PHILHEALTH ONLINE ACCESS FORM

(POAF) Form No. 002

NO.	Registration Date

Name of Accredited Institutional Health Care Provider		PhilHealth Accreditation Number
Business Address		
User Profile		
Complete Name		Signature
Position	Email address	Mobile No.
Approved by: Medical Administrator		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		***Date Confirmed***