

Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION

Citystate Centre Building, 709 Shaw Boulevard, Pasig City Healthline 441-7444 www.philhealth.gov.ph

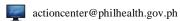


ase No		Annex "G - RF/RHD"
HEALTH CAI	RE INSTITUTION (HCI)	
ADDRESS OF	HCI	
A. PATIENT	1. Last Name, First Name, Mide	dle Name, Suffix SEX
	2. PhilHealth ID Number	- Nate - Penate
B. MEMBER (answer only if	1. Last Name, First Name, Mide	dle Name, Suffix
the patient is a dependent)	2. PhilHealth ID Number	
TER OF INTE	NT FOR TRANSFER OF RF/R	HD CARE TO A REFERRAL RF/RHD PROV
This is to certif	y that I,	, born on, (Date of Birth)
		,
was diagnosed	with rheumatic fever/rheumatic	(Address) heart disease on at the
		RF/RHD provider)
I receive	(antibiotic prophylaxis)	I would like to request for
transfer of RF/		under the care of RF/RHD provider)
	(Name of referral I	RF/RHD provider)
(Name of Physici	an)	
subsequent RF referring RF/R	/RHD claims in my referring RI	RF/RHD provider, I will have to waive all my F/RHD facility. In case I decide to return to the HD Care, I will have to abide by the policies set
Conforme by:		Certified correct by:
(Printed name and signature) Patient/ Parent/ Guardian		(Printed name and signature) Physician, Referring RF/RHD Center
		PhilHealth Accreditation No.
		Certified correct by:
		(Printed name and signature) RF/RHD Coordinator, Referring RD/RHD Center

As of January 2019 teamphilhealth

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Acknowledged by:	Acknowledged by:
(Printed name and signature) BAS Head, PhilHealth Regional Office in-charge of the referring HCI (to be returned to the referring HCI five working days upon receipt of the form)	(Printed name and signature) Head/PD Coordinator, Referral PD Center





