
Registration No. | Registration Date: (month - date - year) | Valid Until: (month - date - year)

Contact Information of Physician 1:
Landline No (Area Code - Number) | Mobile No. (+ Country Code - Number (ex.9100000000))
Email Address @

5. Sex: ☐ Male ☐ Female

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

2. Name of Licensed Physician 2 (Skip section if only one physician filled out the survey):
Last Name (ex. DELA CRUZ) | First Name (ex. Juan) | Middle Name (ex. SIPAG) | Suffix

Professional Regulatory Commission (PRC) License
Registration No. | Registration Date: (month - date - year) | Valid Until: (month - date - year)

Contact Information of Physician 2:
Landline No. (Area Code - Number) | Mobile No. (+ Country Code - Number (ex.9100000000))
Email Address @

5. Sex: ☐ Male ☐ Female

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Health Care Facility Address (Skip if same as Physician 1)

Name of Health Care Facility

Unit/Room No./Floor | Building Name | Lot/Blk/House/Bldg. No. | Street

Subdivision/Village | Barangay | City/Municipality

Province | Country | Zip Code

3. Name of Licensed Physician 3 (Skip section if only one physician filled out the survey):

Last Name (ex. DELA CRUZ) | First Name (ex. Juan) | Middle Name (ex. SIPAG) | Suffix

Professional Regulatory Commission (PRC) License

Registration No. | Registration Date: month - date - year | Valid Until: month - date - year

Contact Information of Physician 3:

Landline No. (Area Code - Number) | Mobile No. (+ Country Code - Number (ex.9100000000))

5. Sex: ☐ Male ☐ Female

Email Address @

Health Care Facility Address (Skip if same as Physician 2)

Name of Health Care Facility

Unit/Room No./Floor | Building Name | Lot/Blk/House/Bldg. No. | Street

Subdivision/Village | Barangay | City/Municipality

Province | Country | Zip Code

PART III - COVID-19 VACCINE INFORMATION

Special Note: If more than one type of vaccine or if multiple doses of the same vaccine was administered, repeat this section

1. Details of the Vaccine administered to the patient (or in the case of birth defects, to the Patient's mother).

Name of Vaccine | Dose administered (check if provided: 1 ☐ 2 ☐) | Expiry Date (dose 1): month - date - year | Expiry Date (dose 2): month - date - year

Batch / Lot No:

2. If known, details of diluent (if any) used with the Vaccine administered to the Patient (or in the case of birth defects, to the Patient's mother).

Name of Vaccine | Dose administered (check if provided: 1 ☐ 2 ☐) | Expiry Date (dose 1): month - date - year | Expiry Date (dose 2): month - date - year

Batch / Lot No:

3. Other Relevant Information

4. Date(s) and places(s) the Vaccine was administered to Patient (or in the case of birth defects, to the Patient's mother).

Dose 1: month - date - year | Vaccine Administration Site

Dose 2: month - date - year | Vaccine Administration Site

PART IV - INFORMATION ABOUT THE INJURY OR ILLNESS SUSTAINED

1.. Describe the injury or illness suffered by the Patient after the Vaccine was administered to Patient (or in the case of birth defects, to the Patient's mother).

Description of the injury:	Examination and tests conducted	Any known relevant congenital birth injuries or defects that is related to the injury

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2. Regarding symptoms, please describe the following:

In providing the details of any sequelae, please mention:

a. any severe local reaction suffered by the Patient after the Vaccine administered to him/her (and whether that reaction extended beyond nearest joint); and

b. any seizures (febrile or afebrile), abscess, sepsis, encephalopathy, toxic shock syndrome, thrombocytopenia, anaphylaxis, fever (above 38 degrees centigrade).

Symptom Experienced	Date (month - date - year)	Extent of seriousness of the symptom	Details of the Sequelae

3. Did the Patient require any treatment for the injury or illness suffered by the Patient after the vaccine was administered to him/her (or in the case of birth defects, to the Patient's mother)? If yes, please describe what treatment was provided to the Patient for the injury/illness suffered by the Patient after the Vaccine was administered to him/her (or in the case of birth defects, to the Patient's mother).

4. Please describe to what extent the Patient has or has not (as applicable) recovered from the injury or illness suffered by the Patient after the Vaccine was administered to him/her (or in the case of birth defects, to the Patient's mother).

