



PROVIDER DATA RECORD HEALTH CARE PROFESSIONAL

ANNEX A
1 x 1
Photo

PHIC-ACCRE-AF-5

THE PRESIDENT & CEO

Philippine Health Insurance Corporation
Pasig City Philippines

Sir/Madam:

I, _____, of legal age, hereby applies for accreditation under Sec. 52 of R. A. 7875 as amended by R. A. 10606 and its Implementing Rules and Regulations thereto. For this purpose, I hereby submit the following pertinent information and documentary requirements.

ACCREDITATION NO.										PHILHEALTH IDENTIFICATION NO.														
1. CLASSIFICATION															2. TYPE OF APPLICATION									
<input type="checkbox"/> General Practitioner (GP) <input type="checkbox"/> GP w/ Training Training: _____ <input type="checkbox"/> Medical Specialist Specialty: _____					<input type="checkbox"/> Dentist <input type="checkbox"/> Midwife <input type="checkbox"/> Nurse					<input type="checkbox"/> Initial <input type="checkbox"/> Re-accreditation <input type="checkbox"/> Continuous														
3. NAME OF PROFESSIONAL															4. FOR FEMALE ONLY (Mother's Maiden Surname)									
First																								
Middle										Last														
5. SEX					6. CIVIL STATUS																			
<input type="checkbox"/> Male <input type="checkbox"/> Female					<input type="checkbox"/> Single <input type="checkbox"/> Widow <input type="checkbox"/> Married <input type="checkbox"/> Separated																			
7. BIRTHDATE (MM/DD/YYYY)					8. E-MAIL ADDRESS					9. FAX NO.					10. MOBILE NO.									
11. RESIDENTIAL ADDRESS																								
No./St./Brgy.										Municipality/City														
Province										ZIP Code					Contact No.									
12. MAILING/BILLING ADDRESS																								
No./St./Brgy.										Municipality/City														
Province										ZIP Code					Contact No.									
13. COLLEGE/UNIVERSITY												14. YEAR GRADUATED												
15. PRC NO.							16. DATE ISSUED (MM/DD/YYYY)					17. VALID UP TO (MM/DD/YYYY)												
18. RESIDENCY TRAINING (For MS/GP with Training)										Year Started		Year Ended												
Name of Hospital: _____										Address of Hospital: _____														
19. HOSPITAL/CLINIC AFFILIATION(S)										ADDRESS														
1																								
2																								
3																								
4																								
20. PARTNER PHYSICIANS (for Maternity Care Package/MCP Providers only)																								
Last Name					First Name					Middle Name					Accreditation No.									
OB																								
PEDIA																								

FOR PHILHEALTH USE ONLY																													
Date Evaluated:					By:					Control No.																			
Date Received:					By:					<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="5">OR No.</td> </tr> <tr> <td colspan="5">Date Paid:</td> </tr> <tr> <td colspan="5">Amount Paid:</td> </tr> </table>					OR No.					Date Paid:					Amount Paid:				
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LHIO					LHIO																								
PRO					PRO																								
LHIO/PRO (Receiving Module)					LHIO/PRO																								
PRO (Data Entry)					PRO																								