PhilHealth Konsulta
Konsultasyong Sulit at Tama

PhilHealth YAKAP
PARA MALAYO SA SAKIT

1 YAKAP CLINIC SERVICES

- Consultations and Case Management
- Provision of Preventive Health Services
- Assistance in Accessing Services in Subcontracted Partner Facilities
- Referral to Specialty and Higher Level of Care

PhilHealth YAKAP

PARA MALAYO SA SAKIT

1 YAKAP CLINIC SERVICES (FORMERLY KONSULTA)

2 OUTPATIENT LABORATORY AND DIAGNOSTICS

3 PHILHEALTH GAMOT

1 YAKAP CLINIC SERVICES

- Complete Blood Count (CBC) w/ platelet count
- Lipid Profile (Total Cholesterol, HDL and LDL Cholesterol, Triglycerides)
- Fasting Blood Sugar (FBS)
- Oral Glucose Tolerance Test (OGTT)
- Glycosylated Hemoglobin (HbA1c)
- Creatinine
- Chest X-Ray
- Sputum Microscopy
- Electrocardiogram (ECG)
- Urinalysis
- Pap smear
- Fecalysis
- Fecal Occult Blood Test

1 YAKAP CLINIC SERVICES

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Antimicrobials

1. Amoxicillin
2. Ciprofloxacin
3. Clarithromycin
4. Co-amoxiclav
5. Co-trimoxazole
6. Nitrofurantoin

Antithrombotics

7. Aspirin

Anti-asthmatics and COPD

8. Prednisone
9. Salbutamol
10. Fluticasone + Salmeterol

Anti-dyslipidemia

11. Simvastatin

Supportive / Other Therapy

12. Chlorphenamine
13. Oral Rehydration Salts
14. Paracetamol

Antidiabetics

15. Gliclazide
16. Metformin

Antihypertensives and Cardiology

17. Amlodipine
18. Enalapril
19. Hydrochlorothiazide
20. Losartan
21. Metoprolol

2

PRIMARY CARE PROVIDER

- Performs health risk assessment
- Requests the test/s (with form)
- Advises the patient re: follow-up consultations or schedule of next screening test

ACCREDITED CANCER SCREENING FACILITY

- Performs the test/s requested
- Gives results to patient and to PCF
- Refers back to PCF

2 OUTPATIENT LABORATORY AND DIAGNOSTICS

Mammogram	Female: 50 to 69 years old, all cases Female: 40 to 49 years old identified as high risk. Risk factors: with family history or previous history of breast cancer.	Every 2 years	**₱ 2, 610.00**
Breast Ultrasound		Every year	**₱ 1, 350.00**
Low Dose CT Scan	Aged 50 and above and with risk factors: smoker or used to smoke; with family history of lung cancer	Every year	**₱ 7,220.00**
Alpha Fetoprotein	50 years old and above or with risk factors: family history or an underlying condition **with** results of FIT or FOBT - positive test results	Every 10 years	**₱ 1,230.00**
Liver Ultrasound	Risk Factors of hepatitis B or C infection, heavy and prolonged alcohol consumption, cirrhosis, diabetes, non- alcoholic fatty liver disease, **or** inherited metabolic diseases	Every 6 months	**₱ 960.00**
Colonoscopy			**₱ 23,640.00**

2

Logo of the Requesting Facility

Screening Tests Request Form

Date of Request:

FROM:	TO:
Name of Referring Facility:	Name of Cancer Screening Facility:
PhilHealth Accreditation Number:	PhilHealth Accreditation Number:

Name of Patient: _____

_____ *(Family Name,* *First Name,*

_____ *Middle Initial)* Age:

Birthday:

PhilHealth Identification Number:

_____

Diagnosis/Assessment: _____ ICD 10: _____

Indications: _____

Screening Test Requested (Please check)

- Mammogram
- Breast Ultrasound
- Low Dose Chest CT Scan
- Colonoscopy
- Alpha Fetoprotein
- Liver Ultrasound

Name and Signature of Requesting Physician:
PRC License Number:
PhilHealth Accreditation Number:

Patient Acknowledgement

I hereby acknowledged that the test/s specified above was/were done to me.

