EMPLOYED GOVERNMENT 420B

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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CF-2

(Claim Form 2)
Revised September 2018

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 CRINIMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.

PART I - HEALTH CARE INSTITUTION (HCI) INFORMATION

1. PhilHealth Accreditation Number (PAN) of Health Care Institution: H 9 3 0 0 5 8 9 6

2. Name of Health Care Institution: MEDSYS MEDICAL CENTER

3. Address: _____ (Building Number and Street Name) | Quezon City (City/Municipality) | Manila (Province)

PART II - PATIENT CONFINEMENT INFORMATION

1. Name of Patient: KAI LN NINETEEN (Last Name) | KAI FN NINETEEN (First Name) | _____ (Name Extension (JR/SR/III)) | KAI MN NINETEEN (Middle Name (ex: 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: 0 4 (month) - 1 1 (day) - 2 0 2 5 (year)
b. Time Admitted: 0 1 (hour) : 4 0 (min) ☐ AM ☑ PM
c. Date Discharged: 0 4 (month) - 1 1 (day) - 2 0 2 5 (year)
d. Time Discharged 1 1 (hour) : 5 9 (min) ☐ AM ☑ PM

4. Patient Disposition: (select only 1)
☐ a. Improved
☑ b. Recovered
☐ c. Home/Discharged Against Medical Advise
☐ d. Absconded
☐ e. Expired, Date: ___ (month) - ___ (day) - ____ (year) Time ___ (hour) : ___ (min) ☐ AM ☐ PM
☐ f. Transferred/Referred
_____ (Name of Referral Health Care Institution)
_____ (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:
testing

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 Operation	Laterality (check applicable boxes)
a.	TEST	N18.5	i. HEMODIALYSIS	90935	04/21/2025	☐ Left ☐ Right ☐ Both
			ii.			☐ Left ☐ Right ☐ Both
			iii.			☐ Left ☐ Right ☐ Both
b.			i.			☐ Left ☐ Right ☐ Both
			ii.			☐ Left ☐ Right ☐ Both
			iii.			☐ Left ☐ Right ☐ Both
c.			i.			☐ Left ☐ Right ☐ Both
			ii.			☐ Left ☐ Right ☐ Both
			iii.			☐ Left ☐ Right ☐ Both
d.			i.			☐ Left ☐ Right ☐ Both
			ii.			☐ Left ☐ Right ☐ Both
			iii.			☐ Left ☐ Right ☐ Both

8. Special Considerations:

a. For the following repetitive procedures, check box that applies and enumerate the procedure/sessions dates [mm-dd-yyyy]. For chemotherapy, see guidelines.

☑ Hemodialysis	04/21/2025	☐ Blood Transfusion	
☐ Peritoneal Dialysis		☐ Brachytherapy	
☐ Radiotherapy (LINAC)		☐ Chemotherapy	
☐ Radiotherapy (COBALT)		☐ Simple Debridement	

b. For Z-Benefit Pckage **Z-Benefit Package Code:**

c. For MCP Package (enumerate four dates [mm-dd-yyyy] of pre-natal check-ups)
1 N/A 2 N/A 3 N/A 4 N/A

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 N/A **Day 3 ARV** N/A **Day 7 ARV** N/A **RIG** N/A **Others (Specify)** N/A

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
☐ Immediate drying of newborn ☐ Timely cord clamping ☐ Weighing of the newborn ☐ BCG vaccination ☐ Hepatitis B vaccination
☐ Early skin-to-skin contact ☐ Eye prophylaxis ☐ Vitamin K administration ☐ 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 90935 b. Second Case Rate _____