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PHILHEALTH IDENTIFICATION NUMBER (PIN)

REMINDERS:

1. Your PhilHealth Identification Number (PIN) is your unique and permanent number.
2. Always use your PIN in all transactions with PhilHealth.
3. For Updating/Amendment check the appropriate box and provide details to be accomplished and submit corresponding supporting documents.
4. Please read instructions at the back before filling-out this form.

PURPOSE:

- REGISTRATION UPDATING/AMENDMENT

Preferred KonSulTa Provider

I. PERSONAL DETAILS

	LAST NAME	FIRST NAME	NAME EXTENSION (Jr./Sr./III)	MIDDLE NAME	NO MIDDLE NAME <small>(Check if applicable only)</small>	MONONYM
MEMBER					<input type="checkbox"/>	<input type="checkbox"/>
MOTHER'S MAIDEN NAME					<input type="checkbox"/>	<input type="checkbox"/>
SPOUSE <small>(If Married)</small>					<input type="checkbox"/>	<input type="checkbox"/>

DATE OF BIRTH <table style="width: 100%; text-align: center;"> <tr> <td style="width: 25px; height: 25px; border: 1px solid black;"></td> <td style="width: 25px; height: 25px; border: 1px solid black;"></td> <td style="width: 25px; height: 25px; border: 1px solid black;"></td> <td style="width: 25px; height: 25px; border: 1px solid black;"></td> </tr> <tr> <td>m</td> <td>d</td> <td>y</td> <td>y</td> </tr> </table>					m	d	y	y	PLACE OF BIRTH (City/Municipality/Province/Country) <small>(Please indicate country if born outside the Philippines)</small>	PHILSYS ID NUMBER (Optional) <table style="width: 100%; text-align: center;"> <tr> <td style="width: 25px; height: 25px; border: 1px solid black;"></td> <td style="width: 25px; height: 25px; border: 1px solid black;"></td> <td style="width: 25px; height: 25px; border: 1px solid black;"></td> <td style="width: 25px; height: 25px; border: 1px solid black;"></td> </tr> </table>				
m	d	y	y											
SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	CIVIL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Annulled <input type="checkbox"/> Married <input type="checkbox"/> Widow/er <input type="checkbox"/> Legally Separated	CITIZENSHIP <input type="checkbox"/> FILIPINO <input type="checkbox"/> FOREIGN NATIONAL <input type="checkbox"/> DUAL CITIZEN	TAX PAYER IDENTIFICATION NUMBER (TIN) (Optional) <table style="width: 100%; text-align: center;"> <tr> <td style="width: 25px; height: 25px; border: 1px solid black;"></td> <td style="width: 25px; height: 25px; border: 1px solid black;"></td> <td style="width: 25px; height: 25px; border: 1px solid black;"></td> <td style="width: 25px; height: 25px; border: 1px solid black;"></td> </tr> </table>											

II. ADDRESS and CONTACT DETAILS

PERMANENT HOME ADDRESS <small>Unit/Room No./Floor Building Name Lot/Block/Phase/House Number Street Name</small>	Home Phone Number <div style="border: 1px solid black; height: 20px;"></div>
<small>Subdivision Barangay Municipality/City Province/State/Country (If abroad) ZIP Code</small>	<small>(COUNTRY CODE + AREA CODE + TELEPHONE NUMBER)</small> Mobile Number (Required) <div style="border: 1px solid black; height: 20px;"></div>
MAILING ADDRESS <input type="checkbox"/> SAME AS ABOVE <small>Unit/Room No./Floor Building Name Lot/Block/Phase/House Number Street Name</small>	Business (Direct Line) <div style="border: 1px solid black; height: 20px;"></div>
<small>Subdivision Barangay Municipality/City Province/State/Country (If abroad) ZIP Code</small>	E-mail Address (Required for OFW) <div style="border: 1px solid black; height: 20px;"></div>

III. DECLARATION OF DEPENDENTS

(Use additional form if necessary)

LAST NAME	FIRST NAME	NAME EXTENSION (Jr./Sr./III)	MIDDLE NAME	RELATIONSHIP	DATE OF BIRTH (mm-dd-yyyy)	CITIZENSHIP	NO MIDDLE NAME <small>(Check if applicable only)</small>	MONONYM	Check # with Permanent Disability
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IV. MEMBER TYPE