_____ _____

Name and Signature of the Patient/PhilHealth Beneficiary Date Signed

PHILHEALTH GAMOT

Guaranteed Accessible Medications for Outpatient Treatment

3

PHILHEALTH GAMOT

1 YAKAP CONSULTATION

Patient consultations

Prescription generation through GAMOT App (Unique Prescription Security Code)

2 MEDICATION DISPENSING

Prescription Validation through GAMOT App

Drug dispensing after transaction validation

3

PHILHEALTH GAMOT

Antimicrobials

1. Albendazole
2. Amoxicillin*
3. Azithromycin
4. Cefixime
5. Cefuroxime
6. Ciprofloxacin*
7. Clarithromycin*
8. Clindamycin
9. Clotrimazole
10. Cloxacillin
11. Co-amoxiclav*
12. Co-trimoxazole* (Sulfamethoxazole + Trimethoprim)
13. Doxycycline
14. Erythromycin
15. Fluconazole
16. Ketoconazole
17. Mebendazole
18. Metronidazole
19. Nitrofurantoin*
20. Oseltamivir
21. Tobramycin

Antithrombotics

22. Aspirin*
23. Clopidogrel

Anti-asthmatics and COPD

24. Montelukast
25. Prednisone*
26. Salbutamol*
27. Tiotropium
28. Fluticasone + Salmeterol*
29. Ipratropium
30. Budesonide + Formoterol
31. Ipratropium + Salbutamol

Anti-dyslipidemia

32. Atorvastatin
33. Rosuvastatin
34. Fenofibrate
35. Simvastatin*

Nervous system

36. Gabapentin

Supportive / Other Therapy

37. Aluminum Hydroxide + Magnesium Hydroxide
38. Butmirate
39. Celecoxib
40. Cetirizine
41. Colchicine
42. Chlorphenamine*
43. Diphenhydramine
44. Elemental Iron
45. Folic acid + Iron Ferrous
46. *Vitex negundo* (Lagundi)
47. Loratadine
48. Ibuprofen
49. Mefenamic Acid
50. Naproxen
51. Omeprazole
52. Oral Rehydration Salts*
53. Paracetamol*
54. Zinc

Antidiabetics

55. Gliclazide*
56. Metformin*
57. Dapagliflozin

Antihypertensives and Cardiology

58. Amlodipine*
59. Atenolol
60. Captopril
61. Clonidine
62. Diltiazem
63. Enalapril*
64. Enalapril + Hydrochlorothiazide
65. Hydrochlorothiazide*
66. Isosorbide Dinitrate
67. Isosorbide Mononitrate
68. Losartan*
69. Methyldopa
70. Metoprolol*
71. Tamsulosin
72. Telmisartan
73. Telmisartan + Hydrochlorothiazide
74. Valsartan
75. Valsartan + Hydrochlorothiazide

** Currently under YAKAP Services*

3

PHILHEALTH GAMOT

MEDICINE	MAXIMUM QUANTITY THAT CAN BE PRESCRIBED
Maintenance medications	Three (3) months
Non-steoidal anti-inflammatory drugs (NSAIDs)	One (1) week
Other medications	Prevailing clinical practice guidelines (CPGs) approved by the DOH and quality standards established by the Corporation, as applicable or available

