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PHILHEALTH

(DATE RECEIVED)

CLAIM FORM 1

Revised May 2000

NOTE: THIS FORM TOGETHER WITH CLAIM FORM 2 SHOULD BE FILED WITH PHILHEALTH WITHIN 60 CALENDAR DAYS FROM DATE OF DISCHARGE.

PART I - MEMBER'S CERTIFICATION (Member to Fill In All Items/Indigent to be Assisted by Hospital Representative)

1. Type of Membership ☐ Employed:( )Private Sector ( )Gov't. Sector ☐ Individually paying: ( ) Self-employed ( )OFW ( )Others ( )OWWA
☐ Indigent ☐ Retiree/Pensioner: ( )SSS ( )GSIS ( ) Military ( ) Judiciary

Identification No.

2. Name of Member
Last Name
First Name
Middle Name

3. Date of Birth
m m d d y y y y

4. Civil Status ☐ Single ☐ Separated ☐ Married ☐ Widow/er

5. Sex ☐ Male ☐ Female

6. Address of Member
No., Street
Barangay
Municipality/City
Province
Zip Code

7. Name of Spouse
Last Name
First Name
Middle Name
☐ Not Applicable

8. Name of Patient ☐ Patient is the Member
Last Name
First Name
Middle Name

9. Date of Birth
m m d d y y y y

10. Age

11. Sex ☐ Male ☐ Female

12. Relationship of Patient to Member (Check applicable box if patient is a dependent)
☐ Legitimate spouse who is not an NHIP Member.
☐ Unmarried and unemployed, legitimate, legitimated, acknowledged and illegitimate or legally adopted/step child, below 21 years old.
☐ Parent who is 60 years old and above, not an NHIP member/retiree/pensioner and wholly dependent on me for support.
☐ Unmarried child 21 years old & above with physical/ mental disability, congenital or acquired and wholly dependent on me for support.

13. CERTIFICATION of MEMBER: I certify that the foregoing information are true and correct and that the three(3) applicable monthly contributions had been paid within six(6) month prior to the month of this confinement.

Signature of Member

Printed Name & Signature of Witness to Thumbmark

If unable to write, affix Right thumbmark

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

14. Registered Name of Employer
Identification No. of Employer

15. Address of Employer (No., Street, Barangay/Municipality/City, Province, Zip Code)
No., Street
Barangay
Municipality/City
Province
Zip Code

16. CERTIFICATION of EMPLOYER: This is to certify that three(3) applicable monthly contributions were collected during the six(6) month period prior to the month of this confinement and that the ***data supplied by the member on Part I are true and conform with our available records.***

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

✂ – cut here

Member's Copy

This portion should be completely filled up, detached by the hospital and given to member

ACKNOWLEDGEMENT RECEIPT

Name of Member : _____ SSS/GSIS/MEC/PhilHealth No. : _____

Name of Patient : _____ Confinement Period : _____

Name of Hospital : _____ PhilHealth Forms Received by : _____

Address of Hospital : _____ Date : _____