

Annex G.2: Sample Claim Form 2 (CF2) for 0 to < 6 Months Old - Tranche 2

Sample Claim Form 2 for 0 to less than 6 months old (Tranche 2)



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CF-2

(Claim Form 2)
 Revised September 2018

Series #

IMPORTANT REMINDERS:

PLEASE WRITE IN CAPITAL LETTERS AND CHECK THE APPROPRIATE BOXES.
 This form together with other supporting documents should be filed within sixty (60) calendar days from date of discharge.
 All information, fields and tick boxes required in this form are necessary. Claim forms with incomplete information shall not be processed.
FALSE/INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CRIMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.

PART I - HEALTH CARE INSTITUTION (HCI) INFORMATION

1. PhilHealth Accreditation Number (PAN) of Health Care Institution: H19310101X1XX
2. Name of Health Care Institution: ABCDF Rural Health Unit
3. Address: SHAW BLVD PASIG CITY
Building Number and Street Name City/Municipality Province

PART II - PATIENT CONFINEMENT INFORMATION

1. Name of Patient: DELA CRUZ JUANA MAPAGPALA
Last Name First Name Middle Name (ex: DELACRUZ, JUAN JR SIPAG)

2. Was patient referred by another Health Care Institution (HCI)?

NO YES

Name of referring Health Care Institution Building Number and Street Name City/Municipality Province Zip code

3. Confinement Period:

a. Date Admitted: 03-04-2024 b. Time Admitted: : : AM PM
month day year hour min
 c. Date Discharge: 06-10-2024 d. Time Discharge: : : AM PM
month day year hour min

4. Patient Disposition: (select only 1)

a. Improved e. Expired f. Transferred/Referred
 b. Recovered c. Home/Discharged Against Medical Advise
 d. Absconded
Name of Referral Health Care Institution Building Number and Street Name City/Municipality Province Zip code

5. Type of Accommodation:

Private Non-Private (Charity/Service)

6. Admission Diagnosis/es:

Severe Acute Malnutrition 0 to less than 6 months

7. Discharge Diagnosis/es (Use additional CF2 if necessary):

Diagnosis	ICD-10 Code/s	Related Procedure/s (if there's any)	RVS Code	Date of Procedure	Laterality (check applicable box)
a. Severe Acute Malnutrition 0 to less than 6 months					<input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both
b. _____					<input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both
c. _____					<input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both

8. Special Considerations:

a. For the following repetitive procedures, check box that applies and enumerate the procedure/sessions dates [mm-dd-yyyy]. For chemotherapy, see guidelines.
 Hemodialysis Blood Transfusion
 Peritoneal Dialysis Brachytherapy
 Radiotherapy (LINAC) Chemotherapy
 Radiotherapy (COBALT) Simple Debridement

b. For Z-Benefit Package **Z-Benefit Package Code:** SAM12 - Tranche 2

c. For MCP Package (enumerate four dates [mm-dd-year] of pre-natal check-ups)

1 _____ 2 _____ 3 _____ 4 _____

d. For TB DOTS Package Intensive Phase Maintenance Phase

e. For Animal Bite Package (write the dates [mm-dd-year] when the following doses of vaccine were given) **Note: Anti Rabies Vaccine (ARV), Rabies Immunoglobulin (RIG)**

Day 0 ARV _____ Day 3 ARV _____ Day 7 ARV _____ RIG _____ Others (Specify) _____

f. For Newborn Care Package Essential Newborn Care Newborn Hearing Screening Test Newborn Screening Test

For Essential Newborn Care (check applicable boxes)

Immediate drying of newborn Timely cord clamping Weighing of the newborn BCG vaccination Hepatitis B vaccination
 Early skin-to-skin contact Eye Prophylaxis Vitamin K administration Non-separation of mother/baby for early breastfeeding initiation

g. For Outpatient HIV/AIDS Treatment Package **Laboratory Number:** _____

9. PhilHealth Benefits:

ICD 10 or RVS Code: a. First Case Rate _____ Second Case Rate _____

- Indicate the date of the 1st Follow-up visit
- Indicate the date of the 15th Follow-up
- Write OUTPATIENT in lieu of time admitted & discharged
- Tick YES if the patient was referred by another HF
- This is not required as OTC Severe Acute Malnutrition services provided is an outpatient setting
- Indicate the diagnosis
- Indicate the appropriate "benefit package code" and Tranche
- This is not required