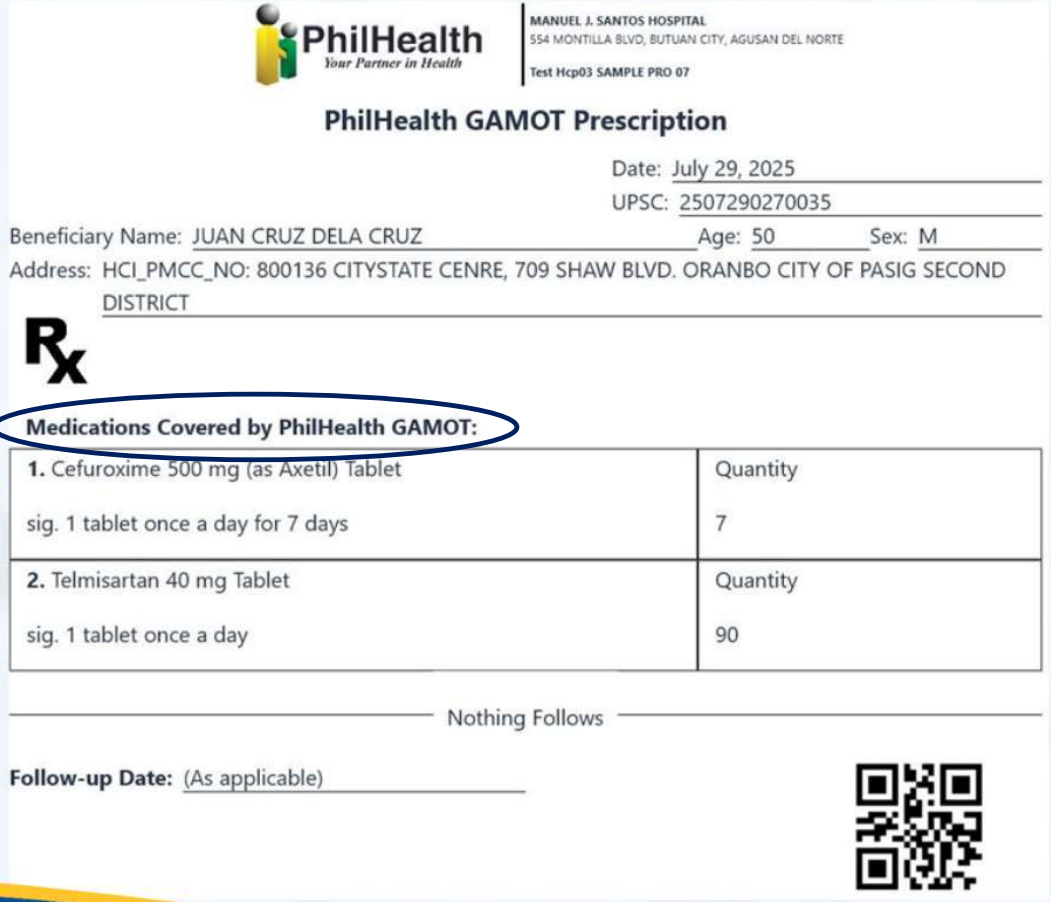
A maximum of 1 monthly provision for at least 1 maintenance medication in the same prescription can be dispensed.

PRESCRIPTION VALIDITY PERIOD

anti-infectious - within 2 days
other medications - within 2 weeks

3

PHILHEALTH GAMOT



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Your Partner in Health

MANUEL J. SANTOS HOSPITAL
554 MONTILLA BLVD, BUTUAN CITY, AGUSAN DEL NORTE
Test Hcp03 SAMPLE PRO 07

PhilHealth GAMOT Prescription

Date: July 29, 2025

UPSC: 2507290270035

Beneficiary Name: JUAN CRUZ DELA CRUZ Age: 50 Sex: M

Address: HCI_PMCC_NO: 800136 CITYSTATE CENRE, 709 SHAW BLVD. ORANBO CITY OF PASIG SECOND DISTRICT

℞

Medications Covered by PhilHealth GAMOT:

1. Cefuroxime 500 mg (as Axetil) Tablet sig. 1 tablet once a day for 7 days	Quantity 7
2. Telmisartan 40 mg Tablet sig. 1 tablet once a day	Quantity 90

Nothing Follows

Follow-up Date: (As applicable)

Patient's Details

List of Medication

Date Prescribed

Unique Prescription Security Code

Prescription QR Code

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BAGONG PILIPINAS

3

PHILHEALTH GAMOT

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BAGONG PILIPINAS

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Blvd, Pasig
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

PhilHealth GAMOT Availment Slip

GAMOT Facility Name: PHARMA 1

Accreditation Number: P01000066 Transaction Number: 25

UPSC: 2507290270035 Date: 07/29/2025

Patient Name: JUAN CRUZ DELA CRUZ Age: 50 Sex: M

PIN: 190270710925 Contact No.:

List of medications availed under PhilHealth GAMOT:

#	Generic Name, Dosage Strength, Drug Formulation	Unit Price	Quantity Dispensed	Price
1	Cefuroxime 500 mg (as Axetil)	₱37.25	7	₱260.75
2	Telmisartan 40 mg	₱10	30	₱300
			TOTAL:	₱560.75
			Amount Covered by PhilHealth: *(Halagang binayaran ng PhilHealth)*	₱560.75
			Remaining Benefit Coverage: *(Natitirang balanse sa benepisyo)*	₱19439.25

