



Annex F: Transmittal Form for the OTC Benefits Package for SAM

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
 Citystate Centre, 709 Shaw Boulevard, Pasig City
 (02) 8662-2588 www.philhealth.gov.ph
 PhilHealthOfficial teamphilhealth

TRANSMITTAL FORM FOR THE OTC BENEFITS PACKAGE FOR SAM

NAME OF ACCREDITED 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. Indicate the PhilHealth Identification Number (PIN) of the patient. If the patient is a dependent, indicate the dependent PIN.
3. For the period of availment, follow the format (mm/dd/yyyy).
4. For the package code, include the code for the order of Tranche payment, example: assessment-1st tranche should be as "SAM11"
5. If the case number is available, include the case no. in the first column.
6. The Remarks column may include some relevant notes which pertain to the filed claim that needs to be relayed to PhilHealth.

Case Number	Name of Patient (Last, First, Middle Initial, Extension)	Period of Confinement		Remarks
		Date admitted	Date discharged	
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

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)		

