ANNEX A

PHILHEALTH ONLINE ACCESS FORM (POAF) Form No. 002		**NO.**	Registration Date
Name of Accredited Institutional Health Care Provider / Third Party Partner		PhilHealth Accreditation Number	
Business Address			
User Profile			
Complete Name		Signature	
Position	Email address	Mobile No.	
Approved by:		Date Signed	
To be filled-out by PhilHealth			
Installation Date	Regional / Branch Office	Email address	
Username	Password		
Processed by	Signature	Date Processed	
Approved by	Signature	Date Signed	
Institutional Confirmation			
Confirmed by: Medical Director/Administrator/Authorized Representative of Third Party Partner		***Date Confirmed***	