Copy given to patient
Signed by pharmacist and patient

← **Covered Medicines**

← **Remaining Balance**

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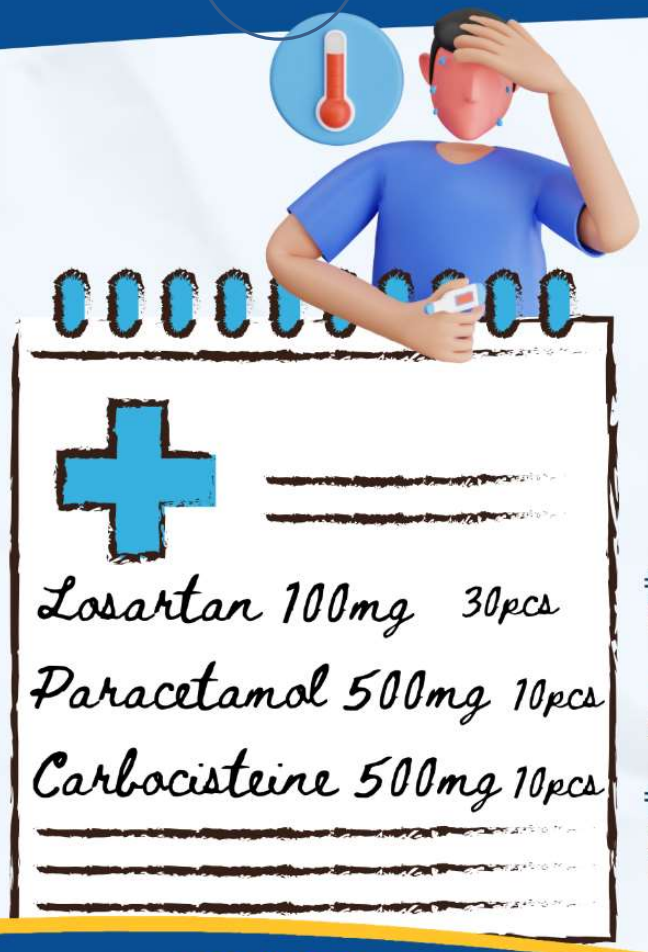
3

PHILHEALTH GAMOT



TOTAL	₱	555.00
OOP		195.00
COVERAGE		360.00
REMAINING BAL		19,640.00

₱12.00 Fixed Rate	→	₱360.00	→ **Covered by PhilHealth GAMOT** Listed in GAMOT
₱2.25 Fixed Rate	→	₱70.00 branded ₱7/ea	→ **OOP Payment** Listed in GAMOT, but px preferred branded
₱12.50 Fixed Rate is NA; follow store price	→	₱125.00	→ **OOP Payment** Not listed in GAMOT

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PHILHEALTH YAKAP PATIENT JOURNEY

1. Register with PhilHealth YAKAP
2. Complete your FPE at your chosen YAKAP Clinic
3. Avail your YAKAP Benefits

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Your Partner in Health

BAGONG PILIPINAS

TRANSFER RULES

NO FPE: May transfer to a different YAKAP Clinic anytime

WITH FPE: May transfer to a different YAKAP Clinic in fourth quarter of the year only

ROLLOVER RULES

NO FPE: No automatic rollover

WITH FPE: Eligible for automatic rollover if with at least one consultation

SUCCESSFUL REGISTRATION

- ☑ Registration is processed and confirmed
- ☑ Member is notified
- ☑ Chosen Primary Care Provider is notified
- ☑ First Patient Encounter (FPE) is scheduled

