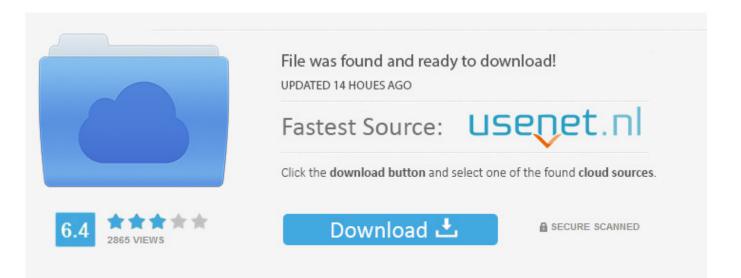


Philhealth Rf1 Form Excel Format.zip

		This form may be reproduced and is NOT FOR SALE CF1 (Claim Form 1) revised November 2013				
MOODTANT	THINDERC.				Ser	ies #
For <b>local avail</b> For <b>availment</b> Representative All information	IN CAPITAL LETTERS AND CHECK TH ment, this form together with other Ph of benefits abroad, this form togethe of the Health Care Institutions (HCI) sh required in this form are necessary. Clai	lHealth c r with ot all assist m forms	aim forms and o ner supporting d the member/aut with incomplete	ocuments should t horized representa information shall r	e filed within 180 da tive in filling out this not be processed.	filed within 60 days from date of discharge. ays from date of discharge.
				I - MEMBER INF		
1. PhilHealth	Identification Number (PIN) of Me	nber:			<u>1 1 1 1 1 - L</u>	
2. Name of Member:					3. Date of Birth:	
Last Name First Name Name Extension (JR/SR/III) Middle Name (example: DELA CRUZ JUAN JR SIPAG 4. Mailing Address:						5) 5. Sex: Male Female
Unit/ Room	No., Floor Building Name	Lot/Block/	House/Bldg. No.	Street	Subdivision/Village	
Barangay 6. Contact inf	City/Municipality	Prov	nce	Country	Zip Code	_
	. (Area Code + Tel. No.):		Mobil	e No.:		Email Address:
7. Patient is t	he member? Yes, proceed to	Part III	No, proce	ed to Part II		
				I - PATIENT INF		
			To be mied-ou	it only if the pat	ent is a dependen	
	Identification Number (PIN) of Dep	endent	·	1 1 1 1		·
2. Name of Pa	itient:					3. Date of Birth:
Last Nam	e First Name Name Extensio	n (JR/SR/I	I) Middle Nam	ne (example: DE	la cruz juan jr sipad	ā)
4. Relationshi	ip to Member: Child Pa	rent	Spouse			5. Sex: Male Female
			PART II	I - MEMBER CER	TIFICATION	
Under the p	enalty of law, I attest that the informati	on I prov	ided in this Form	n are true and acc	urate to the best of r	ny knowledge.
	Signature Over Printed I	ame of I	1ember		Signature Over	Printed Name of Member's Representative
Date Signed:					Date Signed:	month day year
If member/representative is unable to write, put right thumbmark. Member/representative should be assisted by an HCI representative. Check the appropriate box: Member Representative				Relationship o representative	f the to the member:	Spouse     Child     Parent       Sibling     Others, Specify
			Reason for signing on behalf of the member:			Member is incapacitated Other reasons:
	PA	RT IV -	EMPLOYER'S C	ERTIFICATION	(for employed me	mbers only)
1. PhilHealth	Employer No. (PEN):				2. Contact	No.:
3. Business N	ame:					
				Business Name of Em	plover	
4. CERTIFICA	TION OF EMPLOYER:					
deduct	able three (3) monthly premium co	ontribut	ons within the	e past six (6) m	onths period prio	er, while employed in this company, including the r to the first day of this confinement, have been or his/her representative on Part I are consistent
Signatu	re Over Printed Name of Employer / Authorized Representative	Official Capacity / Designation			Date Signed: month day year	
			PARTV	- FOR PHILHEAL	TH USE ONLY	Fillable Form by James Lee™
		1				Downloaded from http://i-hopeithelps.blogspot.com/
Date Received:	LHIO	By:				
	PRO		LHIO/PRO Sign	ature Over Printed	Name	

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