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**CF1**  
(Claim Form 1)  
revised November 2013

Series # \_\_\_\_\_

**IMPORTANT REMINDERS:**

PLEASE WRITE IN CAPITAL LETTERS AND CHECK THE APPROPRIATE BOXES.

For **local availment**, this form together with other PhilHealth claim forms and other supporting documents should be filed within 60 days from date of discharge.

For **availment of benefits abroad**, this form together with other supporting documents should be filed within 180 days from date of discharge.

Representative of the Health Care Institutions (HCI) shall assist the member/authorized representative in filling out this form.

All information 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 - MEMBER INFORMATION**

1. PhilHealth Identification Number (PIN) of Member: \_\_\_\_\_

2. Name of Member:

\_\_\_\_\_  
Last Name First Name Name Extension (JR/SR/III) Middle Name (example: DELA CRUZ JUAN JR SIPAG)

3. Date of Birth: \_\_\_\_\_  
month day year

4. Mailing Address:

\_\_\_\_\_  
Unit/ Room No., Floor Building Name Lot/Block/House/Bldg. No. Street Subdivision/Village  
\_\_\_\_\_  
Barangay City/Municipality Province Country Zip Code

5. Sex:  Male  Female

6. Contact information:

Landline No. (Area Code + Tel. No.): \_\_\_\_\_ Mobile No.: \_\_\_\_\_ Email Address: \_\_\_\_\_

7. Patient is the member?  Yes, proceed to Part III  No, proceed to Part II

**PART II - PATIENT INFORMATION**  
(To be filled-out only if the patient is a dependent)

1. PhilHealth Identification Number (PIN) of Dependent: \_\_\_\_\_

2. Name of Patient:

\_\_\_\_\_  
Last Name First Name Name Extension (JR/SR/III) Middle Name (example: DELA CRUZ JUAN JR SIPAG)

3. Date of Birth: \_\_\_\_\_  
month day year

4. Relationship to Member:  Child  Parent  Spouse

5. Sex:  Male  Female

**PART III - MEMBER CERTIFICATION**

Under the penalty of law, I attest that the information I provided in this Form are true and accurate to the best of my knowledge.

Signature Over Printed Name of Member

Date Signed: \_\_\_\_\_  
month day year

Signature Over Printed Name of Member's Representative

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 of the representative to the member:  Spouse  Child  Parent

Sibling  Others, Specify \_\_\_\_\_

Reason for signing on behalf of the member:  Member is incapacitated

Other reasons: \_\_\_\_\_

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

1. PhilHealth Employer No. (PEN): \_\_\_\_\_

2. Contact No.: \_\_\_\_\_

3. Business Name:

\_\_\_\_\_  
Business Name of Employer

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

**PART V - FOR PHILHEALTH USE ONLY**

Fillable Form by James Lee™

Downloaded from <http://i-hopeithelps.blogspot.com/>

Date Received: LHIO  
PRO

By: \_\_\_\_\_  
LHIO/PRO Signature Over Printed Name

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