PhilHealth Konsulta Registration Form (PKRF)

INSTRUCTIONS

1. All information should be written in UPPER CASE/CAPITAL LETTER.
2. All fields are mandatory.
3. If the beneficiary is dependent, use the dependent PIN.
4. If the beneficiary is below 21 years old, the signatory should be the parent/guardian.

TO BE FILLED-OUT BY THE BENEFICIARY

☐ MEMBER ☐ DEPENDENT

PIN: _____ DATE: _____ (MM/DD/YYYY)

FULL NAME: _____ (LAST NAME / FIRST NAME / MIDDLE NAME)

ADDRESS: _____ (BARANGAY /TOWN / MUNICIPALITY/CITY / PROVINCE)

DATE OF BIRTH: _____ (MM/DD/YYYY) CONTACT NO: _____

☐ REGISTER TO A KONSULTA PACKAGE PROVIDER (KPP)

☐ REGISTER ALL MY DECLARED MINOR DEPENDENTS
(please use additional form if necessary)

FULL NAME: _____ (LAST NAME / FIRST NAME / MIDDLE NAME)

1ST CHOICE KPP: _____

ADDRESS: _____ (BARANGAY /TOWN / MUNICIPALITY/CITY / PROVINCE)

2ND CHOICE KPP: _____

ADDRESS: _____ (BARANGAY /TOWN / MUNICIPALITY/CITY / PROVINCE)

☐ TRANSFER

PREVIOUS KPP: _____

1ST CHOICE KPP: _____

ADDRESS: _____ (BARANGAY /TOWN / MUNICIPALITY/CITY / PROVINCE)

2ND CHOICE KPP: _____

ADDRESS: _____ (BARANGAY /TOWN / MUNICIPALITY/CITY / PROVINCE)

I HEREBY CERTIFY THAT I DID NOT AVAIL OF FIRST PATIENT ENCOUNTER (FPE) IN MY PREVIOUS KPP.

_____
(Signature over Printed Name)

PHILHEALTH'S COPY

TO BE FILLED-OUT BY PHILHEALTH KONSULTA PERSONNEL

PHILHEALTH KONSULTA REGISTRATION CONFIRMATION SLIP

REGISTRATION NO.: _____ DATE REGISTERED: _____ (MM/DD/YYYY)

FULL NAME: _____ (LAST NAME / FIRST NAME / MIDDLE NAME)

PIN: _____ DATE OF BIRTH: _____ (MM/DD/YYYY)

KPP: _____

ADDRESS: _____ (BARANGAY /TOWN / MUNICIPALITY/CITY / PROVINCE)

_____
(Signature over Printed Name of Authorized Personnel)

BENEFICIARY'S COPY

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TO BE FILLED-OUT BY THE BENEFICIARY

☐ MEMBER ☐ DEPENDENT

PIN: _____ DATE: _____ (MM/DD/YYYY)

FULL NAME: _____ (LAST NAME / FIRST NAME / MIDDLE NAME)

ADDRESS: _____ (BARANGAY /TOWN / MUNICIPALITY/CITY / PROVINCE)

DATE OF BIRTH: _____ (MM/DD/YYYY) CONTACT NO: _____

☐ REGISTER TO A KONSULTA PACKAGE PROVIDER (KPP)

☐ REGISTER ALL MY MINOR DEPENDENTS (DECLARED)
(please use additional form if necessary)

FULL NAME: _____ (LAST NAME / FIRST NAME / MIDDLE NAME)

1ST CHOICE KPP: _____

ADDRESS: _____ (BARANGAY /TOWN / MUNICIPALITY/CITY / PROVINCE)

2ND CHOICE KPP: _____

ADDRESS: _____ (BARANGAY /TOWN / MUNICIPALITY/CITY / PROVINCE)

☐ TRANSFER

PREVIOUS KPP: _____

1ST CHOICE KPP: _____

ADDRESS: _____ (BARANGAY /TOWN / MUNICIPALITY/CITY / PROVINCE)

2ND CHOICE KPP: _____

ADDRESS: _____ (BARANGAY /TOWN / MUNICIPALITY/CITY / PROVINCE)

I HEREBY CERTIFY THAT I DID NOT AVAIL OF FIRST PATIENT ENCOUNTER (FPE) IN MY PREVIOUS KPP.

_____
(Signature over Printed Name)

PHILHEALTH'S COPY

TO BE FILLED-OUT BY PHILHEALTH KONSULTA PERSONNEL

PHILHEALTH KONSULTA REGISTRATION CONFIRMATION SLIP

REGISTRATION NO.: _____ DATE REGISTERED: _____ (MM/DD/YYYY)

FULL NAME: _____ (LAST NAME / FIRST NAME / MIDDLE NAME)

PIN: _____ DATE OF BIRTH: _____ (MM/DD/YYYY)

KPP: _____

ADDRESS: _____ (BARANGAY /TOWN / MUNICIPALITY/CITY / PROVINCE)

_____
(Signature over Printed Name of Authorized Personnel)

BENEFICIARY'S COPY