10. Accreditation Number/Name of Accredited Health Care Professional/Date Signed and Professional Fees/Charges
(Use additional CF2 if necessary):

Accreditation number/Name of Accredited Health Care Professional/Date Signed	Details
Accreditation No.: <u>1 2 3 4 5 6 7 8 9 0 1 2</u> (sgd) <u>MARY DELA ROSAS, MD</u> Signature Over Printed Name Date Signed: <u> </u> - <u> </u> - <u> </u> month day year	<input checked="" type="checkbox"/> No co-pay on top of PhilHealth Benefit <input type="checkbox"/> With co-pay on top of PhilHealth Benefit P _____
Accreditation No.: _____ Signature Over Printed Name Date Signed: <u> </u> - <u> </u> - <u> </u> month day year	<input type="checkbox"/> No co-pay on top of PhilHealth Benefit <input type="checkbox"/> With co-pay on top of PhilHealth Benefit P _____
Accreditation No.: _____ Signature Over Printed Name Date Signed: <u> </u> - <u> </u> - <u> </u> month day year	<input type="checkbox"/> No co-pay on top of PhilHealth Benefit <input type="checkbox"/> With co-pay on top of PhilHealth Benefit P _____

Tick this box if patient paid no additional Professional fee

SAM Benefits Package does not allow co-payment

PART III - CERTIFICATION OF CONSUMPTION OF BENEFITS AND CONSENT TO ACCESS PATIENT RECORD/S
NOTE: Member/Patient should sign only after the applicable charges have been filled-out

A. CERTIFICATION OF CONSUMPTION OF BENEFITS:

PhilHealth benefit is enough to cover HCI and PF Charges.
No purchase of drugs/medicines, supplies, diagnostics, and co-pay for professional fees by the member/patient.

	Total Actual Charges*
Total Health Care Institution Fees	6,000.00
Total Professional Fees	
Grand Total	6,000.00

The benefit of the member/patient was completely consumed prior to co-pay OR the benefit of the member/patient is not completely consumed BUT with purchases/expenses for drugs/medicines, supplies, diagnostics and others.

a.) The total co-pay for the following are:

	Total Actual Charges*	Amount after Application of Discount (i.e., personal discount, Senior Citizen/PWD)	PhilHealth Benefit	Amount after PhilHealth Deduction
Total Health Care Institution Fees	6,000.00		6,000.00	Amount P <u>0.00</u> Paid by (check all that applies): <input type="checkbox"/> Member/Patient <input type="checkbox"/> HMO <input checked="" type="checkbox"/> Others (i.e., PCSO, Promissory note, etc.)
Total Professional Fees (for accredited and non-accredited professionals)				Amount P _____ Paid by (check all that applies): <input type="checkbox"/> Member/Patient <input type="checkbox"/> HMO <input type="checkbox"/> Others (i.e., PCSO, Promissory note, etc.)

b.) Purchases/Expenses **NOT** included in the Health 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	<input type="checkbox"/> None <input type="checkbox"/> Total Amount P _____
Total cost of diagnostic/laboratory examinations paid by the patient/member done within/outside the HCI during confinement	<input type="checkbox"/> None <input type="checkbox"/> Total Amount P _____

* NOTE: Total Actual Charges should be based on Statement of Account (SOA)

Tick this box if patient has No co-payment

SAM Benefits Package does not

B. CONSENT TO ACCESS PATIENT RECORD/S:

I hereby consent to the submission and examination of the patient's pertinent medical records for the purpose of verifying the veracity of this claim to effect efficient processing of benefit payment.
I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all legal liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim for reimbursement before PhilHealth.

JUANA MAPAGPALA DELA CRUZ
Signature Over Printed Name of Member/Patient/Authorized Representative
Date Signed: 06-10-2024
month day year

Relationship of the representative to the member/patient: Spouse Child Parent Sibling Others, Specify _____

Reason for signing on behalf of the member/patient: Patient is Incapacitated Patient Other Reasons _____ Representative

If patient/representative is unable to write, put right thumbmark. Patient/Representative should be assisted by an HCI representative.

Affix signature of the patient/p parent/authorized

Indicate date signed

PART IV - CERTIFICATION OF CONSUMPTION OF HEALTH CARE INSTITUTION

I certify that services rendered were recorded in the patient's chart and health care institution records and that the herein information given are true and correct.

CARDING DELOS REYES RECORDS OFFICER
Signature Over Printed Name of Authorized HCI Representative Official Capacity/Designation
Date Signed: 07-01-2024
month day year

Affix signature of HF representative