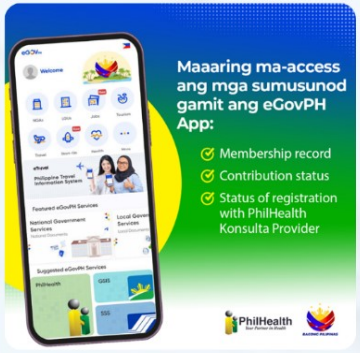
eGovPH

SCAN HERE

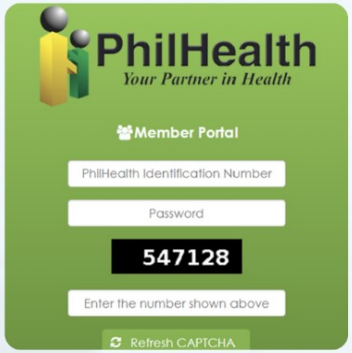
HOW TO Register with PhilHealth YAKAP

PhilHealth Member Portal

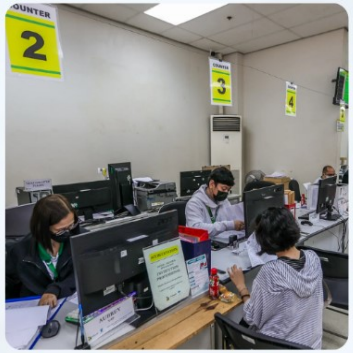
SCAN HERE



EGOV MOBILE APP

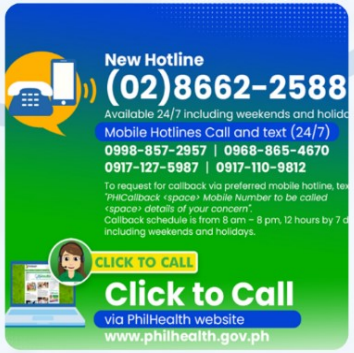


PHILHEALTH MEMBER PORTAL



PHILHEALTH LOCAL HEALTH INSURANCE OFFICES

YAKAP CLINICS



OTHER CHANNELS

PhilHealth YAKAP
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INSTRUCTIONS

1.All information should be written in UPPER CASE/CAPITAL LETTER.
2.All fields are mandatory.
3.If the beneficiary is dependent, use the dependent PIN.
4.If the beneficiary is below 21 years old, the signatory should be the parent/guardian.

TO BE FILLED-OUT BY THE BENEFICIARY

☐ MEMBER ☐ DEPENDENT

PIN: _____ DATE: _____ (MM/DD/YYYY)

FULL NAME: _____ (LAST NAME / FIRST NAME / MIDDLE NAME)

ADDRESS: _____ (BARANGAY /TOWN / MUNICIPALITY/CITY / PROVINCE)

DATE OF BIRTH: _____ (MM/DD/YYYY) CONTACT NO: _____

☐ REGISTER TO A KONSULTA PACKAGE PROVIDER (KPP)
☐ REGISTER ALL MY DECLARED MINOR DEPENDENTS (please use additional form if necessary)

FULL NAME: _____ (LAST NAME / FIRST NAME / MIDDLE NAME)

1ST CHOICE KPP: _____

ADDRESS: _____ (BARANGAY /TOWN / MUNICIPALITY/CITY / PROVINCE)

2ND CHOICE KPP: _____

ADDRESS: _____ (BARANGAY /TOWN / MUNICIPALITY/CITY / PROVINCE)

☐ TRANSFER

PREVIOUS KPP: _____

1ST CHOICE KPP: _____

ADDRESS: _____ (BARANGAY /TOWN / MUNICIPALITY/CITY / PROVINCE)

2ND CHOICE KPP: _____

ADDRESS: _____ (BARANGAY /TOWN / MUNICIPALITY/CITY / PROVINCE)

I hereby certify that I did not avail of FPE in other KPP. Moreover, I grant my free and voluntary consent to the collection, transmission and processing of my personal data and health records to PhilHealth for the purpose of paying and monitoring the provider for the Konsulta benefit in accordance with Republic Act No. 10173, otherwise known as the "Data Privacy Act of 2012".

_____
(Signature over Printed Name)

PHILHEALTH'S COPY

TO BE FILLED-OUT BY PHILHEALTH KONSULTA PERSONNEL

PHILHEALTH KONSULTA REGISTRATION CONFIRMATION SLIP

REGISTRATION NO.: _____ DATE REGISTERED: _____ (MM/DD/YYYY)

FULL NAME: _____ (LAST NAME / FIRST NAME / MIDDLE NAME)

PIN: _____ DATE OF BIRTH: _____ (MM/DD/YYYY)

KPP: _____

ADDRESS: _____ (BARANGAY /TOWN / MUNICIPALITY/CITY / PROVINCE)

_____
(Printed Name of Authorized Personnel)

BENEFICIARY'S COPY

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center (02) 411-7442 Trunkline (02) 441-7444
www.philhealth.gov.ph

Registration Confirmation Receipt

Registration Number: K20211216002448

Date Registered: 12/16/2021

PhilHealth ID Number: 030509120286

Name: RAFAEL ALEJO QUITORIANO,

Konsulta HCI: PASIG CITY MATERNITY CLINIC & FAMILY WELLNESS CENTER

Konsulta Address: CARUNCHO AVE., SAN NICOLAS PASIG CITY METRO MANILA

**** This is a system generated form. Signature is not required. ****

This form may be presented to the chosen Konsulta Health Care Institution (HCI)

