



**Important Reminders for the
Implementation of PhilHealth Claim
Forms 1, 2 and 3
(November 2013)**

I. General Reminders

- A. In conjunction with the implementation of the All Case Rates Policy, all claims for PhilHealth reimbursements shall utilize the PhilHealth Claim Form 1 (CF1), Claim Form 2 (CF2), and Claim Form 3 (CF3) revised November 2013.
- B. All claim forms submitted to PhilHealth shall be properly and completely filled out following the guidelines contained in Annex 11. Otherwise, it shall be returned to sender (RTS).
- C. As mentioned in the Implementing Guidelines on Medical and Procedure Case Rates (ACR POLICY No. 2), Health Care Providers shall comply with the following rules:
 1. The Corporation shall only allow return of claims to the sender (RTS) for correction/revision/completion for claims with admission dates on or before March 31, 2014. RTS shall no longer be allowed for all claims with date of admission starting April 1, 2014. Instead, these claims shall be denied.
 2. All claims that were returned to the sender for correction or completion shall be re-filed within 60 days from receipt of notice; otherwise, it shall be denied. The basis for the receipt of notice shall be the date received by the HCI representative.
- D. Claim forms shall be returned to sender (RTS) if the said documents were submitted by fax or sent via email including any or all attachments thereto.
- E. Health Care Institutions shall ensure that the attached document is consistent with the name of the patient reflected in the claim forms. Any discrepancies shall result to return of the claim.
- F. Printed forms must be filled out completely using BLACK/BLUE BALLPOINT PEN. Computerized or typewritten mode of filling out the claims form is acceptable.
- G. Use additional claim forms if necessary. Fill out applicable fields only.
- H. Claim forms shall be reproduced by all providers in Long-size paper (8½ inches x 13 inches) by any electronic or manual means for the purpose of filing claims. However, all rights to these forms shall reside solely with PhilHealth.

II. Specific Reminders for Claim Form 1 (CF1)

- A. For local availment, Claim Form 1, together with other PhilHealth Claim Forms and other supporting documents, should be filed within sixty (60) calendar days from the date of discharge.
- B. For reimbursement of claims for benefits availed abroad, Claim Form 1, together with other supporting documents, should be filed within one hundred eighty (180) calendar days from the date of discharge. All pertinent documents should be translated into English when confinement is in non-English speaking countries.
- C. In CF1 Part III (Member Certification), the thumbmark of the member/representative must be affixed and duly witnessed/assisted by a HCI representative in case either the member or representative is unable to sign the said document.
- D. For employed members, CF1 shall be returned to sender (RTS) if the date of signature in employer's certification (Part IV, item 4) is **more than 30 days** before the start of confinement.

III. Specific Reminders for Claim Form 2 (CF2)

- A. The health care provider shall indicate the **complete** admitting and discharge diagnoses in Part II item 6 and 7 of Claim Form 2. Additional copies of CF2 may be used if the space provided for the diagnoses is not sufficient. The health care provider shall only fill out the appropriate parts and shall leave the rest of CF 2 blank. Additional codes for specific requirements for each case rate shall be reflected in the discharge diagnosis (e.g., dehydration code for acute enteritis).
- B. The health care provider shall write legibly the correct and complete ICD-10 and RVS codes corresponding to the discharge diagnosis/es and shall be held primarily responsible for any errors that may be found therein on post audit.
- C. For procedures with laterality (see ACR Policy No 2, Annex 7), the health care provider shall tick the appropriate box (left, right, or both) in item 7; otherwise, the claim shall be returned to sender. Tick boxes for laterality shall be left blank for other procedures (i.e., procedures without laterality).
- D. The health care provider shall ensure that the **amount** indicated in Part III item A of Claim Form 2 is based on what is written in the Statement of Account (SOA).
- E. For repetitive procedures (see ACR Policy No 2, Table 2 – Procedure List A):
 - 1. The health care provider shall indicate the discharge diagnosis with corresponding ICD 10 code, and related procedures with corresponding RVS code/s in Item 7 of CF2. The date of procedure shall be left blank. Instead, the health care provider shall tick the appropriate box in item 8 of CF2 and indicate the dates of session/procedure in the blank space opposite the procedure.
 - 2. A maximum of two repetitive procedures shall be ticked in Item 8a of CF 2. All procedures checked under Item 8a of CF2 shall be reflected in Item 9 as first and second case rates respectively.
 - 3. Multiple sessions/cycles of the repetitive procedures can be indicated per claim. However, a maximum of one month of procedures shall be included per claim.
 - 4. All procedures ticked in Item 8a shall be written in Item 9 under 'ICD 10/RVS Code'. Only one case rate (indicated by the ICD 10 or RVS code) shall be written per line.
- F. Under Part II, Item 9 of CF2, only one code shall be indicated for the first case rate and one code for the second case rate (if applicable).
- G. In CF2 Part III item B, the thumbmark of the patient/representative must be affixed and duly witnessed/assisted by a HCI representative in case either the patient or representative is unable to sign the said document.

IV. Specific Reminder for Claim Form 3 (CF3)

A properly and completely filled out Claim Form 3 shall be required for Maternity Care Package claims and for all cases managed in Primary Care Facilities.