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**Phil Health**

**Series #**

**February 2020**

**Claim Form (CF4)**

**II. PATIENT'S DATA**

1. Name of Patient: 
   - Last Name
   - First Name
   - Middle Name

2. PIN

3. Age

4. Sex
   - Male
   - Female

5. Chief Complaint

6. Admitting Diagnosis

7. Discharge Diagnosis

8a. 1st Case Rate Code

8b. 2nd Case Rate Code

9a. Date Admitted: 
   - Month
   - Day
   - Year

9b. Time Admitted: 
   - AM
   - PM

10a. Date Discharged: 
    - Month
    - Day
    - Year

10b. Time Discharged: 
     - AM
     - PM

**III. REASON FOR ADMISSION**

1. History of Present Illness:

2a. Pertinent Past Medical History:

2b. OB/GYN History
   - G: 
   - P: 
   - R: 
   - LMP: 
     - NA

3. Pertinent Signs and Symptoms on Admission (Tick applicable box/es):
   - Altered mental status
   - Diarrhea
   - Hematamia
   - Paresthesia
   - Abdominal cramp/pain
   - Dizziness
   - Hematoxilia
   - Seizures
   - Anorexia
   - Dyspnea
   - Hemoptysis
   - Skin rash
   - Bleeding gums
   - Gynoema
   - Hemoptosis
   - Skup
   - Body weakness
   - Ophthalmia
   - Irritability
   - Lower extremity edema
   - Anorexia
   - Dysphagia
   - Hematuria
   - Weight loss
   - Blurring of vision
   - Headache
   - Dysuria
   - Urgency
   - Constipation
   - Pain, ___ (site)
   - Vomiting
   - Others

4. Referred from another health care institution (HCI):
   - Yes, Specify Reason
     - Name of Originating HCI

5. Physical Examination on Admission (Pertinent Findings per System)
   - General Survey
     - Awake and alert
     - Altered sensorium
     - Height: ___ (cm)
     - Weight: ___ (kg)
   - Vital Signs:
     - BP:
     - HR:
     - RR:
     - Temp:
   - HEENT:
     - Essentially normal
     - Petechia
     - Abnormal capillary reaction
     - Cervical lymphadenopathy
     - dry mucous membrane
     - Others:

   - Others:

   **IMPORTANT REMINDERS:**
   - Please fill out appropriate fields. Write in capital letters and check the appropriate boxes.
   - All information, fields and tick boxes in this form are necessary. Claim forms with incomplete information shall not be processed.
   - False/incorrect information or misrepresentation shall be subject to criminal, civil or administrative liabilities.
   - This form, together with other supporting documents, should be filed within sixty (60) calendar days from date of discharge.
### 5. Physical Examination continued (Pertinent Findings per System)

**CHEST/LUNGS:**
- Essentially normal
- Asymmetrical chest expansion
- Decreased breath sounds
- Wheezes
- Lump(s) over breast(s)
- Rales/crackles/rhonchi
- Intercostal rib/clavicular retraction

**CVS:**
- Essentially normal
- Irregular rhythm
- Displaced apex beat
- Heaves and/or thrills
- Muffled heart sounds
- Murmur
- Lumbar
- Rales/crackles
- Pericardial bulge

**ABDOMEN:**
- Essentially normal
- Abdominal rigidity
- Abdominal tenderness
- Hyperactive bowel sounds
- Pulsation
- Rales/crackles
- Tympanic/dull abdomen
- Umbilical contraction

**GU (CE):**
- Essentially normal
- Bladder tenderness
- Blood stained in exam finger
- Cervical distention
- Presence of abnormal discharge

**SKIN/EXTREMITIES:**
- Essentially normal
- Clubbing
- Cold clammy skin
- Cyanosis/mottled skin
- Edema/swelling
- Decreased mobility
- Decreased mobility
- Pale nailbeds
- Poor skin turgor

**NEURO-EXAM:**
- Essentially normal
- Abnormal gait
- Abnormal position sense
- Abnormal/decreased sensation
- Abnormal/decreased sensation
- Poor muscle tone/strength
- Poor coordination

### IV. COURSE IN THE WARD (Attach photocopy of laboratory/imaging results)

<table>
<thead>
<tr>
<th>Date</th>
<th>DOCTOR'S ORDER/ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

### V. DRUGS/MEDICINES

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Quantity/Dosage/Route/Frequency</th>
<th>Total Cost</th>
<th>Generic Name (cont)</th>
<th>Quantity/Dosage/Route/Frequency (cont)</th>
<th>Total Cost (cont)</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

### VI. OUTCOME OF TREATMENT

- [ ] IMPROVED
- [ ] RECOVERED
- [ ] HAMADAM
- [ ] EXPIRED
- [ ] ABSCONDED
- [ ] TRANSFERRED

Specify reason:

### VII. CERTIFICATION OF HEALTH CARE PROFESSIONAL

Certification of Attending Health Care Professional:

I certify that the above information given in this form, including all attachments, are true and correct.

Signature over Printed Name of Attending Health Care Professional

Month Day Year