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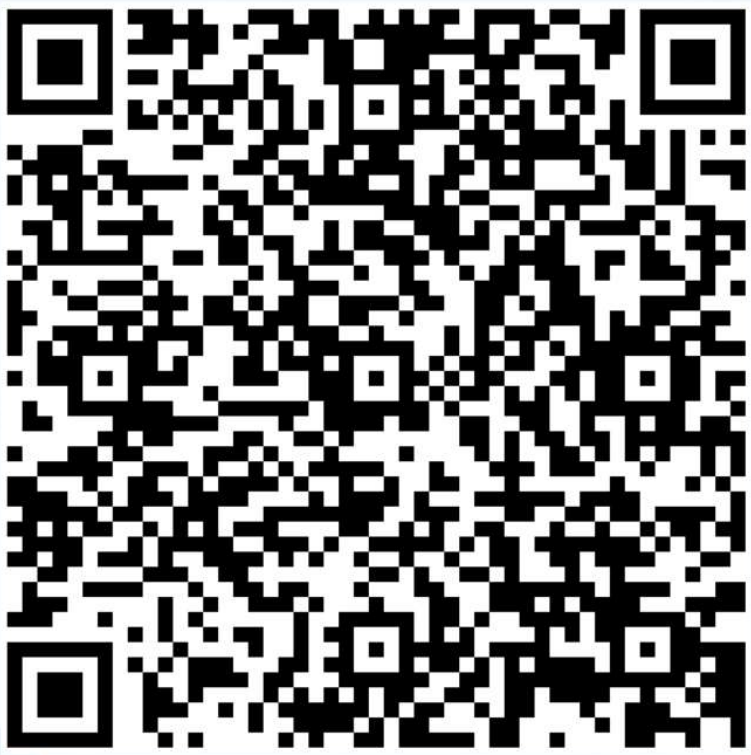
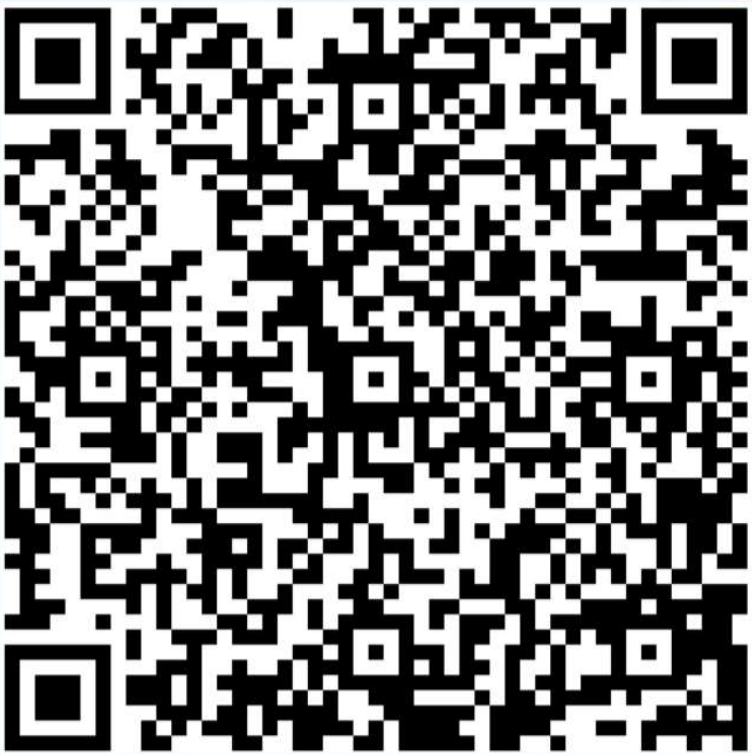


