



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 CRIMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.****PART I - HEALTH CARE INSTITUTION (HCI) INFORMATION**1. PhilHealth Accreditation Number (PAN) of Health Care Institution: H 1 9 | 3 1 0 | 0 1 5 | 8 9 | 6 |2. Name of Health Care Institution: MEDSYS MEDICAL CENTER3. Address: \_\_\_\_\_ Quezon City \_\_\_\_\_ Manila  
 Building Number and Street Name City/Municipality Province**PART II - PATIENT CONFINEMENT INFORMATION**1. Name of Patient: KAI LN THIRTY KAI FN THIRTY KAI MN THIRTY  
 Last Name First Name Name Extension Middle Name  
 (ex: DELA CRUZ JUAN JR SIPAG)

2. Was patient referred by another Health Care Institution (HCI)?

 NO  YES3. Confinement Period: a. Date Admitted: 0 4 - 0 7 - 2 0 2 5 b. Time Admitted: 1 0 : 1 4  AM  PM  
 month day year hour min  
 c. Date Discharged: 0 4 - 0 7 - 2 0 2 5 d. Time Discharged 0 4 : 3 9  AM  PM  
 month day year hour min

4. Patient Disposition: (select only 1)

- a. Improved  e. Expired, Date:    -    -    Time    :     AM  PM  
 month day year hour min  
 b. Recovered  f. Transferred/Referred  
 c. Home/Discharged Against Medical Advise  
 d. Absconded

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:

End-Stage Renal Disease

## 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. END-STAGE RENAL DISEASE | <u>N18.5</u>  | i. HEMODIALYSIS                      | <u>90935</u> | <u>04/10/2025</u> | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both |
|                            |               | ii. _____                            |              |                   | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both |
|                            |               | iii. _____                           |              |                   | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both |
| b. _____                   |               | i. _____                             |              |                   | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both |
|                            |               | ii. _____                            |              |                   | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both |
|                            |               | iii. _____                           |              |                   | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both |
| c. _____                   |               | i. _____                             |              |                   | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both |
|                            |               | ii. _____                            |              |                   | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both |
|                            |               | iii. _____                           |              |                   | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both |
| d. _____                   |               | i. _____                             |              |                   | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both |
|                            |               | ii. _____                            |              |                   | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both |
|                            |               | iii. _____                           |              |                   | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> 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 04/07/2025  Blood Transfusion \_\_\_\_\_  
 Peritoneal Dialysis \_\_\_\_\_  Brachytherapy \_\_\_\_\_  
 Radiotherapy (LINAC) \_\_\_\_\_  Chemotherapy \_\_\_\_\_  
 Radiotherapy (COBALT) \_\_\_\_\_  Simple Debridement \_\_\_\_\_

b. For Z-Benefit Package **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/Ad. For TB DOTS Package  Intensive Phase  Maintenance Phasee. 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/Af. 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 \_\_\_\_\_