Annex E: Letter of Intent for the Transfer of MH Care to a Referral MH Provider
As of October 2023

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8441-7442 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐-☐☐☐☐☐☐☐☐-☐	
B. MEMBER	**(Answer only if the patient is a dependent; otherwise, write, "same as above")** 1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐-☐☐☐☐☐☐☐☐-☐	

LETTER OF INTENT FOR THE TRANSFER OF CARE TO A REFERRAL MH PROVIDER

This is to certify, that patient _____, born on _____,
(Name of the Patient) (Date of Birth)
age _____ years old, residing at _____,
(Address)
was diagnosed with _____ on _____
(Diagnosis) (Date: mm/dd/yyyy)
at the _____
(Name of the Referring MH Provider)

The patient has completed:
_____ number of follow-up visits and the next scheduled visit is on (Number of Visit) _____. Attached is a photocopy of the MH passport for reference. (mm/dd/yyyy)

We would like request for transfer of MH Care to _____
(Name of Referral MH Provider)
under the care of _____.
(Name of Physician/Specialist)

We understand that upon transfer to a referral MH provider, we will have to waive all subsequent MH claims as the referring MH facility.

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	**(Answer only if the patient is a dependent; otherwise, write, "same as above")** 1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

Conforme by:	Certified correct by:
(Printed name and signature) Patient/Parent/Guardian	(Printed name and signature) Physician, Referring MH Provider
Date signed (mm/dd/yyyy)	PhilHealth Accreditation No. ☐☐☐☐.☐☐☐☐☐☐.☐
	Date signed (mm/dd/yyyy)

Certified correct by:
(Printed name and signature) MH Coordinator, Referring MH Provider
Date signed (mm/dd/yyyy)

Acknowledged by:	Acknowledged by:
(Printed name and signature) BAS Head or Authorized Signatory, PhilHealth Regional Office _____ In-charge of the Referring MH Provider (To provide a copy to the referring MH provider five working days upon receipt of the form; scanned copy allowed)	(Printed name and signature) Head or MH Coordinator, Referral MH Provider
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)