IMPORTANT REMINDERS:

PLEASE WRITE IN CAPITAL **LETTERS** AND **CHECK** THE APPROPRIATE BOXES.

Series #

Signature Over Printed Name of Member's Representative

Date Signed (month-day-year)

Date Signed (month-day-year)

PART II - EMPLOYER'S CERTIFICATION (for employed members only)

1.PhilHealth Employer No. (PEN):

This is to certify that all monthly premium contributions for and in behalf of the member, while employed in this company, including the applicable three (3) monthly premium contributions within the past six (6) months period prior to the first day of this confinement, have been deducted/collected and remitted to PhilHealth, and that the information supplied by the member or his/her representative on Part I are consistent with our available records.

Signature Over Printed Name of Employer / Authorized Representative

Official Capacity / Designation

Date Signed (month-day-year)

PART III - 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)

PART IV - HEALTH CARE PROFESSIONAL INFORMATION

Accreditation No. [ ] - [ ] - [ ]

Signature Over Printed Name

[ ] - [ ] - [ ]
Date Signed (month-day-year)

Accreditation No. [ ] - [ ] - [ ]

Signature Over Printed Name

[ ] - [ ] - [ ]
Date Signed (month-day-year)

Accreditation No. [ ] - [ ] - [ ]

Signature Over Printed Name

[ ] - [ ] - [ ]
Date Signed (month-day-year)

PART V - PROVIDER INFORMATION AND CERTIFICATION

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 Authorized HCI Representative

Official Capacity / Designation

Date Signed (month-day-year)