Annex A: PhilHealth Konsulta Registration Form

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 FPE in other KPP. Moreover, I grant my free and voluntary consent to the collection, transmission and processing of my personal data and health records to PhilHelth for the purpose of paying and monitoring the provider for the Konsulta benefit in accordance with Republic Act No. 10173, otherwise known as the "Data Privacy Act of 2012".

.....
(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

PhilHealth Konsulta Registration Form (PKRF)

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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: .....

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

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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*

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(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