PhilHealth
Your Partner in Health

Republic of the Philippines
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CF5

Supplementary Form for DRG
v0.4 revised February 2024

Series # ☐☐☐☐☐☐☐☐☐☐☐☐☐☐
(For PhilHealth use only)

IMPORTANT REMINDERS:

- If you are utilizing this form, you are a health facility participating in the Shadow Billing of Diagnosis-Related Groups. Please fill up this supplementary form.
- Please be reminded that the Health Facility filing this claim shall be reimbursed using All Case Rates.
- PLEASE WRITE IN **CAPITAL** LETTERS AND **CHECK (✓)** THE APPROPRIATE BOXES
- This form, together with suporting documents should be filed within thirty **(30) calendar days** from date of discharge.
- All information required in this form are necessary and 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 - DRG Information

1. Primary Diagnosis (PDx):

☐ PDx

1. Input only 1 valid ICD-10 code. A list of valid ICD-10 codes can be found on PhilHealth's DRG Manual.
2. For dagger-asterisk codes, please input the DAGGER code as the Primary Diagnosis.
3. Please make sure to input the value after the decimal point of the ICD code, as applicable.

2. Secondary Diagnosis (SDx):

☐ SDx 1 ☐ SDx 2 ☐ SDx 3 ☐ SDx 4 ☐ SDx 5 ☐ SDx 6
☐ SDx 7 ☐ SDx 8 ☐ SDx 9 ☐ SDx 10 ☐ SDx 11 ☐ SDx 12

1. Input up to 12 valid ICD-10 codes. A list of valid ICD-10 codes can be found on PhilHealth's DRG Manual.
2. Ensure there are no repeat codes across all secondary diagnoses, and with the primary diagnosis.
3. For dagger-asterisk codes, please input the ASTERISK code as a Secondary Diagnosis.
4. Please make sure to input the value after the decimal point of the ICD code, as applicable.

3. Applicable Procedures:

RVS 1	RVS 2	RVS 3	RVS 4	RVS 5	RVS 6	RVS 7	RVS 8	RVS 9	RVS 10
☐ L ☐ R ☐ B	☐ L ☐ R ☐ B	☐ L ☐ R ☐ B	☐ L ☐ R ☐ B	☐ L ☐ R ☐ B	☐ L ☐ R ☐ B	☐ L ☐ R ☐ B	☐ L ☐ R ☐ B	☐ L ☐ R ☐ B	☐ L ☐ R ☐ B
+ ☐☐	+ ☐☐	+ ☐☐	+ ☐☐	+ ☐☐	+ ☐☐	+ ☐☐	+ ☐☐	+ ☐☐	+ ☐☐
RVS 11	**RVS 12**	**RVS 13**	**RVS 14**	**RVS 15**	**RVS 16**	**RVS 17**	**RVS 18**	**RVS 19**	**RVS 20**
☐ L ☐ R ☐ B	☐ L ☐ R ☐ B	☐ L ☐ R ☐ B	☐ L ☐ R ☐ B	☐ L ☐ R ☐ B	☐ L ☐ R ☐ B	☐ L ☐ R ☐ B	☐ L ☐ R ☐ B	☐ L ☐ R ☐ B	☐ L ☐ R ☐ B
+ ☐☐	+ ☐☐	+ ☐☐	+ ☐☐	+ ☐☐	+ ☐☐	+ ☐☐	+ ☐☐	+ ☐☐	+ ☐☐

1. Input up to 20 valid RVS codes. A list of valid RVS codes can be found on PhilHealth's DRG Manual, or the PhilHealth's website.
2. Make sure to indicate the laterality (left, right, or both), as applicable. If there is no laterality applicable, leave the field blank.
3. Extension codes shall be indicated for each procedure, as necessary (after the "+" sign). Please check the DRG Implementation Manual for specific rules on adding extension codes.

4. Newborn Data (if applicable):

Admission weight (up to 1 decimal point): ☐☐ . ☐ **kg**

1. Fill up this portion only when the claim is for a newborn
2. Admission weight less than 0.3kg is considered invalid.
3. Provide the admissioon weight for newborn infant patients aged 0-27 days.

PART II - CERTIFICATION OF CONSUMPTION OF BENEFITS AND CONSENT TO ACCESS PATIENT RECORD/S

PATIENT CERTIFICATIONS:

1. 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.

2. 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.

3. I hereby hold PhilHealth or any of its officers, employees, and/or representatives free from any and all legal liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim before PhilHealth.

4. I hereby consent to allowing PhilHealth to store the information provided on this form for research and policy purposes of the Corporation.

_____
Signature Over Printed Name of Member/Patient/Authorized Representative

If the patient/representative is unable to write, affix their right thumbmark. Patient/ representative should be assisted by an Health Facility representative.

☐
Right Thumb Mark

_____
Relationship of the representative to the member/patient (if applicable):

☐ Spouse ☐ Child ☐ Parent
☐ Sibling ☐ Others, specify: _____

Reason for signing on behalf of the member/patient (if applicable):

☐ Patient is incapacitated
☐ Other reasons: _____

Date signed: _____

PART III - CERTIFICATION OF CONSUMPTION OF HEALTH FACILITY

I hereby certify that services rendered were recorded in the patient's chart and health facility records and that the herein information given are true and correct.

_____ _____ _____
Signature Over Printed Name of Attending Physician | Date Signed | Official Capacity / Designation