PhilHealth
Your Partner in Health

CF4

(Claim Form 4)
February 2020

Series # _____

IMPORTANT REMINDERS:
PLEASE FILL OUT APPROPRIATE FIELDS. 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 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.

I. HEALTH CARE INSTITUTION (HCI) INFORMATION

1. Name of HCI	2. Accreditation Number

3. Address of HCI

Bldg No. and Name/Lot/Block	Street/Subdivision/Village	Barangay/City/Municipality	Province	Zip Code

II. PATIENT'S DATA

1. Name of Patient

Last Name	First Name	Middle Name

2. PIN

3. Age

4. Sex ☐ Male ☐ Female

5. Chief Complaint

6. Admitting Diagnosis	7. Discharge Diagnosis	8. a. 1st Case Rate Code 8. b. 2nd Case Rate Code

9. a. Date Admitted: ___ - ___ - ___ (month - day - year)
9. b. Time Admitted: ___ : ___ ☐ AM ☐ PM (hour : min)

10. a. Date Discharged: ___ - ___ - ___ (month - day - year)
10. b. Time Discharged: ___ : ___ ☐ AM ☐ PM (hour : min)

III. REASON FOR ADMISSION

1. History of Present Illness:

2.a. Pertinent Past Medical History:

2.b. OB/GYN History
G ____ P ____ (____ - ____ - ____ - ____) LMP: _____ ☐ NA

3. Pertinent Signs and Symptoms on Admission (tick applicable box/es):

☐ Altered mental sensorium	☐ Diarrhea	☐ Hematemesis	☐ Palpitations
☐ Abdominal cramp/pain	☐ Dizziness	☐ Hematuria	☐ Seizures
☐ Anorexia	☐ Dysphagia	☐ Hemoptysis	☐ Skin rashes
☐ Bleeding gums	☐ Dyspnea	☐ Irritability	☐ Stool, bloody/black tarry/mucoid
☐ Body weakness	☐ Dysuria	☐ Jaundice	☐ Sweating
☐ Blurring of vision	☐ Epistaxis	☐ Lower extremity edema	☐ Urgency
☐ Chest pain/discomfort	☐ Fever	☐ Myalgia	☐ Vomiting
☐ Constipation	☐ Frequency of urination	☐ Orthopnea	☐ Weight loss
☐ Cough	☐ Headache	☐ Pain, _____(site)	☐ Others _____

4. Referred from another health care institution (HCI): ☐ No ☐ Yes, Specify Reason _____

Name of Originating HCI _____

5. Physical Examination on Admission (Pertinent Findings per System)

Height: _____(cm)
Weight: _____(kg)

General Survey ☐ Awake and alert ☐ Altered sensorium: _____

Vital Signs: BP: ____ / ____ HR: _____ RR: _____ Temp: _____

HEENT:
☐ Essentially normal ☐ Abnormal pupillary reaction ☐ Cervical lymphadenopathy ☐ Dry mucous membrane
☐ Icteric sclerae ☐ Pale conjunctivae ☐ Sunken eyeballs ☐ Sunken fontanelle

Others: _____

5. Physical Examination continued (Pertinent Findings per System)

CHEST/LUNGS: ☐ Essentially normal ☐ Asymmetrical chest expansion ☐ Decreased breath sounds ☐ Wheezes
☐ Lump/s over breast(s) ☐ Rales/crackles/rhonchi ☐ Intercostal rib/clavicular retraction
Others: _____

CVS: ☐ Essentially normal ☐ Displaced apex beat ☐ Heaves and/or thrills ☐ Pericardial bulge
☐ Irregular rhythm ☐ Muffled heart sounds ☐ Murmur
Others: _____

ABDOMEN: ☐ Essentially normal ☐ Abdominal rigidity ☐ Abdomen tenderness ☐ Hyperactive bowel sounds
☐ Palpable mass(es) ☐ Tympanitic/dull abdomen ☐ Uterine contraction
Others: _____

GU (IE): ☐ Essentially normal ☐ Blood stained in exam finger ☐ Cervical dilatation ☐ Presence of abnormal discharge
Others: _____

SKIN/EXTREMITIES: ☐ Essentially normal ☐ Clubbing ☐ Cold clammy skin ☐ Cyanosis/mottled skin
☐ Edema/swelling ☐ Decreased mobility ☐ Pale nailbeds ☐ Poor skin turgor
☐ Rashes/petechiae ☐ Weak pulses
Others: _____

NEURO-EXAM: ☐ Essentially normal ☐ Abnormal gait ☐ Abnormal position sense ☐ Abnormal/decreased sensation
☐ Abnormal reflex(es) ☐ Poor/altered memory ☐ Poor muscle tone/strength ☐ Poor coordination
Others: _____

IV. COURSE IN THE WARD (Attach photocopy of laboratory/imaging results) ☐ Check box if there is/are additional sheet(s).

Date	DOCTOR'S ORDER/ACTION

SURGICAL PROCEDURE/RVS CODE (Attach photocopy of OR technique):

V. DRUGS/MEDICINES ☐ Check box if there is/are additional sheet(s).

Generic Name	Quantity/Dosage/Route/Frequency	Total Cost	Generic Name (cont)	Quantity/Dosage/Route/Frequency (cont)	Total Cost (cont)

VI. OUTCOME OF TREATMENT

☐ IMPROVED ☐ RECOVERED ☐ HAMA/DAMA ☐ EXPIRED ☐ ABSCONDED ☐ TRANSFERRED Specify reason: _____

VII. CERTIFICATION OF HEALTH CARE PROFESSIONAL

Certification of Attending Health Care Professional:

I certify that the above information given in this form, including all attachments, are true and correct.

_____
Signature over Printed Name of Attending Health Care Professional

__ - __ - ____
month day year
Date Signed