Case No. _____

Annex "G – RF/RHD"

HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
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)	1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

LETTER OF INTENT FOR TRANSFER OF RF/RHD CARE TO A REFERRAL RF/RHD PROVIDER

This is to certify that I, _____, born on _____,
(Name of Patient) *(Date of Birth)*
age _____ years old, residing at _____,
(Address)
was diagnosed with rheumatic fever/rheumatic heart disease on _____ at the
_____
(Name of referring RF/RHD provider)
I receive _____. I would like to request for
(antibiotic prophylaxis)
transfer of RF/RHD care to _____ under the care of
(Name of referral RF/RHD provider)
_____.
(Name of Physician)

I understand that upon transfer to a referral RF/RHD provider, I will have to waive all my subsequent RF/RHD claims in my referring RF/RHD facility. In case I decide to return to the referring RF/RHD Center to resume my RF/RHD Care, I will have to abide by the policies set by them as a new RF/RHD patient.

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

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