PHILHEALTH MEMBER REGISTRATION FORM



PHILHEALTH YAKAP REGISTRATION FORM

PhilHealth YAKAP
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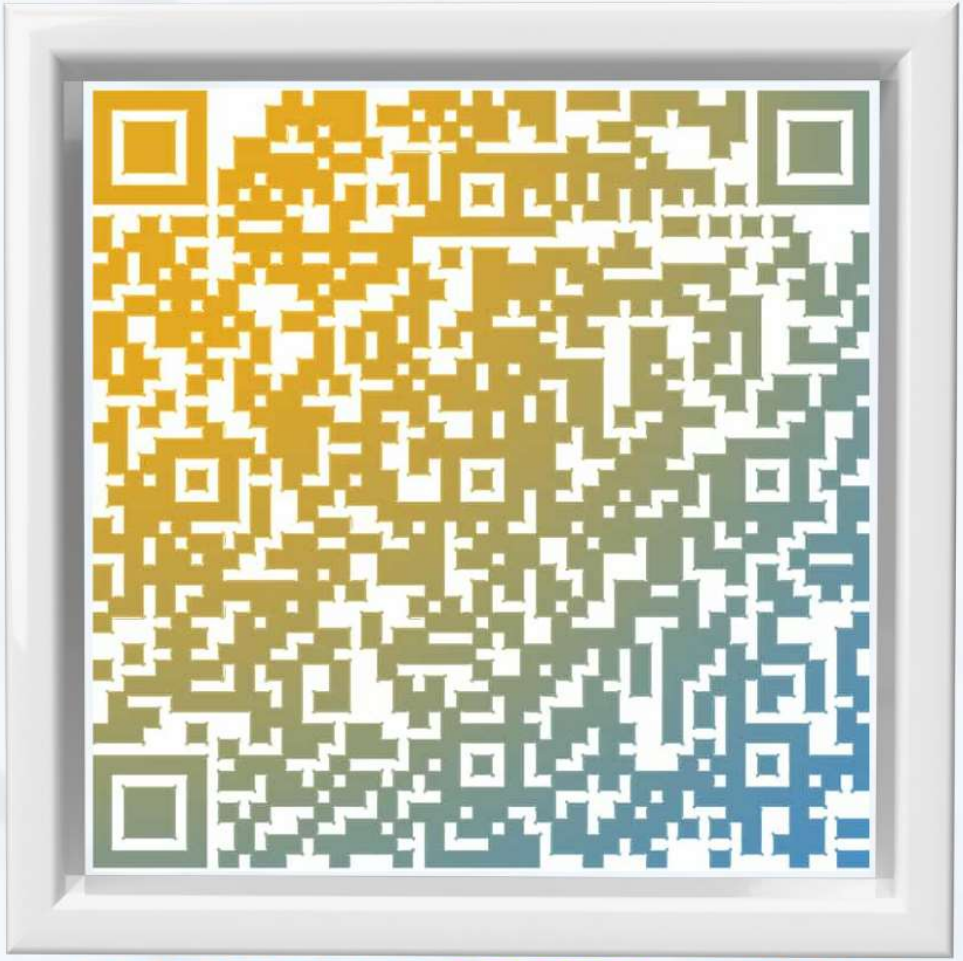

