



Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
 Citystate Centre, 709 Shaw Boulevard, Pasig City
 Healthline 637-9999 www.philhealth.gov.ph



PHILHEALTH CIRCULAR

No. 16, s-2010

July
 TO

: ALL HEALTH CARE PROVIDERS, INDIVIDUALLY PAYING MEMBERS (IPMs), PHILHEALTH REGIONAL OFFICES, AND ALL OTHERS CONCERNED

SUBJECT : Bayad Center Payment Form as proof of premium payments

In line with the Corporation's continuing efforts to provide paying members better accessibility and convenience in remitting premium contributions, the **CIS Bayad Center Inc. (CBCI)**, hereby joins PhilHealth's list of Accredited Collecting Agents (ACAs) effective March 4, 2010.

By virtue of the signed Collection Remittance Agreement (CRA), **CBCI**, a non-bank collecting agent, shall accept PhilHealth premium payments from Individually Paying Members (IPM) with PhilHealth Identification Number (PIN). CBCI shall acknowledge premium payments by issuing a duly validated CBCI Payment Form ("Annex A"). Article III item 1.a. of the CRA states that:

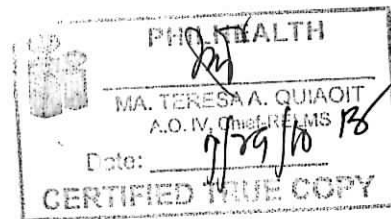
"CBCI shall indicate the Payor's Name, PhilHealth Identification Number (PIN), Full Name of the Member, Applicable Period, Member Type, Date and Amount Paid in the validated CBCI Payment Form."

In relation thereto, all concerned are advised that CBCI Payment Form, *when duly validated* with the abovementioned information, shall be recognized as proof of premium payments of NHIP members.

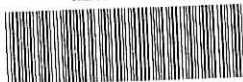
Please be guided accordingly.

Dr. REY B. AQUINO
 President and CEO

19 July 10
 Date signed



PhilHealth
 Your Partner in Health



OP-S10-32179

Annex "A"



TRANSACTION / PAYMENT FORM

PLEASE PROVIDE ALL THE REQUIRED INFORMATION BELOW

1 → **BILLER:** _____ **DATE:** _____ ← 2

3.1 → **ACCOUNT NUMBER:** _____

4.1 → **ACCOUNT NAME:** _____

5 → **AMOUNT DUE:** _____ **DUE DATE:** _____ ← 6

SOA NO.: _____ **STATEMENT DATE:** _____

TELEPHONE / MOBILE NUMBER: _____

FOR ENCASHMENTS
PAYEE'S SIGNATURE: _____

PAYMENT DETAILS

Amount to be paid: Php _____

Cash Check Cash and Check

Cash Php _____ Check No. _____

Check Php _____ Bank _____

Total Php _____ Branch _____

MACHINE VALIDATION

DECLARATION: The information provided above and documents hereby submitted have been made in good faith, verified correct to the best of my knowledge, pursuant to any laws and regulations applicable. I fully understand that CIS BAYAD CENTER, INC. and its outlet are authorized to accept and process my payments and documents submitted.

 Signature over Printed Name ← 7

BAYAD CENTER COPY

Paying member shall fill-out the CBCI Payment form with the following information:

No.	CBCI Form	PhilHealth Required Details
1	Billor	PhilHealth
2	Date	Date of Payment
3.1	Account Number	PhilHealth identification Number (PIN)
4.1	Account Name	Member's Name
5	Amount Due	Payment Amount
6	Due Date	Applicable Period
7	Signature over Printed Name	Member's Signature



PAYMENT ACKNOWLEDGEMENT

3.2 → **ACCOUNT NUMBER:** _____

4.2 → **ACCOUNT NAME:** _____

BAYAD CENTER ACKNOWLEDGES RECEIPT OF YOUR PAYMENT AS INDICATED IN THE MACHINE VALIDATION