DIRECT CONTRIBUTOR <input type="checkbox"/> Employed Private <input type="checkbox"/> Kasambahay <input type="checkbox"/> Family Driver <input type="checkbox"/> Employed Government <input type="checkbox"/> Migrant Worker <input type="checkbox"/> Professional Practitioner <input type="checkbox"/> Land-Based <input type="checkbox"/> Sea-Based <input type="checkbox"/> Self-Earning Individual <input type="checkbox"/> Individual <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Group Enrollment Scheme <input type="checkbox"/> Lifetime Member <input type="checkbox"/> Filipinos with Dual Citizenship / Living Abroad <input type="checkbox"/> Foreign National PRA SRRV No. _____ ACR I-Card No. _____	INDIRECT CONTRIBUTOR <input type="checkbox"/> Listahanan <input type="checkbox"/> LGU-sponsored <input type="checkbox"/> 4Ps/MCCT <input type="checkbox"/> NGA-sponsored <input type="checkbox"/> Senior Citizen <input type="checkbox"/> Private-sponsored <input type="checkbox"/> PAMANA <input type="checkbox"/> Person with Disability <input type="checkbox"/> KIA/KIPO PWD ID No. _____ <input type="checkbox"/> Bangsamoro/Normalization		
PROFESSION: (Except Employed, Lifetime Members and Sea-based Migrant Worker)	MONTHLY INCOME:	PROOF OF INCOME:	For PhilHealth Use only: <input type="checkbox"/> Point of Service (POS) Financially Incapable <input type="checkbox"/> Financially Incapable

V. UPDATING/AMENDMENT

Please check:	FROM	TO
<input type="checkbox"/> Change/Correction of Name <small>(Last Name, First Name, Name Extension (Jr./Sr./III) Middle Name)</small>		
<input type="checkbox"/> Correction of Date of Birth		
<input type="checkbox"/> Correction of Sex		
<input type="checkbox"/> Change of Civil Status		
<input type="checkbox"/> Updating of Personal Information/Address/ Telephone Number/Mobile Number/e-mail Address		

Under penalty of law, I hereby attest that the information provided, including the documents I have attached to this form, are true and accurate to the best of my knowledge. I agree and authorize PhilHealth for the subsequent validation, verification and for other data sharing purposes only under the following circumstances:

- As necessary for the proper execution of processes related to the legitimate and declared purpose;
- The use or disclosure is reasonably necessary, required or authorized by or under the law; and,
- Adequate security measures are employed to protect my information.

_____ **Member's Signature over Printed Name** _____ **Date**



Please affix right thumbmark if unable to write

FOR PHILHEALTH USE ONLY	
RECEIVED BY:	
Full Name:	_____
PRO/LHIO/Branch:	_____
Date & Time:	_____

INSTRUCTIONS

- All information should be written in UPPER CASE/CAPITAL LETTERS. If the information is not applicable, write "N/A."
 - All fields are mandatory unless indicated as optional. By affixing your signature, you certify the truthfulness and accuracy of all information provided.
 - A properly accomplished PMRF shall be accompanied by a valid proof of identity for first time registrants, and supporting documents to establish relationship between member and dependent/s for updating or request for amendment.
 - On the PURPOSE, check the appropriate box if for **Registration** or for **Updating/Amendment** of information.
 - Indicate preferred KonSulTa provider near the place of work or residence.
 - For PERSONAL DETAILS, all name entries should follow the format given below. Check the appropriate box if registrant has no middle name and/or with single name (mononym).
- | | | | |
|------------------|-------------------|-------------------------------------|--------------------|
| LAST NAME | FIRST NAME | NAME EXTENSION (Jr./Sr./III) | MIDDLE NAME |
| SANTOS | JUAN ANDRES | III | DELA CRUZ |
- Indicate registrant's/member's name as it appears in the birth certificate.
 - The full mother's maiden name of registrant/member must be indicated as it appears in the birth certificate.
 - Indicate the full name of spouse if registrant/member is married.
 - Indicate the complete permanent and mailing addresses and contact numbers.
 - For updating/amendment, check the appropriate box to be updated/amended and indicate the correct data.
 - For MEMBER TYPE, check the appropriate box which best describes your current membership status.
 - For Direct Contributors, except employed, sea-based migrant workers and lifetime members, indicate the profession, monthly income and proof of income to be submitted.
 - For Self-earning individuals, Kasambahays and Family Drivers, indicate the actual monthly income in the space provided.
 - In declaring dependents, provide the full name of the living spouse, children below 21 years old, and parents who are 60 years old and above totally dependent to the member.
 - Dependents with disability shall be registered as principal members in accordance with Republic Act 11228 on mandatory PhilHealth coverage for all persons with disability (PWD).
 - The registrant must affix his/her signature over printed name (or right thumbmark if unable to write) and indicate the date when the PMRF was signed.