5. In your opinion, what was the cause of the injury or illness suffered by the Patient? Please elaborate your response.

6. If known, please provide the date and place when the injury or illness suffered by the Patient was first reported to a Registered Healthcare Professional or to the health system

Reported Injury	Date (month - date - year)	Reported place of Injury

7. Describe the extent of any permanent impairment of the Patient and the prognosis for the Patient as a result of such impairment

8. What is the functional impact on the Patient of the injury or illness suffered by the Patient (or in the case of birth defects, to the Patient's mother)?

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9. Details of any hospitalization, or prolongation of existing hospitalization, of the Patient for more than 24 consecutive hours in connection with the injury or illness suffered by the Patient after the Vaccine was administered to the Patient (or in the case of birth defects, to the Patient's mother)

Date of Admission			Date of Discharge			Type of care or treatment provided to the patient during hospitalization her (or in the case of birth defects, to the Patient's mother)
month	date	year	month	date	year	

10. Details of any medicines taken by, and/or any other vaccines administered to, the Patient after the Vaccine was administered to the Patient and/or during the period of 6 weeks before such administration

Name of Medicine / Vaccine	Dose	Date of Administration / Prescription (month / date / year)

11. In the case of birth defects, details of any medicines taken by, and/or any othervaccines administered to, the Patient's mother during the pregnancy and/or 6 weeks before the start of the pregnancy

Name of Medicine / Vaccine	Dose	Date of Administration / Prescription (month / date / year)

12. Details of previous long-term medication, to the extent known. Details of any medicines not described above that were taken by the Patient for a consecutive period of more than 3 weeks, during the 24 months before the Vaccine was administered to the Patient, including:

Name of Medicine / Vaccine	Dose	Date of Administration / Prescription (month / date / year)

13. Details of any known pre-existing medical conditions of the Patient or in the case of birth defects, of the Patient's mother (i.e., medical conditions existing before the period the Vaccine was administered to the Patient or in the case of birth defects, to the Patient's mother)

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14. Has the Patient suffered any similar injury or illness before? If yes, please describe the previous similar injury or illness.

15. In the case of birth defects, did the Patient's mother have another unborn or new-born child with a congenital birth injury or illness? If yes, please provide details.

16. In your opinion, is it possible that the injury or illness suffered by the Patient after the Vaccine was administered to the Patient (or in the case of birth defects, to the Patient's mother) was caused by, or resulted from, any previous injury or illness of the Patient (or in the case of birth defects, of the Patient's mother)? If yes, please provide details.

17. To the extent known, has a close family member of the Patient, such as brother, sister, parent, child, aunt, uncle, or 1st cousin, suffered any similar injury or illness before? If yes, please indicate which close family member and describe the similar injury or illness.

18. Have you seen any injury or illness similar to that suffered by the Patient amongst other patients who received (or in the case of birth defects, whose mother received) the same Vaccine?

19. Has the patient died due to the vaccine injury? ☐ Yes, proceed to next section ☐ No, skip PART V

PART V - INFORMATION ABOUT THE PATIENT'S DEATH

1. Date of Patients Death

☐☐ - ☐☐ - ☐☐☐☐
month date year

2. Cause/s of death stated on the death certificate

3. Autopsy details (if available)

4. In your opinion, what is/are the cause of death of the patient? Please elaborate on your answer.

5. Have you seen death similar to that suffered by the Patient among other patients who received the same Vaccine as the Patient? If yes, please provide details.

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6. Other Information

PART VI - DECLARATION AND SIGNATURE OF LICENSED PHYSICIAN

By signing below, I/we hereby certify that:

1. before this Supporting Evidence form was completed, a waiting period of 30 days has been observed since the Vaccine was administered to the Patient (or in the case of birth defects, to the Patient's mother); and
2. the statements and answers contained in this survey form are true and correct to the best of my/our knowledge and belief.

I/We understand that should these statement or answers not be true, PhilHealth shall have the right, where applicable, to conduct further investigation and pursue legal action.

Date Signed	month - date - year	Physician 1	Signature over Printed Name
Date Signed	month - date - year	Physician 2	Signature over Printed Name
Date Signed	month - date - year	Physician 3	Signature over Printed Name

NOTES ON REQUIRED ATTACHMENTS TO THE CLAIM

1. Please provide documentation confirming that the Vaccine was administered to the Patient (or in the case of birth defects, to the Patient's mother). This includes a copy the immunization card or certificate, a copy of the service point immunization log documenting the administration of the Vaccine, or any other government document that shows proof of vaccine administration

2. Please attach a copy of all available medical documentation and records related to the injury or illness sustained by the Patient after administration of the Vaccine. This includes the case sheet, case notes, discharge summary, laboratory reports, autopsy report, as well as prescriptions for concomitant and/or long-term medication, as referred to above, etc. if available.

