

PHILHEALTH

CLAIM FORM 1

Revised May 2000

Note: This form together with Claim Form 2 should be filed with PhilHealth within 60 calendar days from date of discharge.

(DATE RECEIVED)

PART I - MEMBER'S CERTIFICATION (Member to Fill in All Items/Indigent to be Assisted by Hospital Representative)

1. Type of Membership Employed: { } Private Sector { } Gov't. Sector Individually paying: { } Self-employed { } OFW { } Others { } OWWA
 Indigent Retiree/Pensioner: { } SSS { } GSIS { } Military { } Judiciary

Identification No.

2. Name of Member Last Name <input type="text"/> First Name <input type="text"/> Middle Name <input type="text"/>	3. Date of Birth <input type="text"/> m m d d y y y y
4. Civil Status <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Widow/er	5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

6. Address of Member

No., Street <input type="text"/>	Barangay <input type="text"/>
Municipality/City <input type="text"/>	Province <input type="text"/> Zip Code <input type="text"/>

7. Name of Spouse

Last Name <input type="text"/>	First Name <input type="text"/>
Middle Name <input type="text"/>	<input type="checkbox"/> Not Applicable

8. Name of Patient <input type="checkbox"/> Patient is the Member Last Name <input type="text"/> First Name <input type="text"/> Middle Name <input type="text"/>	9. Date of Birth <input type="text"/> m m d d y y y y
	10. Age <input type="text"/> 11. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

12. Relationship of Patient to Member (Check applicable box if patient is a dependent)

<input type="checkbox"/> Legitimate spouse who is not an NHIP Member. <input type="checkbox"/> Unmarried and unemployed, legitimate, legitimated, acknowledged and illegitimate or legally adopted/step child, below 21 years old.	<input type="checkbox"/> Parent who is 60 years old and above, not an NHIP member/retiree/pensioner and wholly dependent on me for support. <input type="checkbox"/> Unmarried child 21 years old & above with physical/ mental disability, congenital or acquired and wholly dependent on me for support.
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13. CERTIFICATION of MEMBER: I certify that the foregoing information are true and correct and that the three(3) applicable monthly contributions had been paid within six(6) month prior to the month of this confinement.

_____ Signature of Member	<input style="width: 100px; height: 50px;" type="text"/>	_____ Printed Name & Signature of Witness to Thumbmark
If unable to write, affix Right thumbmark		

PART II - EMPLOYER'S CERTIFICATION (For employed members only)

14. Registered Name of Employer

Identification No. of Employer

15. Address of Employer (No., Street, Barangay/Municipality/City, Province, Zip Code)

No., Street <input type="text"/>	Barangay <input type="text"/>
Municipality/City <input type="text"/>	Province <input type="text"/> Zip Code <input type="text"/>

16. CERTIFICATION of EMPLOYER: This is to certify that three(3) applicable monthly contributions were collected during the six(6) month period prior to the month of this confinement and that the **data supplied by the member on Part I are true and conform with our available records.**

_____ Signature Over Printed Name of Authorized Representative	_____ Date Signed	_____ Official Capacity
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--- cut here ---

Member's Copy **This portion should be completely filled up, detached by the hospital and given to member**

ACKNOWLEDGEMENT RECEIPT

Name of Member : _____	SSS/GSIS/MEC/PhilHealth No. : _____
Name of Patient : _____	Confinement Period : _____
Name of Hospital : _____	PhilHealth Forms Received by : _____
Address of Hospital : _____	Date : _____

IMPORTANT

1. For currently employed member, the original and properly accomplished Form 1 is sufficient. In case item no. 16 (Certification of Employer) is not properly accomplished (ex. separated from employment, but contribution is still qualified for the confinement period) submit RF-1 **and** ME-5 and/or applicable receipts
2. Beneficiary/Hospital representative to attach the following supporting document/s for:
 - a) Individually paying (voluntary, self-employed or OFW members), **any** of the following:
 - ✓ Official Receipts of PhilHealth accredited collecting banks or PhilHealth Bank Receipts (PBR)
 - ✓ Duly validated MI-5 (Contributions Payment Return Form) for individually paying members starting January 2000
 - ✓ Official Receipts issued by PhilHealth (for over the counter payments)
 - b) SSS/GSIS Retirees, **any** of the following:
 - ✓ Latest pension voucher
 - ✓ Copy of bank account passbook (with pages indicating name of pensioner and latest pension entry)
 - ✓ Retirement Certificate issued by the GSIS/SSS
 - c) AFP/PNP Retirees, **any** of the following:
 - ✓ General or Special Orders
 - ✓ Latest pension voucher
 - ✓ Certification of 120 monthly Medicare/NHIP contributions from the GSIS or from previous employer
 - ✓ Service record
 - d) Retired Judges, **any** of the following:
 - ✓ Certificate of retirement from the Office of the Court Administration (OCA)
 - ✓ Certification of 120 monthly Medicare/NHIP contributions from the GSIS or from previous employer
 - ✓ Service record
 - e) SSS partial disability pensioners - certificate from SSS indicating coverage/period of pension
 - f) Dependents of a, b, c, d and e - approved M1b **or** E1/E4 for SSS members **or**
 - SPOUSE** - copy of marriage contract
 - CHILD** - copy of birth or baptismal certificate
 - Illegitimate/Legitimated child - birth certificate acknowledged by the father/mother or notarized affidavit of support
 - Legally adopted child - legal adoption paper or notarized affidavit that child is legally adopted
 - Step-child
 - birth or baptismal certificate with copy of marriage contract **or**
 - affidavit by the step-mother or step-father
 - PARENT** - affidavit of support (original or Certified True Copy)
 - g) OWWA member/dependent - Certified True Copy of Medicare Eligibility Certificate (MEC)

Legend:

- RF-1 - Quarterly Remittance Report form
- ME-5 - Contributions Payment Return form for employed sector
- MI-5 - Contributions Payment Return form for individually paying members
- M1b - Membership Data Record form for individually paying
- E1 - SSS Membership form for new member
- E4 - SSS Member's Data Amendment form