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

223

DEP ED-DIVISION OF CAGAYAN DE ORO
CAGAYAN DE ORO CITY
RELEASED
DATE: MAR 18 2019
BY:

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

March 14, 2019

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

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.

13238

January 28, 2019

DepED-X
Cagayan de Oro City
27 FEB 2019
1605
RELEASED

REGIONAL MEMORANDUM
No. 121, s. 2019

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 on or before February 22, 2019.

e. For information and compliance.

DR. ARTURO B. BAYOCOT, CESO V
Regional Director

JET

Republic of the Philippines
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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/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)

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email: actioncenter@philhealth.gov.ph

CF-1

(Claim Form 1)

Revised September 2018

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)

PART V - FOR PHILHEALTH USE ONLY

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CF-2
(Claim Form 2)
Revised September 2018

Series #

IMPORTANT REMINDERS:
PLEASE WRITE IN CAPITAL **LETTERS** AND **CHECK** THE APPROPRIATE BOXES
This form together with other supporting documents should be filed within sixty (60) calendar days from date of discharge.
All information, fields and tick boxes 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 - HEALTH CARE INSTITUTION (HCI) INFORMATION

1. PhilHealth Accreditation Number (PAN) of Health Care Institution:

2. Name of Health Care Institution:

3. Address:
Building Number and Street Name | City/Municipality | Province

PART II - PATIENT CONFINEMENT INFORMATION

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

2. Was patient referred by another Health Care Institution (HCI)?
☐ NO ☐ YES
Name of referring Health Care Institution | Building Number and Street Name | City/Municipality | Province | Zip code

3. Confinement Period:
a. Date Admitted (month-day-year) b. Time Admitted (hour:min) ☐ AM ☐ PM
c. Date Discharge (month-day-year) d. Time Discharge (hour:min) ☐ AM ☐ PM

4. Patient Disposition: (select only 1)
☐ a. Improved
☐ b. Recovered
☐ c. Home/Discharged Against Medical Advise
☐ d. Absconded
☐ e. Expired (month-day-year) Time: (hour:min) ☐ AM ☐ PM
☐ f. Transferred/Referred
Name of Referral Health Care Institution
Building Number and Street Name | City/Municipality | Province | Zip code
Reason/s for referral/transfer:

5. Type of Accomodation: ☐ Private ☐ Non-Private (Charity/Service)

6. Admission Diagnosis/es:

7. Discharge Diagnosis/es (Use additional CF2 if necessary):

	Diagnosis	ICD-10 Code/s		Related Procedure/s (if there's any)	RVS Code	Date of Procedure	Laterality (check applicable box)
a.			i.				☐ left ☐ right ☐ both
			ii.				☐ left ☐ right ☐ both
			iii.				☐ left ☐ right ☐ both
b.			i.				☐ left ☐ right ☐ both
			ii.				☐ left ☐ right ☐ both
			iii.				☐ left ☐ right ☐ both

8. Special Considerations:

a. For the following repetitive procedures, check box that applies and enumerate the procedure/sessions dates [mm-dd-yyyy]. For chemotherapy, see guidelines.
☐ Hemodialysis ☐ Peritoneal Dialysis ☐ Radiotherapy (LINAC) ☐ Radiotherapy (COBALT)
☐ Blood Transfusion ☐ Brachytherapy ☐ Chemotherapy ☐ Simple Debridement

b. For Z-Benefit Package **Z-Benefit Package Code:**

c. For MCP Package (enumerate four dates [mm-dd-year] of pre-natal check-ups)
1 2 3 4

d. For TB DOTS Package ☐ Intensive Phase ☐ Maintenance Phase

e. For Animal Bite Package (write the dates [mm-dd-year] when the following doses of vaccine were given) **Note: Anti Rabies Vaccine (ARV), Rabies Immunoglobulin (RIG)**
Day 0 ARV **Day 3 ARV** **Day 7 ARV** **RIG** **Others (Specify)**

f. For Newborn Care Package ☐ Essential Newborn Care ☐ Newborn Hearing Screening Test ☐ Newborn Screening Test
For Newborn Screening, *please attach NBS Filter Sitcker here*

For Essential Newborn Care (check applicable boxes)
☐ Immediate drying of newborn ☐ Timely cord clamping ☐ Weighing of the newborn ☐ BCG vaccination ☐ Hepatitis B vaccination
☐ Early skin-to-skin contact ☐ Eye Prophylaxis ☐ Vitamin K administration ☐ Non-separation of mother/baby for early breastfeeding initiation

g. For Outpatient HIV/AIDS Treatment Package **Laboratory Number:**

9. PhilHealth Benefits:

ICD 10 or RVS Code: a. First Case Rate 2. Second Case Rate