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| dmission Diagnosis/es: ischarge Diagnosis/es (Use a Diagnosis ICD-10 | Private Non-Private (| (Chanty/Service/ | | | | by another |
| ischarge Diagnosis/es (Use a Diagnosis ICD-10 | | | | | | HF |
| Diagnosis ICD-10 | Schizophrenia | | | | | |
| Diagnosis ICD-10 | | | | | | This is not |
| | | (. / (| | to the first state of the | Problem 1 | required as |
| | Code/s Related Procedure/ | | S Code Date of Procedu | | | mental hea |
| | I | | | left righ | | services |
| | | | | left righ | | provided is |
| | i. | | | left righ | | out-patien |
| | ii. | | | left righ | | setting |
| | iii | | | left igh | t 🚺 both | |
| pecial Considerations: | | | | | | |
| For the following repetitive procedu | res, check box that applies and en | numerate the procedure/session | ons dates [mm-dd-yyyy]. For che | motherapy, see guid elines. | | Indicate th |
| Hemodialysis | | Bloo | Transfusion | | | |
| Peritoneal Dialysis | | Brac | ytherapy | | | ulagilosis |
| Radiotherapy (LINAC) | | | notherapy | | | |
| Radiotherapy (COBALT) | | | le Debridement | | | Indicate th |
| For Z-Benefit Package | Z-Benefit Package C | | | | | appropriat |
| For MCP Package (enumerate four o | - | | | | | "benefit |
| - | | 3 | | 4 | | package co |
| | | ntenance Phase | | | | |
| For Animal Bite Package (write the c | | | ven) Note: Anti Rabies Vaco | ine (ARV), Rabies Immuno | globulin (RIG) | |
| | Day 3 ARV | | | Others (Specify) | | |
| | Essential Newborn Care | | _ | | ning, | |
| For Essential Newborn Care (che | | B an | | please attach NBS F | | |
| Immediate drying of newborn | Timely cord clamping | Weighing of the newborn | BCG vaccination | Hepatitis Bvaccini | ation | |
| Early skin-to-skin contact | Eye Prophylaxis | Vitamin K administration | | other/baby for early breastfeedir | | This is not |
| For Outpatient HIV/AIDS Treatment | | | | | - | required |
| hilHealth Benefits: | | | | | | |

| Accreditation Number (Use additional CF2 if necessa | | d Health Care Profession | al/ | Date Signed and Pro | ofessional Fees/Charges | | |
|--|--|--|-------|--|--|------------|------------------------------------|
| Accreditation number/Name | | rofessional/Date Signed | Г | | Details | _ | |
| Accreditation No.: 112 | | | t | | D CONS | | Tick this box |
| | A DELA CRUZ, MD | | | 1 | | | if patient paid |
| Signature Over Printed Name | | | | No co-pay on top of | | | no additional |
| | | | | With co-pay on top | of PhilHealth Benefit P | - | Professional |
| | | | | | | | fee |
| Accreditation No.: | | | | No co-pay on top of | f Dhilliasth Ranafit | | |
| | Signature Over Printed Nar | ne | | | of PhilHealth Benefit P | | |
| Date Signed: | | | | | | - | Ti ala thia haar |
| Accreditation No.: | | | t | | | | Tick this box if patient paid |
| | | | | No co-pay on top of | f PhilHealth Benefit | | an additional |
| | Signature Over Printed Nar | | | With co-pay on top | of PhilHealth Benefit P | _ | Professional |
| Date Signed: | month day ye | ar | | | | | fee |
| PART III - CER | | NSUMPTION OF BENEFI r/Patient should sign only after the | | | D ACCESS PATIENT RECORD/S filled-out | | |
| CERTIFICATION OF CON | SUMPTION OF BEN | EFITS: | | | | | |
| PhilHealth benefit is end | ough to cover HCI and PFC | harges. | | | | | Tick this box |
| No purchase of drugs/m | nedicines, supplies, diagno | stics, and co-pay for professional fe | ees l | by the member/patient. | | | if patient has |
| | | | | То | tal Actual Charges* | | NO co- |
| Total Health Care Insti | tution Fees | | | 5,4 | 00.00 | | payment |
| Total Professional Fee | S | | | | | | |
| Grand Total | | | | 5,4 | 00.00 | | |
| The benefit of the mem | her/patientwas completely | consumed prior to co-pay OR the | her | nefit of the member/patient | t is not completely consumed BUT with | | |
| purchases/expenses for | drugs/medicines, supplies | , diagnostics and others. | | | | | |
| a.) The total co-pay for | the following are: | | _ | | | | Tick this box |
| | Total Actual Charges* | Amount after Application of Discount (i.e., personal discount, Senior Citizen/PWD) | | PhilHealth Benefit | Amount after PhilHealth Deduction | | if patient has a co-payment |
| | | | + | | Amount P 1,000.00 | | |
| Total Health Care Institution Fees | 6,400.00 | | | 5,400.00 | Paid by (check all that applies): Member/Patient HMO Others (i.e., PCSO, Promisory note, etc.) | | |
| Total Professional | | | t | | Amount P | | |
| Fees (for accredited | | | | | Paid by (check all that applies): | | |
| and non-accredited | | | | | Member/Patient HMO Others (i.e., PCSO, Promisory note, etc.) | | |
| professionals) | | | | | Others (i.e., PCSO, Promisory note, etc.) | ļ | |
| | | th Care Institution Charges | | | | | |
| | Total cost of purchase/s for drugs/medicines and/or medical supplies bought by the patient/member within/outside the HCI during confinement | | | None None | Total Amount P | | |
| Total cost of diagnosti within/outside the HCI | | paid by the patient/member done | 2 | None None | Total Amount P | | |
| * NOTE: Total Actual C | Charges should be based or | n Statement of Account (SOA) | _ | | | 1 | |
| CONSENT TO ACCESS P | ATIENT RECORD/S. | | | | | l Ir | |
| | | | | | | - 11 | Affix signature |
| hereby consent to the submis fficient processing of benefit | | he patient's pertinent medical rec | cord | ds for the purpose of verify | ving the veracity of this claim to effect | - H | of the |
| hereby hold PhilHealth or an | y of its officers, employees | | | , , | elative to the herein-mentioned consent | - H | patient/parent /authorized |
| | | n with this claim for reimburseme | ent | before PhilHealth. | | | representative |
| JUAN MAPAGPALA | DELA CRUZ, III | | | | | | representative |
| ignature Over Printed Name o | | | | If patient/represent | tative | | |
| Date Signed: | 2 2 9 2 0 month day ye | | | is unable to write, p | | 1 1 | |
| | month day ye | ar | | right thumbmark. F Representative sho | | | Indicate date |
| elationship of the representat | tive to Spouse | Child Parent | | assisted by an HCI r | | [] | signed |
| he member/patient: | | Others, Specify | | | | I ' | |
| Reason for signing on behalf of nember/patient: | | apacitated ns | | Patient Representativ | /e | | |
| | PART IV - CERTIFI | CATION OF CONSUMPTI | 101 | N OF HEALTH CARE | | | Affix |
| I certify that services render CARDING DEL | red were recorded in the p OS REYES | | | tution records and that th OFFICER | e herein information given are true and correct. 1 2 3 0 2 0 2 | 3 | signature of HF |
| ignature Over Printed Name o | f Authorized HCI Peoresent | | | y/Designation | Date Signed: | - | representative |
| ignature over Printed Name 0 | n Autrionzed Hici Represent | auve Official Cap | acit | y/Designation | | | - |