

PHILHEALTH

CLAIM FORM 1

Revised May 2000

(DATE RECEIVED)

NOTE: THIS FORM TOGETHER WITH CLAIM FORM 2 SHOULD BE FILED WITH PHILHEALTH WITHIN 60 CALENDAR DAYS FROM DATE OF DISCHARGE.

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
 First Name
 Middle Name

3. Date of Birth
 m m d d y y y y

4. Civil Status Single Separated Married Widow/er
 5. Sex Male Female

6. Address of Member
 No., Street Barangay
 Municipality/City Province Zip Code

7. Name of Spouse
 Last Name First Name
 Middle Name Not Applicable

8. Name of Patient Patient is the Member
 Last Name
 First Name
 Middle Name

9. Date of Birth
 m m d d y y y y

10. Age 11. Sex Male Female

12. Relationship of Patient to Member (Check applicable box if patient is a dependent)
 Legitimate spouse who is not an NHIP Member. Parent who is 60 years old and above, not an NHIP member/retiree/pensioner and wholly dependent on me for support.
 Unmarried and unemployed, legitimate, legitimated, acknowledged and illegitimate or legally adopted/step child, below 21 years old. Unmarried child 21 years old & above with physical/ mental disability, congenital or acquired and wholly dependent on me for support.

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



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 Barangay
 Municipality/City Province Zip Code

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

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 Ammendment form