Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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TRANSMITTAL FORM OF CLAIMS FOR THE PHYSICAL MEDICINE, REHABILITATION SERVICES AND ASSISTIVE MOBILITY DEVICES

NAME OF CONTRACTED HEALTH FACILITY	ADDRESS OF HF

Instructions for filling out this Transmittal Form. Use additional sheets if necessary.
1. Use CAPITAL letters or UPPER CASE letters in filling out the form.
2. For the period of confinement, follow the format (mm/dd/yyyy).
3. For the Benefits Package Code, indicate the code based on the services provided. Example: PMR05A
4. For the Case Number, copy the case number that is provided in the approved pre-authorization checklist and request.
5. The Remarks column may include some relevant notes which pertain to the filed claim that need to be relayed to PhilHealth.

Case Number	**Name of Patient** (Last, First, Middle Initial, Extension)	**Period of Confinement**		**Package Code**	**Remarks**
		Date admitted	**Date discharged**		
1.					
2.					
3.					
4.					
5.					
6.					
7.					

Certified correct by authorized representative of the HF		**For PhilHealth Use Only**	**Initials**	**Date**
Printed Name and Signature	Designation	Received by Local Health Insurance Office (LHIO)		
	Date signed (mm/dd/yyyy)	Received by the Benefits Administration Section (BAS)		