

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: H 4 2 0 0 8 8 4 0

2. Name of Health Care Institution: Mary Mediatrix Medical Center, Inc.

3. Address: J.P. Laurel Highway Lipa City Batangas
Building Number and Street Name City/Municipality Province

PART II - PATIENT CONFINEMENT INFORMATION

1. Name of Patient: _____
Last Name First Name Name Extension (JR/SR/III) Middle Name (example: DELA CRUZ 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: _____ b. Time Admitted: _____ AM _____ PM
month day year hour min
 c. Date Discharged: _____ d. Time Discharged: _____ AM _____ PM
month day year hour min

4. Patient Disposition: (select only 1)
 a. Improved e. Expired, Date: _____ Time: _____ AM _____ PM
 b. Recovered f. Transferred/Referred _____
 c. Home/Discharged Against Medical Advise Name of Referral Health Care Institution
 d. Absconded Building Number and Street Name City/Municipality Province Zip Code
 Reason/s for referral/transfer: _____

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

6. Admission Diagnosis/es: _____

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 boxes)
a. _____	_____	i. _____	_____	_____	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
_____	_____	ii. _____	_____	_____	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
_____	_____	iii. _____	_____	_____	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
b. _____	_____	i. _____	_____	_____	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
_____	_____	ii. _____	_____	_____	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
_____	_____	iii. _____	_____	_____	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
c. _____	_____	i. _____	_____	_____	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
_____	_____	ii. _____	_____	_____	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
_____	_____	iii. _____	_____	_____	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
d. _____	_____	i. _____	_____	_____	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
_____	_____	ii. _____	_____	_____	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
_____	_____	iii. _____	_____	_____	<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/session 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:** _____

c. For MCP Package (enumerate four dates [mm-dd-yyyy] 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-yyyy] 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 Newborn Screening, please attach NBS Filter Sticker here**

For Essential Newborn Care, (check applicable boxes)

<input type="checkbox"/> Immediate drying of newborn	<input type="checkbox"/> Timely cord clamping	<input type="checkbox"/> Weighing of the newborn	<input type="checkbox"/> BCG vaccination	<input type="checkbox"/> Hepatitis B vaccination
<input type="checkbox"/> Early skin-to-skin contact	<input type="checkbox"/> Eye prophylaxis	<input type="checkbox"/> Vitamin K administration	<input type="checkbox"/> 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 _____ b. Second Case Rate _____

10. Professional Fees / Charges (Use additional CF2 if necessary):

Accreditation Number / Name of Accredited Health Care Professional / Date Signed	Details
Accreditation No.: _____ _____ Signature Over Printed Name Date Signed: _____ 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: _____ 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: _____ 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 _____

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 purchases of drugs/medicines, supplies, diagnostics, and co-pay for professional fees by the member/patient.

	Total Actual Charges*
Total Health Care Institution Fees	
Total Professional Fees	
Grand Total	

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				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.)
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 for 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)

B. CONSENT TO ACCESS PATIENT RECORD/S

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

Signature Over Printed Name of Member/Patient/Authorized Representative

Date Signed: _____
 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
 Other Reasons: _____

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



PART IV - CERTIFICATION 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.

Signature Over Printed Name of Authorized HCI Representative

Official Capacity / Designation

Date Signed: _____
 month day year