PHILHEALTH

CLAIM FORM 2

Revised May 2000

Note: This form together with Claim Form 1 should be filed with PhilHealth within 60 calendar days from date of discharge.

HEALTH CARE PROVIDER'S CERTIFICATION

(DATE RECEIVED)

PART I - HOSPITAL DATA AND CHARGES (Hospital to Fill in All Items)

1. PhilHealth Accreditation No.
2. Accreditation Category ☐ Primary ☐ Secondary ☐ Tertiary ☐ Ambulatory
3. Name of Hospital/Ambulatory Clinic
4. Address of Hospital/Ambulatory Clinic
   No., Street | Barangay
   Municipality/City | Province | Zip Code
5. Name of Member and Identification
   Last Name | First Name
   Middle Name | Identification No.
6. Address of Member
   No., Street | Barangay
   Municipality/City | Province | Zip Code
7. Name of Patient
   Last Name
   First Name
   Middle Name
8. Age
9. Sex ☐ M ☐ F
10. Admission Diagnosis
11. Confinement Period
    a. Date Admitted (m m d d y y y y) | c. Date Discharged (m m d d y y y y) | e. Claimed No.of Days
    b. Time Admitted (AM/PM) | d. Time Discharged (AM/PM) | f. Date of Death (If Applicable) (m m d d y y y y)

12. Hospital/Ambulatory Services	ACTUAL HOSPITAL/ AMBULATORY CHARGES	BENEFIT CLAIM		REDUCTION CODE
		HOSPITAL	PATIENT	
a. Room and Board				
b. Drugs and Medicines (Part III for details)				
c. X-ray/Lab. Test/Others (Part IV for details)				
d. Operating Room Fee				
e. Medicines bought & laboratory performed outside hospital during confinement period				
TOTAL				

13. CERTIFICATION of HOSPITAL/AMBULATORY CLINIC: I certify that the services rendered are duly recorded in the patient's chart and that the information given in this form are true and correct.

Signature Over Printed Name of Authorized Representative | Date Signed | Official Capacity

PART II - PROFESSIONAL DATA AND CHARGES (Doctor/s to Fill in Respective Portions)

14. Complete Final Diagnosis

FOR PHILHEALTH USE
Relative Unit Value

15. Case Type ☐ Ordinary ☐ Intensive ☐ Catastrophic

16. Name of Attending Physician | Signature & Date Signed

Illness Code

17. PHIC Accreditation No. | 18. BIR/TIN No. (- -)

Reduction Code

19. Services Performed

20. Actual Professional Charges	Benefit Claim	
	Physician	Patient
P	P	P

21. Name of Surgeon | Signature & Date Signed

Reduction Code

22. PHIC Accreditation No. | 23. BIR/TIN No. (- -)

24. Services Performed

Date of Operation

25. Actual Professional Charges	Benefit Claim	
	Surgeon	Patient
P	P	P

26. Name of Anesthesiologist | Signature & Date Signed

Reduction Code

27. PHIC Accreditation No. | 28. BIR/TIN No. (- -)

29. Services Performed

30. Actual Professional Charges	Benefit Claim	
	Physician	Patient
P	P	P

NOTE: Anyone who supplies false or incorrect information requested by this or a related form or commits misrepresentation shall be subject to criminal,civil or administrative prosecution under the law.All data required on this form are necessary for adjudication of the claim.PhilHealth will not adjudicate any claim where forms are not properly or completely accomplished.

PART III - DRUGS AND MEDICINES

Generic name	Brand	Preparation (cap/sy/inj/tab with ml/mg/gm content)	Qty.	Unit Price	Actual Charges	Benefit Claim	
						Hospital	Patient
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10							
11.							
12.							
13.							
14.							
15.							
		TOTAL					

NOTE: Official Receipts for drugs and medicines purchased by patient must be attached to this claim.

PART IV - X-RAY, LABORATORIES AND OTHERS

Particulars	Qty.	Unit Price	Actual Charges	Benefit Claim	
				Hospital	Patient
A. X-ray/Lab.					
1.					
2.					
3.					
4.					
5.					
B. Supplies					
1.					
2.					
3.					
4.					
5.					
C. Others					
1.					
2.					
3.					
4.					
5.					
TOTAL					

NOTE: Official Receipts for laboratory procedures performed outside the hospital during this confinement period must be attached to this claim.

PART V - CERTIFICATION of PATIENT/MEMBER

I hereby certify that:

☐ The amount of **P** _____ was deducted from the hospital charges.

☐ The amount of **P** _____ was deducted from the professional fee charges.

☐ The amount of **P** _____ was paid for medicines/lab. acquired outside the hospital during this confinement (Official Receipts attached).

☐ No deduction was made from the hospital charges.

☐ No deduction was made from the professional fee charges.

_____ Date

_____ Signature Over Printed Name of Patient/Member