3. If available, please also attach a copy of the AEFI investigation form, AEFI committee causality assessment, and other related documentation.

4. If space alloted in the specific section of this survey is insufficient, please fill out the details in a separate sheet of the applicable section and append it to the survey.

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PhilHealth
Your Partner in Health

PMRF

PHILHEALTH MEMBER REGISTRATION FORM
UHC v.1 January 2020

PHILHEALTH IDENTIFICATION NUMBER (PIN)

REMINDERS:

1. Your PhilHealth Identification Number (PIN) is your unique and permanent number.
2. Always use your PIN in all transactions with PhilHealth.
3. For Updating/Amendment check the appropriate box and provide details to be accomplished and submit corresponding supporting documents.
4. Please read instructions at the back before filling-out this form.

PURPOSE:
☐ REGISTRATION ☐ UPDATING/AMENDMENT

Preferred KonSulTa Provider

I. PERSONAL DETAILS

	LAST NAME	FIRST NAME	NAME EXTENSION (Jr./Sr./III)	MIDDLE NAME	NO MIDDLE NAME (Check if applicable only)	MONONYM (Check if applicable only)
MEMBER					☐	☐
MOTHER's MAIDEN NAME					☐	☐
SPOUSE (If Married)					☐	☐

DATE OF BIRTH m m d d y y y y

PLACE OF BIRTH (City/Municipality/Province/Country)
(Please indicate country if born outside the Philippines)

PHILSYS ID NUMBER (Optional)

SEX
☐ Male ☐ Female

CIVIL STATUS
☐ Single ☐ Annulled ☐ Married ☐ Widow/er ☐ Legally Separated

CITIZENSHIP
☐ FILIPINO ☐ FOREIGN NATIONAL ☐ DUAL CITIZEN

TAX PAYER IDENTIFICATION NUMBER (TIN) (Optional)

II. ADDRESS and CONTACT DETAILS

PERMANENT HOME ADDRESS
Unit/Room No./Floor | Building Name | Lot/Block/Phase/House Number | Street Name

Subdivision | Barangay | Municipality/City | Province/State/Country (If abroad) | ZIP Code

MAILING ADDRESS ☐ SAME AS ABOVE
Unit/Room No./Floor | Building Name | Lot/Block/Phase/House Number | Street Name

Subdivision | Barangay | Municipality/City | Province/State/Country (If abroad) | ZIP Code

Home Phone Number
(COUNTRY CODE + AREA CODE + TELEPHONE NUMBER)

Mobile Number (Required)

Business (Direct Line)

E-mail Address (Required for OFW)

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III. DECLARATION OF DEPENDENTS (Use additional form if necessary)

LAST NAME	FIRST NAME	NAME EXTENSION (Jr./Sr./III)	MIDDLE NAME	RELATIONSHIP	DATE OF BIRTH (mm-dd-yyyy)	CITIZENSHIP	NO MIDDLE NAME (Check if applicable only)	MONONYM (Check if applicable only)	Check if with Permanent Disability
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐

DC: mus

IV. MEMBER TYPE

DIRECT CONTRIBUTOR

☐ Employed Private
☐ Employed Government
☐ Professional Practitioner
☐ Self-Earning Individual
  ☐ Individual
  ☐ Sole Proprietor
  ☐ Group Enrollment Scheme
  _____
☐ Kasambahay
☐ Migrant Worker
  ☐ Land-Based ☐ Sea-Based
☐ Lifetime Member
☐ Filipinos with Dual Citizenship / Living Abroad
☐ Foreign National
  PRA SRRV No. _____
  ACR I-Card No. _____
☐ Family Driver

INDIRECT CONTRIBUTOR

☐ Listahanan
☐ 4Ps/MCCT
☐ Senior Citizen
☐ PAMANA
☐ KIA/KIPO
☐ Bangsamoro/Normalization
☐ LGU-sponsored
☐ NGA-sponsored
☐ Private-sponsored
☐ Person with Disability
PWD ID No. _____

