PhilHealth
Your Partner in Health

CF1

(Claim Form)
revised February 2010

IMPORTANT REMINDERS:

PLEASE WRITE IN **CAPITAL LETTERS** AND **CHECK** THE APPROPRIATE BOXES.
For **local confinement**, this form together with CF2 and other supporting documents should be filed within **60 DAYS** from date of discharge.
For **confinement abroad**, this form together with other supporting documents should be filed within **180 DAYS** from date of discharge.
Only one (1) original copy of this Form is required per claim application/availment.
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 - MEMBER and PATIENT INFORMATION

(Member/Representative to fill out all items with the assistance of the Health Care Provider)

1. PhilHealth Identification No. (PIN): ☐☐ – ☐☐☐☐☐☐☐☐☐☐ – ☐

2. Member Category:
☐ Employed ☐ Government ☐ Private
☐ Sponsored
☐ OFW
☐ Individually Paying
☐ Lifetime

3. Name of Member

Last Name First Name Middle Name (example: Dela Cruz, Juan Jr., Sipag)

4. Mailing Address:

(House Number & Name of Street) (Barangay)

(City / Municipality) (Province) (ZIP Code)

5. Date of Birth: ☐☐ – ☐☐ – ☐☐☐☐
(Month) (Day) (Year)

6. Contact Information (if available):

E-mail Address: _____ Mobile No.: _____ Landline No.: _____

7. Name of Patient:

Last Name First Name Middle Name (example: Dela Cruz, Juan Jr., Sipag)

8. ☐ Patient is the Member
☐ Patient is a Dependent
☐ Child ☐ Parent
☐ Spouse

9. CERTIFICATION OF MEMBER:

I hereby certify that the herein information are true and correct and may be used for any legal purpose.

Signature Over Printed Name of Member
☐☐ – ☐☐ – ☐☐☐☐
Date Signed (month-day-year)

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

10. Relationship of the Representative to the Member:
☐ Child ☐ Parent
☐ Spouse ☐ Guardian / Next of Kin

11. Reason for Signing on Behalf of the Member:
☐ Member is Abroad / Out-of-Town ☐ Member is Incapacitated ☐ Other Reasons: _____

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

1. PhilHealth Employer No. (PEN): ☐☐ – ☐☐☐☐☐☐☐☐☐☐ – ☐ 2. Contact No.: _____

3. Business Name and Official Address:

(Business Name of Employer)

(Building Number and Street Name)

(City / Municipality) (Province) (ZIP Code)

4. CERTIFICATION OF EMPLOYER:

This is to certify that all monthly premium contributions for and in behalf of the member, while employed in this company, including the applicable three (3) monthly premium contributions within the past six (6) months period prior to the first day of this confinement, have been deducted/collected and remitted to PhilHealth, and that 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)

(For PhilHealth use only)