Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 • Trunkline (02) 441-7444
www.philhealth.gov.ph
email: actioncenter@philhealth.gov.ph

CSF
(Claim Signature Form)
Revised September 2018

IMPORTANT REMINDERS:
PLEASE WRITE IN CAPITAL **LETTERS** AND **CHECK** THE APPROPRIATE BOXES.
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.

Series # ☐☐☐☐☐☐☐☐☐☐☐☐☐

PART I - MEMBER AND PATIENT INFORMATION AND CERTIFICATION

1. PhilHealth Identification Number (PIN) of Member:

2. Name of Member:

Last Name | First Name | Name Extension (JR/SR/III) | Middle Name (ex: DELA CRUZ JUAN JR SIPAG)

3. Member Date of Birth: month day year

4. PhilHealth Identification Number (PIN) of Dependent:

5. Name of Patient:

Last Name | First Name | Name Extension (JR/SR/III) | Middle Name (ex: DELA CRUZ JUAN JR SIPAG)

6. Relationship to Member: ☐ child ☐ parent ☐ spouse

7. Confinement Period:

a. Date Admitted: month day year

b. Date Discharged: month day year

8. Patient Date of Birth: month day year

9. CERTIFICATION OF MEMBER:

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

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

Signature Over Printed Name of Member's Representative

Date Signed: month day year

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

1. PhilHealth Employer Number (PEN):

2. Contact No.: _____

3. Business Name: _____
Business Name of Employer

4. CERTIFICATION OF EMPLOYER:

"This is to certify that the required 3/6 monthly premium contributions plus at least 6 months contributions preceding the 3 months qualifying contributions within 12 month period prior to the first day of confinement (sufficient regularity) have been regularly remitted to PhilHealth. Moreover, 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 III - CONSENT TO ACCESS PATIENT RECORD/S

I hereby consent to the submission and examination of the patient's pertinent medical records for the purpose of verifying the veracity of this claim to effect efficient processing of benefit payment.
I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any legal liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim for reimbursement before PhilHealth.

Signature Over Printed Name of Member

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.
☐ Patient ☐ Representative

Relationship of the representative to the patient: ☐ Spouse ☐ Child ☐ Parent ☐ Sibling ☐ Others, Specify _____

Reason for signing on behalf of the patient: ☐ Patient is incapacitated ☐ Other reasons: _____

PART IV - HEALTH CARE PROFESSIONAL INFORMATION

Accreditation No. _____ Signature Over Printed Name | Date Signed: month day year

Accreditation No. _____ Signature Over Printed Name | Date Signed: month day year

Accreditation No. _____ Signature Over Printed Name | Date Signed: month day year

PART V - PROVIDER INFORMATION AND CERTIFICATION

1. PhilHealth Benefits: **ICD 10 or RVS Code:** 1. First Case Rate _____ 2. Second Case Rate _____

I certify that services rendered were recorded in the patient's chart and health care institution records and that the herein information given are true and correct.

Signature Over Printed Name of Authorized HCI Representative | Official Capacity/Designation | Date Signed: month day year