PROFESSION: (Except Employed, Lifetime Members and Sea-based Migrant Worker)	MONTHLY INCOME:	PROOF OF INCOME:

For PhilHealth Use only:
☐ Point of Service (POS) Financially Incapable
☐ Financially Incapable

Continue at the back

V. UPDATING/AMENDMENT

Please check:	FROM	TO
☐ Change/Correction of Name (Last Name, First Name, Name Extension (Jr./Sr./III) Middle Name)		
☐ Correction of Date of Birth		
☐ Correction of Sex		
☐ Change of Civil Status		
☐ Updating of Personal Information/Address/ Telephone Number/Mobile Number/e-mail Address		

Under penalty of law, I hereby attest that the information provided, including the documents I have attached to this form, are true and accurate to the best of my knowledge. I agree and authorize PhilHealth for the subsequent validation, verification and for other data sharing purposes only under the following circumstances:

- As necessary for the proper execution of processes related to the legitimate and declared purpose;
- The use or disclosure is reasonably necessary, required or authorized by or under the law; and,
- Adequate security measures are employed to protect my information.

Member's Signature over Printed Name _____ **Date** _____

Please affix right thumbmark if unable to write

FOR PHILHEALTH USE ONLY

RECEIVED BY:

Full Name: _____

PRO/LHIO/Branch: _____

Date & Time: _____

INSTRUCTIONS

1. All information should be written in UPPER CASE/CAPITAL LETTERS. If the information is not applicable, write "N/A."
2. All fields are mandatory unless indicated as optional. By affixing your signature, you certify the truthfulness and accuracy of all information provided.
3. A properly accomplished PMRF shall be accompanied by a valid proof of identity for first time registrants, and supporting documents to establish relationship between member and dependent/s for updating or request for amendment.
4. On the PURPOSE, check the appropriate box if for Registration or for Updating/Amendment of information.
5. Indicate preferred KonSulTa provider near the place of work or residence.
6. For PERSONAL DETAILS, all name entries should follow the format given below. Check the appropriate box if registrant has no middle name and/or with single name (mononym).

LAST NAME	FIRST NAME	NAME EXTENSION (Jr./Sr./III)	MIDDLE NAME
SANTOS	JUAN ANDRES	III	DELA CRUZ

7. Indicate registrant's/member's name as it appears in the birth certificate.
8. The full mother's maiden name of registrant/member must be indicated as it appears in the birth certificate.
9. Indicate the full name of spouse if registrant/member is married.
10. Indicate the complete permanent and mailing addresses and contact numbers.
11. For updating/amendment, check the appropriate box to be updated/amended and indicate the correct data.
12. For MEMBER TYPE, check the appropriate box which best describes your current membership status.
13. For Direct Contributors, except employed, sea-based migrant workers and lifetime members, indicate the profession, monthly income and proof of income to be submitted.
14. For Self-earning individuals, Kasambahays and Family Drivers, indicate the actual monthly income in the space provided.
15. In declaring dependents, provide the full name of the living spouse, children below 21 years old, and parents who are 60 years old and above totally dependent to the member.
16. Dependents with disability shall be registered as principal members in accordance with Republic Act 11228 on mandatory PhilHealth coverage for all persons with disability (PWD).
17. The registrant must affix his/her signature over printed name (or right thumbmark if unable to write) and indicate the date when the PMRF was signed.

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UNIVERSAL HEALTH CARE

Annex H: Sample for Motion for Reconsideration or Appeal

Date: _____

To: PhilHealth President and CEO

Attention: Project Management Office for Indemnity Fund (if Motion for Reconsideration)
Protest and Appeals Department (if Appeal)

Subject: Motion for Reconsideration (or Appeal) of Denied Claims for COVID-19 Vaccine Injury Compensation Package
Principal's Name: _____
Claimant's Name: _____

Dear Sir/Ma'am:

I am writing to (request for reconsideration/appeal) the PhilHealth's decision to deny my claim under the COVID-19 Compensation Package dated (date of notification of denial).

I am requesting this for the following reason/s:

1. (state the reason/s).
2.

Attached herewith are the documents supporting my request.

Should you require additional information, you may contact me at (phone number/email address). I look forward to hearing from you in the near future.

Sincerely yours,

Signature over printed name

Attachments:
Original claim documents that were returned during denial.
New documents that may provide new information during claims review.

MASTER COPY Date: 6/4/2021 DC: MJS