

[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]

PhilHealth Office

[PhilHealth Office Address]
[City, State, Zip Code]

Subject: Authorization Letter for Medical Expenses

Dear PhilHealth Officer,

I, [Your Name], with PhilHealth Member ID number [Your Member ID], hereby authorize [Authorized Person's Name] to act on my behalf regarding all matters related to my medical expenses incurred on [Date of Medical Treatment] at [Name of Hospital/Clinic].

Please allow [Authorized Person's Name], holding a valid ID number [Authorized Person's ID Number], to access my records and facilitate any necessary documents related to my claim.

Thank you for your assistance.

Sincerely,

[Your Signature]

[Your Name]

[Your PhilHealth Member ID]