PROVIDER DATA RECORD
HEALTH CARE PROFESSIONALS

4.5cm x 3.5 cm
(Passport Size)
Photo

INSTRUCTIONS

1. Please read each sections carefully and check applicable boxes.
2. All information should be written in UPPER CASE/ CAPITAL LETTERS. If the information is not applicable, write "N/A"
3. All fields are mandatory. By affixing your signature, you certify the truthfulness and accuracy of all information provided.
4. For profile updating, fill up item no. 3 and check the appropriate box to be updated. Proceed to item no. 19 and indicate the correct data.
5. *Indicate all affiliated health facilities. Use separate sheet if necessary.*

THE PRESIDENT & CEO

Philippine Health Insurance Corporation
Pasig City Philippines

PHILHEALTH ACCREDITATION NUMBER

				-								-	

Not applicable for initial application

Sir/Madam:

I, of legal age, hereby applies for accreditation under Sec. *61* of R.A. 7875 as amended by R.A. 10606 and its Implementing Rules and Regulations thereto. For this purpose, I hereby submit the following pertinent information and documentary requirements.

PHILSYS NUMBER:					-					-					-						
TAX IDENTIFICATION NO.											**PHILHEALTH IDENTIFICATION NO.**					-				-				

1. CLASSIFICATION

- ☐ General Practitioner (GP)
- ☐ GP w/ Training
  Training: _____
- ☐ Medical Specialist
  Specialty: _____
- ☐ Primary Care Physician (as Konsulta Provider)
- ☐ General Dentist
- ☐ Dental Specialist
  Specialty: _____
- ☐ Midwife
- ☐ Nurse
- ☐ Others: _____

2. TYPE OF APPLICATION

- ☐ Initial
- ☐ Renewal
- ☐ Re-accreditation

3. PROFILE UPDATE

- ☐ Update of civil status
- ☐ Update of name
- ☐ Update of health facility affiliations
- ☐ Update of Family Planning Training
  _____
- ☐ Others: _____

4. PERSONAL INFORMATION

	LAST NAME	FIRST NAME	Name Extension (Jr./Sr./III)	MIDDLE NAME	NO MIDDLE NAME
HEALTH CARE PROFESSIONAL					☐
MOTHER'S MAIDEN NAME					☐
SPOUSE (if Married)					☐

5. SEX
☐ Male ☐ Female

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

7. BIRTHDATE (MM/DD/YYYY)	**8. E-MAIL ADDRESS**	**9. LANDLINE NO.**	**10. MOBILE NO.**

11. MAILING/ BILLING ADDRESS

No./St./Brgy.	City/Municipality	
Province	**Zip Code**	**Contact No.**

Continue at the back

12. COLLEGE/ UNIVERSITY	13. YEAR GRADUATED

14. PRC NO.	15. DATE ISSUED (MM/DD/YYYY)	16. VALID UP TO (MM/DD/YYYY)

17. RESIDENCY TRAINING (For MS/ GP with Training) Name of Health Facility	Address of Health Facility	Year Started	Year Ended

	18. HOSPITAL/CLINIC AFFILIATION(S)/ RETAILER OF MEDICAL DEVICES	ADDRESS
1		
2		
3		
4		
5		

Continue in a separate sheet if necessary

19. PROFILE UPDATE

Check all applicable:	FROM	TO
☐ Change/correction of Name (Last Name, First Name, Name extension, Middle Name)		
☐ Upgrading or Downgrading		
☐ Correction of Date of Birth		
☐ Correction of Sex		
☐ Change of Civil Status		
☐ Updating of Personal Information/ Address/ Telephone Number/ Mobile Number/ Email address		
☐ Others:		

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 thelaw;
- Adequate security measures are employed to protect my information; and
- I am allowing PhilHealth to access my PRC details to verify status of my professional license.

Health Care Professional's Signature over Printed Name **Date**

FOR PHILHEALTH USE ONLY

Date Evaluated	LHIO		By:	LHIO	
	PRO		By:	PRO	
Date Received:	LHIO		By:	LHIO	
	PRO			PRO	
Date Encoded:	LHIO/PRO (Receiving Module)			LHIO	
	PRO (Data Entry)			PRO	

iPAS Generated Control No.