

PHILHEALTH DIALYSIS DATABASE Registration Form

I would like to register under the PhilHealth Dialysis Database. I understand that the following information will be used by PhilHealth for my claims reimbursement. Also, I am giving my consent to access on my pertinent clinical information.

New Registration Reactivation

1. PhilHealth Identification Number (PIN)

2. Name of CKD Patient _____

Last Name
First Name
Name Extension (JR/SR/III)
Middle Name
(example: DELA CRUZ JUAN JR SIPAG)

3. Currently, I am a Principal Member Dependent

4. Date of Birth - - **5. Sex** Male Female **6. Civil Status:** _____

month day year

7. Mailing Address

Unit/ Room No., Floor
Building Name
Lot/Block/House/Bldg. No.
Street
Subdivision/Village

Barangay
City/Municipality
Province
Country
Zip Code

8. Email Address _____ **9. Mobile Number** _____ **10. Landline** _____

11. Is the patient enrolled under the Z benefits?

- **PD First Policy** Yes No
- **Kidney Transplantation** Yes No

12. Previous availment under All Case Rates?

- **Kidney Transplantation** Yes No

13. I started dialysis on _____ (month & year)

14. For HD: Type of dialyzer Low flux High flux Others: _____

15. For PD: Current PD system CAPD CIPD-C CIPD-M CCPD NIPD

I certify that the herein information given are true and correct.

16. Signature/Thumbmark _____ **17. Date** - -

Printed Name
month day year

18. PDD Registration No. _____

19. Registered by _____ **20. Accreditation No.** _____

Name of Health Care Institution

21. Registration Date - -

month day year