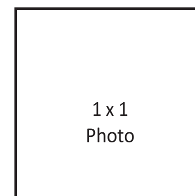
PROVIDER DATA RECORD
HEALTH CARE PROFESSIONALS



PHIC-ACCRE-AF-5 V.2022

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. 52 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: ____________________
  ____
  ____
  ____
- ☐ Dentist
- ☐ Midwife
- ☐ Nurse

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.

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)	**ADDRESS**
1	
2	
3	
4	
5	

Continue in a separate sheet if necessary

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Continue at the back

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; and,
- Adequate security measures are employed to protect my information.

____ ______________

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

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. By affixing your signature, you certify the truthfulness and accuracy of all information provided.
3. A properly accomplished PDR shall be accompanied by a valid proof of supporting documents such as a valid PRC license or its alternative proof and the specific requirement/s as to the type professional classification. The original PRC card shall be presented for verification.
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 affiliate health facilities. An official certification from the health facility is required to be submitted.

FOR PHILHEALTH USE ONLY

Date Evaluated	LHIO	By:	LHIO	______________ Control No.
	PRO		PRO	
Date Received:	LHIO	By:	LHIO	
	PRO		PRO	
Date Encoded:	LHIO/PRO (Receiving Module)	By:	LHIO	
	PRO (Data Entry)		PRO	