Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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CSF
(Claim Signature Form)
Revised September 2018

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

Series # [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

All information required in this form are necessary. Claim forms with incomplete information shall not be processed.
FALSE/INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CRIMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.

PART I - MEMBER AND PATIENT INFORMATION AND CERTIFICATION

1. PhilHealth Identification Number (PIN) of Member: 19-027063334-3

2. Name of Member: KAI LN FORTY,KAI FN FORTY KAI MN FORTY
Last Name | First Name | Name Extension (JR/SR/III) | Middle Name (ex: DELA CRUZ JUAN JR. SIPAG)

3. Member Date of Birth: 02-10-1974
month - day - year

4. PhilHealth Identification Number (PIN) of Dependent: [ ][ ]-[ ][ ][ ][ ][ ][ ][ ][ ]-[ ]

5. Name of Patient: KAI LN FORTY, KAI FN FORTY KAI MN FORTY
Last Name | First Name | Name Extension (JR/SR/III) | Middle Name (ex: DELA CRUZ JUAN JR. SIPAG)

6. Relationship to Member: ☐ Child ☐ Parent ☐ Spouse

7. Confinement Period:
a. Date Admitted: 04-16-2025 (month - day - year)
c. Date Discharged: 04-16-2025 (month - day - year)

8. Patient Date of Birth: 02-10-1974
month - day - year

9. CERTIFICATION OF MEMBER:
Under the penalty of law, I attest that the information I provided in this Form are true and accurate to the best of my knowledge.

Signature Over Printed Name of Member
Date Signed [ ][ ] - [ ][ ] - [ ][ ][ ][ ] (month - day - year)

Signature Over Printed Name of Member's Representative
Date Signed [ ][ ] - [ ][ ] - [ ][ ][ ][ ] (month - day - year)

If member/representative is unable to write, put right thumbmark. Member/representative should be assisted by an HCI representative. Check the appropriate box:
☐ Member ☐ Representative

Relationship of the representative to the member.
☐ Spouse ☐ Child ☐ Parent
☐ Sibling ☐ Others, specify _____

Reason for signing on behalf of the member:
☐ Member is incapacitated
☐ Other reasons: _____

PART II - EMPLOYER'S CERTIFICATION

1. PhilHealth Employer Number (PEN): [ ][ ]-[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]-[ ]

2. Contact No.: _____

3. Business Name:
Business Name of Employer

4. CERTIFICATION OF EMPLOYER:
"This is to certify that the required 3/6 monthly premium contributions plus at least 6 months contributions preceding the 3 months qualifying contributions within 12 month period prior to the first day of confinement (sufficient regularity) have been regularly remitted to PhilHealth. Moreover, 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 RECORDS

I hereby consent to the submission and examination of the patient's pertinent medical records for the purpose of verifying the veracity of this claim to effect efficient processing of benefit payment.
I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any legal liabilities relative to the herein-mentioned and consent which I have voluntarily and willingly given in connection with this claim for reimbursement before PhilHealth.

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

Signature Over Printed Name of Member/Patient/Authorized Representative

If member/representative is unable to write, put right thumbmark. Member/ Representative should be assisted by an HCI representative. Check the appropriate box:
☐ Patient ☐ Representative

Relationship of the representative to the patient.
☐ Spouse ☐ Child ☐ Parent
☐ Sibling ☐ Others, specify _____

Reason for signing on behalf of the patient:
☐ Patient is incapacitated
☐ Other reasons: _____

PART IV - HEALTH CARE PROFESSIONAL INFORMATION

Accreditation No. 1504-240001 5-3 — ON, LIFE G. (Signature Over Printed Name) — Date Signed 04-16-2025 (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

1. PhilHealth Benefits **ICD 10 or RVS Code** **a. First Case Rate** 90935 **b. Second Case Rate** _____

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.

arnold — Signature Over Printed Name Authorized HCI Representative
programmer — Official Capacity / Designation
Date Signed [ ][ ] - [ ][ ] - [ ][ ][ ][ ] (month - day - year)