Annex I: Letter of Intent for Transfer to a Contracted Health Facility





Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

- ♥ Citystate Centre, 709 Shaw Boulevard, Pasig City
- **७** (02) 8662-2588 ⊕www.philhealth.gov.ph
- ₱ PhilHealthOfficial

 ※ teamphilhealth

Case No			
HEALTH FAC	CILITY (HF)		
ADDRESS OF	HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female	
	2. PhilHealth ID Number □□ - □□□□	10000-0	
B. MEMBER	(Answer only if the patient is a dependent; otherwise, write, "same as above") 1. Last Name, First Name, Middle Name, Suffix		
	2. PhilHealth ID Number	10000-0	
Letter of This is to certif	of Intent for the Transfer of Care to a Refe	erral Contracted HF	
	(Name of the Patient)	(Date of Birth)	
agey	ears old, residing at(Address)		
was diagnosed	with(Diagnosis)	on(Date: mm/dd/yyyy)	
at the	(Name of the Referring Contracted HF)		
We would like 1	request for transfer of Breast Cancer Care to		
under the care		Name of Referral Contracted HF)	

We understand that upon transfer to a referral contracted HF, we will have to waive all subsequent claims as the referring contracted HF.



HEALTH FACILITY (HF)			
ADDRESS OF HF			
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix SEX		
	,	☐ Male ☐ Female	
	a Dhilliaghth ID Numbe		
D MEMBER	2. PhilHealth ID Number		
B. MEMBER	(Answer only if the patient is a dependent; otherwise, write, "same as above")		
	1. Last Name, First Name, Middle Name, Suffix		
	1. Last Ivalite, Pitot Ivalite, Wilduit Ivalite, Sullix		
	2. PhilHealth ID Numbe	er	
Conforme by:		Certified correct by:	
(Printed name and signature)		(Printed name and signature)	
Patient/Parent/Guardian		Attending Physician, Referring Contracted HF	
Date signed (mm/dd/yyyy)		PhilHealth Accreditation No.	
		Date signed (mm/dd/yyyy)	
		0 () 10000	
		Certified correct by:	
		Certified correct by.	
		(Printed name and signature)	
		Z Benefits Coordinator, Referring Contracted	
		HF	
		Date signed (mm/dd/yyyy)	
Acknowledged	hv•	Acknowledged by:	
71cmiowicagea	by.	rickito wiedged by:	
(Derivato du	and simustums)	(Dwinted name and signature)	
(Printed name and signature) BAS Head or Authorized Signatory,		(Printed name and signature) Head or Z Benefits Coordinator, Referral	
		Contracted HF	
PhilHealth Regional Office		Contracted III	
In-charge of the Referring Contracted			
HF			
(To provide a copy to the referring Contracted			
HF five working days upon receipt of the form; scanned copy is allowed)			
Date signed (n		Date signed (mm/dd/yyyy)	