GUIDELINES ON THE PROPER ACCOMPLISHMENT OF PHILHEALTH CLAIM FORM 1 (November 2013)

I. General Guidelines applicable to all Claim Forms:

1. CF1 shall be accomplished using capital letters and by checking the appropriate boxes. All items should be marked legibly by using ballpen only.
2. Names should be written starting with last name, first name, name extension and middle name. Extensions such as (but not limited to the following) Jr., Sr., III should be indicated after the first name.

   Illustration: ***DELA CRUZ*** ***JUAN*** ***JR.*** ***SIPAG***

   Last name *First Name* *Name Extension* *Middle Name*
3. All dates should be filled out following this format: MONTH-DAY-YEAR (MM-DD-YYYY).

   Illustration: December 25, 2013 should be written as ***12 - 25 - 2013***
4. PhilHealth Identification No. (PIN) and PhilHealth Employer No. (PEN) should be filled out following the 2-9-1 format.

   Illustration: ***12-123456789-1***

II. Specific Guidelines:

A. Claim Form 1 (CF1)

CF1 is divided into five (5) parts:

- **Part I - Member Information** requires information about the member to ascertain the identity of the member for eligibility to PhilHealth benefits.
- **Part II - Patient Information** requires information about the patient to ascertain the relationship to the member for eligibility to PhilHealth benefits.
- **Part III - Member Certification** provides the information about the member and the correctness of the supplied information.
- **Part IV - Employer's Certification (for employed members' only)** provides the basic information about the employer and contains the certification of qualifying contributions and correctness of the information supplied by the member.
- **Part V - For PhilHealth Use Only** (this part is for PhilHealth use only.)

The tables below explain the proper way of accomplishing CF1:

Part I - Member Information

Item	Description and Instruction
1	**PhilHealth Identification Number (PIN)** Write the member's PhilHealth Identification Number (PIN), a 12 digit number, as reflected in the PhilHealth Number Card/Identification Card/Member Data Record (MDR). *Illustration:* *07-123456789-1*

Item	Description and Instruction
2	**Name of Member** Write the complete name of the member starting with last name, first name, name extension and middle name. Extensions such as (but not limited to the following) Jr., Sr., III should be indicated after the first name. *Illustration:* *Name with Suffix: The name **Juan Sipag Dela Cruz, Jr.** should be written as* ***DELA CRUZ*** *Last name* ***JUAN*** *First Name* ***JR.*** *Name Extension* ***SIPAG*** *Middle Name*
3	**Date of Birth** Write the date of birth of member following the prescribed format for date.
4	**Mailing Address** Write the mailing address of the member, indicating the Unit/Room No., Floor, Building Name, Lot/Block/House/Building Number, Street, Subdivision/Village Barangay, City/Municipality, Province, Country and Zip Code. The name of sitio/purok/poblacion (if applicable) of the mailing address should be indicated before the barangay.
5	**Sex** Check appropriate box whether the member is male or female.
6	**Contact Information** Write the member's contact information such as landline (area code + tel. no), mobile no. and email address, if available.
7	**Patient is the Member** Check appropriate box whether the patient is the member or not. If YES, the patient/member should proceed to Part III (Member Certification) for proper accomplishment of the form. If NO, the patient should proceed to Part II (Patient Information) also for proper filling out of the said form.

Part II - Patient Information (To be filled-out only if the patient is a dependent)

Item	Description and Instruction
1	**PhilHealth Identification Number (PIN)** Write the dependent's PhilHealth Identification Number (PIN), if applicable. *Illustration: 07-123456789-1*
2	**Name of Patient** Write the complete name of the patient starting with last name, first name, name extension and middle name. Extensions such as (but not limited to the following) Jr., Sr., III should be indicated after the first name. *Illustration:* *Name with Suffix: The name **Juan Sipag Dela Cruz, Jr.** should be written as* ***DELA CRUZ*** *Last name* ***JUAN*** *First Name* ***JR.*** *Name Extension* ***SIPAG*** *Middle Name*

Item	Description and Instruction
3	**Date of Birth** Write the date of birth of patient following the prescribed format for date.
4	**Relationship to member** Check the appropriate box whether the patient is his/her child, parent or spouse.
5	**Sex** Check appropriate box whether the patient is male or female.

Part III - Member Certification

	Signature over printed name of member The member affixes his/her signature over printed name attesting that the information provided in CF1 are true and accurate. **Date signed** The member indicates the date when he/she signed the certification following the prescribed format for date. **Signature over printed name of member's representative** An authorized representative of the member may sign on his/her behalf. **Date signed** The authorized representative of the patient indicates the date when he/she signed on behalf of the patient following the prescribed format for date. **Relationship of the Representative to the member** Check the appropriate box whether the representative of the member is his/her spouse, child (must be 18 years old and above), parent, siblings or others (please specify). **Reason for signing on behalf of the member** Indicate the reason for signing on behalf of the member: (1) Member is incapacitated and (2) Other reasons. For other reasons, please specify. In case the member/patient/representative is unable to write, put the right thumbmark on the space provided (member/representative should be assisted by an HCI representative). Check the appropriate box provided.

Part IV - Employer's Certification (for employed members only)

Item	Description and Instruction
1	**PhilHealth Employer No. (PEN)** Write the PhilHealth Employer Number (PEN) as reflected in the Certificate of Registration (CoR).
2	**Contact Number** Write the contact number (landline and/or mobile number) of the employer.
3	**Business Name:** Write the Business Name (as reflected in the Certificate of Registration [CoR]) of the employer

Item	Description and Instruction
4	**Certification of Employer** **Signature over printed name of employer/authorized representative:** The employer or his/her authorized representative shall affix his/her signature certifying that all monthly premium contributions for and in behalf of the member, while employed in their company, including the applicable three (3) monthly premium contributions within the past six (6) months period prior to the first day of the confinement, have been deducted/collected and remitted to PhilHealth, and that the information supplied by the member or his/her representative on Part I are consistent with PhilHealth's available records. **Official capacity/designation:** The employer or authorized representative shall indicate his/her official capacity/designation. **Date signed:** The employer/authorized representative shall indicate the date when he/she signed the claim form in the following the prescribed format for date.
Part V - For PhilHealth Use Only	This part is for PhilHealth use only.