ACCREDITED YAKAP CLINICS
WITHIN NCR AND RIZAL

PhilHealth YAKAP
PARA MALAYO SA SAKIT

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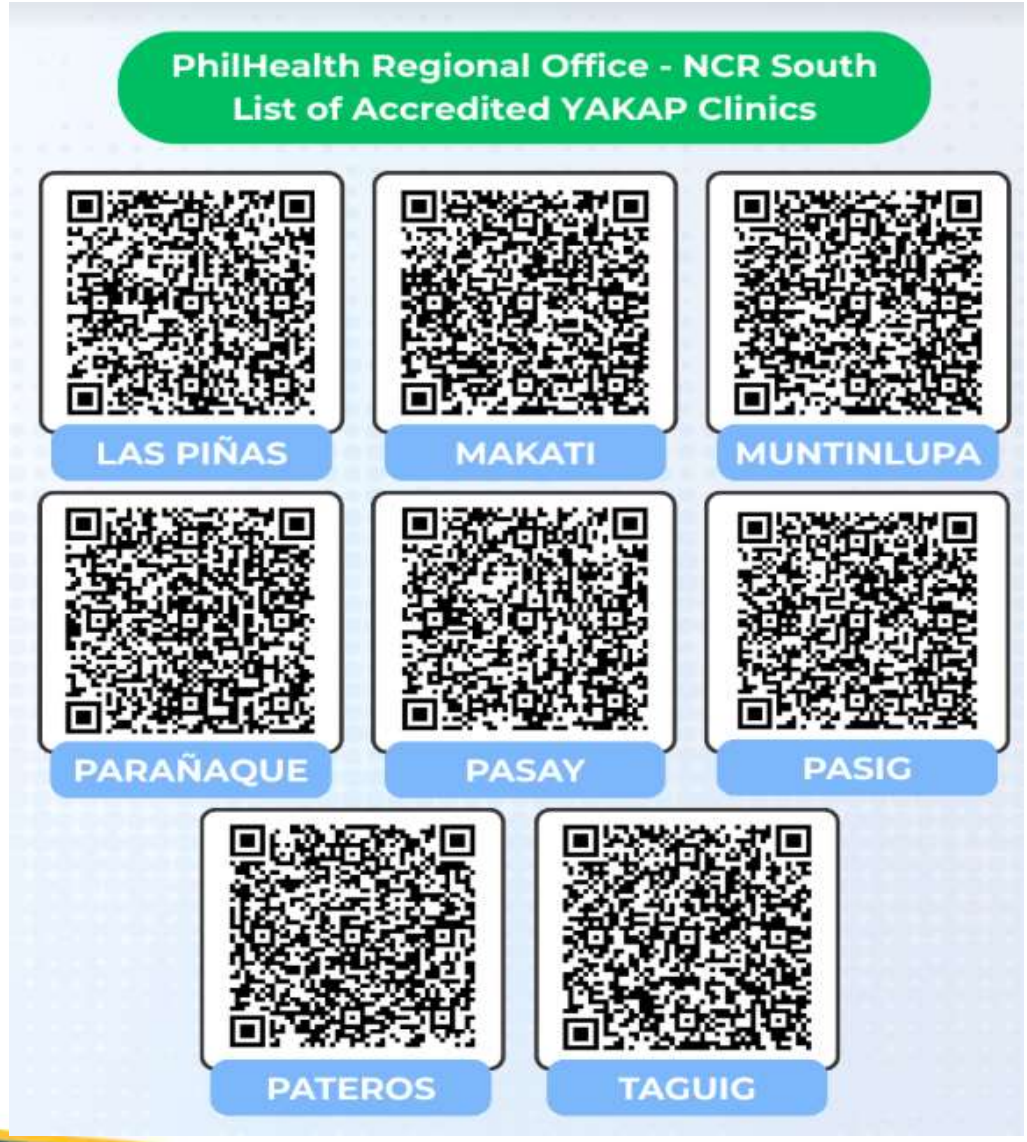
PhilHealth Regional Office - NCR South
List of Accredited YAKAP Clinics
LAS PIÑAS
MAKATI
MUNTINLUPA
PARAÑAQUE
PASAY
PASIG
PATEROS
TAGUIG

(Please put your Company logo or you can use your company template)

Annex C. Certification from Workplaces

CERTIFICATION

This is to certify that as of the date of this issuance, all employees of (Name of Company), located at (Company address), listed in the Registration Consent List, attached hereto as "Annex E", are alive and actively engaged in their respective roles. Further, we certify that the address and other information given are true and correct to the best of our knowledge and accurately reflect the official records on file.

We also certify that all employees were properly informed of the objectives, benefits, and procedures of the Primary Care Benefit through Meetings, Memorandums or other informational Materials.

Accordingly, we confirm that all individuals mentioned have voluntarily and willingly given their consent to be registered in the Primary Care Benefit, specifically under the package provider: (Name of Primary Care Provider).

Furthermore, the company is fully confident and aware that the choice of the Primary Care Provider (PCP) is anchored in the PCP's commitment to provide high quality, accessible and beneficiary-centered care to our employees.

The signatory has the necessary and proper authorization to issue this certification; that this certification is being issued for registration and documentation, and for whatever legal and administrative purpose it may serve.

Issued this ___ day of _____, _____, at _____.

[Signature over printed name]

[President]

[Signature over printed name]

[Human Resource/ Other Designation]

(Please put your Company logo or you can use your company template)

Name of Company: _____

Annex E. Registration Consent List

[indicate the Name of PCP]

SURNAME	GIVEN NAME	MIDDLE NAME	DATE OF BIRTH	ADDRESS	PHILHEALTH IDENTIFICATION NUMBER	SIGNATURE

SA BAGONG PILIPINAS, MALAYO KA SA SAKIT

PhilHealth YAKAP
PARA MALAYO SA SAKIT

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