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
- ☐ General Practitioner (GP)
- ☐ GP w/ Training — Training: _____
- ☐ Medical Specialist — Specialty: _____
- ☐ Dentist
- ☐ Midwife
- ☐ Nurse

2. TYPE OF APPLICATION
- ☐ Initial
- ☐ Re-accreditation
- ☐ Continuous

3. NAME OF PROFESSIONAL
First

Middle | Last

4. FOR FEMALE ONLY (Mother's Maiden Surname)

5. SEX
☐ Male ☐ Female

6. CIVIL STATUS
☐ Single ☐ Widow ☐ Married ☐ 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) Name of Hospital:	Address of Hospital:	Year Started	Year Ended

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:	LHIO	By:	LHIO
	PRO		PRO
Date Received:	LHIO	By:	LHIO
	PRO		PRO
Date Encoded:	LHIO/PRO (Receiving Module)	By:	LHIO
	PRO (Data Entry)		PRO

_____
Control No.

OR No.
Date Paid:
Amount Paid: