Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
City State 709 Shaw Blvd., Pasig City
Health line 441-7442, 441-7444; www.philhealth.gov.ph

1 x 1
Photo

HEALTH CARE PROFESSIONAL PROVIDER DATA RECORD

THE PRESIDENT & CEO
Philippine Health Insurance Corporation
Pasig City,

Sir/Madam:

I, _____, of legal age, hereby applies for accreditation under Sec. 52 of R.A. 7875 as amended by R.A 10606 and its Implementing Rules and Regulations thereto. For this purpose, I hereby submit the following pertinent information and documentary requirements.

ACCREDITATION NO. | PHILHEALTH IDENTIFICATION NO. – –

1. CLASSIFICATION
- ☐ Physician
  - ☐ General Practitioner (GP)
  - ☐ GP w/ Training Training : _____
  - ☐ Medical Specialist Specialty : _____
- ☐ Dentist
- ☐ Midwife

2. TYPE OF APPLICATION
- ☐ Initial
- ☐ Re-accreditation
- ☐ Continuous

3. NAME OF PROFESSIONAL
First
Middle
Last

4. For Females Only (Mother's Maiden Surname)

5. SEX
☐ Male ☐ Female

6. CIVIL STATUS
☐ Single ☐ Widow ☐ Married ☐ Separated

7. BIRTHDATE (mm/dd/yyyy)

8. E-MAIL ADDRESS

9. FAX NO.

10. MOBILE NO.

11. RESIDENTIAL ADDRESS
No. / St. / Brgy.
Municipality / City
Province
Zip Code
Contact No.

12. MAILING/ BILLING ADDRESS (If different from the residential address)
No. / St. / Brgy.
Municipality / City
Province
Zip Code
Contact No.

13. COLLEGE/UNIVERSITY

14. YEAR GRADUATED

15. PRC NO.

16. Date Issued (mm/dd/yy)

17. Valid up to (mm/dd/yy)

18. RESIDENCY TRAINING (For Medical Specialist/ GP with Training)
Name of Hospital:
Address of Hospital:
Year Started
Year Ended

19. HOSPITAL AFFILIATION(S)	**ADDRESS**
1	
2	
3	
4	

20. PARTNER PHYSICIANS (for Maternity Care Package/MCP Providers only)

Last Name	First Name	Middle Name	Accreditation No.
OB			
Pedia			

For PhilHealth Use Only

Date Evaluated: LHIO / PRO By: LHIO / PRO _____ Control No.

Date Received: LHIO / PRO By: LHIO / PRO OR No._____ Date Paid: _____ Amt. Paid. _____

Date Encoded: LHIO/PRO (Receiving Module) / PRO (Data Entry) By: LHIO/PRO / PRO