


Annex G.4: Sample Claim Form 2 (CF2) for 6 to 60 months old - Tranche 2

Sample Claim Form 2 for 6 to 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: H19310101X1 X X X

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

3. Confinement Period:
 a. Date Admitted: 03-04-2024 b. Time Admitted: _____ AM PM
 c. Date Discharge: 06-10-2024 d. Time Discharge: _____ AM PM

4. Patient Disposition: (select only 1)
 a. Improved e. Expired
 b. Recovered f. Transferred/Referred
 c. Home/Discharged Against Medical Advice
 d. Absconded

OUTPATIENT

5. Type of Accommodation: Private Non-Private (Charity/Service)

6. Admission Diagnosis/es:
Severe Acute Malnutrition 6 to 60 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. <u>Severe Acute Malnutrition 6 to 60 months</u> | | | | | <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.

| | |
|--|---|
| <input type="checkbox"/> Hemodialysis | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Peritoneal Dialysis | <input type="checkbox"/> Brachytherapy |
| <input type="checkbox"/> Radiotherapy (LINAC) | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Radiotherapy (COBALT) | <input type="checkbox"/> Simple Debridement |

b. For Z-Benefit Package **Z-Benefit Package Code:** SAM22 - 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)
Day 0 ARV _____ **Day 3 ARV** _____ **Day 7 ARV** _____ **RIG** _____ **Others (Specify)** _____
Note: Anti Rabies Vaccine (ARV), Rabies Immunoglobulin (RIG)

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
For Newborn Screening, please attach NBS Filter Strip here

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 visit

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 No.

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</u> <u>2</u> <u>3</u> <u>4</u> <u>5</u> <u>6</u> <u>7</u> <u>8</u> <u>9</u> <u>0</u> <u>1</u> <u>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.: <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> 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.: <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> 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 the 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 benefits 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 | 15,000.00 | |
| Total Professional Fees | | |
| Grand Total | 15,000.00 | |

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 | 15,000.00 | | 15,000.00 | 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 if there is no co-payment

SAM Benefits Package does not allow co-payment

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/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 Date Signed: 07 01 2024
Signature Over Printed Name of Authorized HCI Representative Official Capacity/Designation month day year

Affix signature of HF representative