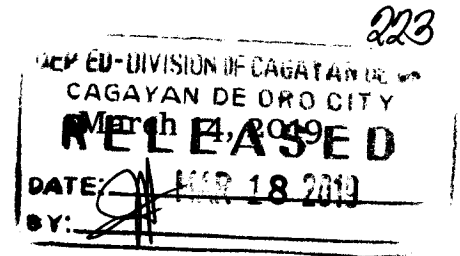
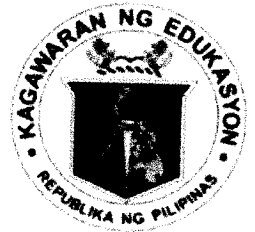




Republic of the Philippines  
DEPARTMENT OF EDUCATION  
Region X-Northern Mindanao  
**DIVISION OF CAGAYAN DE ORO**  
Fr. William Masterson Road  
Upper Balulang, Cagayan de Oro City



**DIVISION MEMORANDUM**

**TO:** Public Schools District Supervisors  
Education Program Supervisors  
Elementary and Secondary School Heads  
Teaching and Non-Teaching Personnel  
All Others Concerned  
This Division

**FROM:** **JONATHAN S. DELA PEÑA, Ph.D., CESO V**  
Schools Division Superintendent [Signature]

**Subject:** **DISSEMINATION OF REGIONAL MEMORANDUM NO. 121**  
**S. 2019 ENTITLED AVAILMENT OF PHILHEALTH BENEFITS**

Pursuant to the Regional Memorandum No. 121 s. 2019, the field is hereby informed of the additional (attached) documentary requirements on availment of PHILHEALTH benefits in addition to the usual Philhealth form.

Widest dissemination of this memorandum is required.

**Competence. Dedication. Optimism**



January 28, 2019 **DepED-X**  
Cagayan de Oro City

**REGIONAL MEMORANDUM**

No. 124, s. 2019

27 FEB 2019  
*100%*  
**RELEASED**

**AVAILMENT OF PHILHEALTH BENEFITS**

To: **Schools Division Superintendents**  
*This Region*

**1. Accomplishment of Claim Signature Form (CSF)**

- a. Recognizing the need to adopt the Electronic Premium Remittance System (EPRS) of PhilHealth, this Region has started the process of matching its data with that of the former office. For this reason, since October 2018 to the present, the remittances have not been issued official receipts due to the none generation of the Statement of Premium Account (SPA). This, in turn, resulted to the inability of the members to immediately avail themselves of the PhilHealth benefits without the Claim Signature Form (copy attached) to be signed by the Employer/Authorized Representative. In the meantime that both offices are still reconciling their records, this form will become a requirement in addition to the usual PhilHealth form.
- b. To ensure that the employees are relieved of the burden of going back to the division for the added document, the field should be advised of the added documentary requirements while this Office is still working on the regularization of its operations.

**2. Reconciliation of Records**

- c. Considering the bulk of the work needed in reconciling the needed records, it can be recalled that a workshop was conducted on January 11, 2019 to seek the assistance of the representatives from the division offices in inputting the required data in the system. However, despite the assistance extended, the Statement of Premium Account (SPA) had not been generated because of system errors in uploading the data.
- d. Records show that errors were on the basic data of the member-employees. As such, this Office is forwarding the data of the employees concerned for validation against the PSIPOP of the divisions. The divisions are therefore, required to designate one or more employees to handle this concern and email the required data to [fatima.villaremo@deped.gov.ph](mailto:fatima.villaremo@deped.gov.ph) on or before February 22, 2019.

e. For information and compliance.



**DR. ARTURO B. BAYOCOT, CESO V**  
Regional Director

JET



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

This form may be reproduced and  
is NOT FOR SALE

**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 SIFAG)

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 SIFAG)

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

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 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/Patient/Authorized 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.

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

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 (ex: DELA CRUZ JUAN JR SIPAG)

3. Date of Birth:

-  -   
month      day      year

4. Mailing Address:

\_\_\_\_\_  
Unit/Room No./Floor                      Building Name                      Lot/Blk/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 (ex: 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

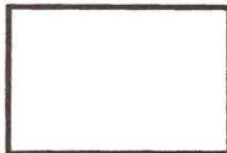
Date Signed  -  -   
month      day      year

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 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

