



*the Philippines*  
**PHILIPPINE HEALTH INSURANCE CORPORATION**  
Citystate Centre Building, 709 Shaw Boulevard, Pasig City  
Healthline 441-7444 [www.philhealth.gov.ph](http://www.philhealth.gov.ph)



June 20, 2012

**PHILHEALTH CIRCULAR**

NO. 031, s. 2012

**TO** *May* : ALL HEALTH CARE PROVIDERS, PHILHEALTH REGIONAL OFFICES, LOCAL HEALTH INSURANCE OFFICES AND ALL OTHERS CONCERNED

**SUBJECT** : Supplemental Guidelines to PhilHealth Circular No. 13 s. 2012 re: New Health Care Provider Engagement Process in Support of Universal Health Care (UHC) or Kalusugan Pangkalahatan (KP)

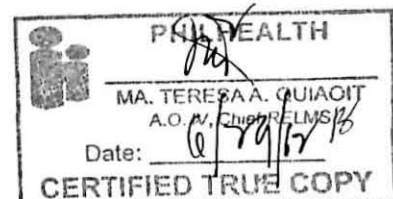
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**RATIONALE AND BACKGROUND**

PhilHealth Circ. No. 13 s. 2012 provided the guidelines and requirements on the new Health Care Provider (HCP) engagement process effective May 10, 2012. For uniform implementation of the said policy and to further enhance provider profile, the following amendments to Section C.6 of the said circular are provided:

**A. REGISTRATION**

1. Parallel with the provisions in the Performance Commitment (PC), the following items shall be submitted to PhilHealth as part of the Provider Data Record:
  - a. Latest audited financial statement/report as stated in item no. 29 of the PC, Annexes 5 and 6, Circ No. 13, s. 2012 reflecting the income/payments received from PhilHealth. This is applicable to all hospitals (public and private) and private out-patient clinics.
  - b. Electronic copies (in JPEG format) of recent photos of the facility, internal and external area (Ex.- PhilHealth ward, emergency room, recovery room, operating room, etc.) labeled with the name of the facility and date taken.
2. All institutional health care providers (IHCPs) with current accreditation are required to submit a duly signed PC, a copy of their latest audited financial statement/report, if applicable (Section A.1.a above), and recent pictures of the facility to the concerned PhilHealth Regional/Local Health Insurance Office (PRO/LHIO) **on or before July 31, 2012.**
3. Subsequent applications for renewal of participation shall also include the above-enumerated items. (Annex 4. Checklist of Requirements for Application as a Health Care Provider of the NHIP)



4. The PROs shall issue a Certificate of Eligibility to Participate (CEP) to the IHCP within thirty (30) days upon receipt of the signed copy of the PC. **For PCB Providers, the deadline for submission of their signed PC is June 30, 2012** (Circ. No. 18 s. 2012).
  5. For the regular engagement process or non-automatic accreditation, the PC shall be submitted within thirty (30) days from receipt of the notice of approval of participation. The start date of participation shall be on the date of complete compliance for participation (applicable documents, except the PC, and/or compliance with applicable standards).
- Late submission of PC shall be counted as one (1) offense in the Provider Assessment Monitoring System (PAMS) and the start date of participation shall be on the date of submission of the PC.
6. To facilitate accomplishment of the PC, please refer to Annex 1: Guidelines in Accomplishing the PC.
  7. The revised Provider Data Record (PDR), revised Flowchart of New Engagement Process, revised Checklist of Requirements, and enhanced Statement of Intent are attached Annexes to this circular.

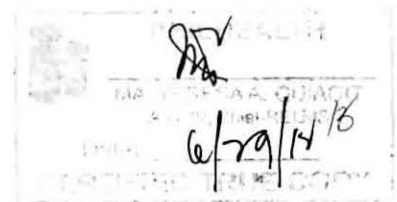
## B. MODIFIED ENGAGEMENT PROCESS FOR INITIAL OR RE-ACCREDITATION

This process applies only to applications of IHCPs **FOR INITIAL PARTICIPATION OR REACCREDITATION** that were filed during the prescribed filing period for renewal of participation of IHCPs, up to the end date of the regular accreditation cycle:

1. Prior to registration, the IHCP management shall choose the start date of its participation as a health care provider and sign the Statement of Intent to reflect this.
  - a. **Option A - IHCPs shall be eligible to participate for two accreditation cycles:**
    1. The start date of initial participation shall be on the date of compliance (as stated in the intent, subject to rules on compliance with requirements of registration and participation) and it shall end coinciding with the applicable accreditation cycle.
    2. Renewal of participation for the next cycle shall be automatic, i.e., the IHCP need not file a new application provided that the preceding application for participation was approved.

Example 1.

Type of IHCP	Date complied	Eligibility to Participate			
		Initial Participation		Renewal of Participation	
		Start date	End date	Start date	End date
Hospital, FDC, ASCs	January 12, 2013	January 12, 2013	April 30, 2013	May 1, 2013	April 30, 2014
PCB, MCP, DOTS, ABTCs, OMPs	October 2, 2012	October 2, 2012	Dec. 31, 2012	January 1, 2013	Dec. 31, 2013



3. Only one (1) set of application shall be submitted, the spaces for initial or reaccreditation and renewal shaded or blocked.
4. Corresponding registration fees for two (2) accreditation cycles shall apply. Hospitals applying as Centers of Quality or Excellence, shall pay for registration fees equivalent to two (2) years of participation only. Centers of Excellence shall pay for the applicable fees for the 3<sup>rd</sup> year within the month of January prior to the start of their 3<sup>rd</sup> year of participation. Hospitals approved as Centers of Quality or Excellence shall still submit the updated hospital license to operate (LTO) every month of January prior to the next cycle of participation.
5. In case the application for participation for the 1<sup>st</sup> accreditation cycle was denied, the registration fee for the 2<sup>nd</sup> accreditation cycle may be used as payment for its next registration for participation in the NHIP. Failure to register within one (1) year from receipt of notice of denial of participation shall forfeit the said registration fee in favor of the Corporation.

**b. Option B -IHCP shall be eligible to participate on the next regular accreditation cycle**

1. The effective date of initial participation shall coincide with the next regular accreditation cycle (subject to rules on compliance with requirements of registration and participation) and it shall end coinciding with the applicable accreditation cycle.

Example 2.

Type of IHCP	Date complied	Eligibility to Participate	
		Start date	End date
Hospital, FDC, ASCs	January 12, 2013	May 1, 2013	April 30, 2014
PCB, MCP, DOTS, ABTCs, OMPs	October 2, 2012	January 1, 2013	Dec. 31, 2013

2. Only one (1) set of application for participation shall be submitted.
  3. Registration fee for one (1) accreditation cycle shall apply.
2. PhilHealth shall issue a Certificate of Eligibility to Participate for each approved application.

**C. ANNEXES:**

The following documents are integral annexes to this circular.

1. Annex 1. Guidelines for implementation of the Performance Commitment
  - 1.1 Accomplishing the Performance Commitment for Health Care Providers (PC for HCP)
  - 1.2 Accomplishing the Performance Commitment for Health Care Providers (PC for HSP)
  - 1.3 Performance Commitment for HCP
  - 1.4 Performance Commitment for HSP
  - 1.5 Specific Provisions for Primary Care Benefit 1 Providers (PC for PCB)
2. Revised Provider Data Record (PDR)
3. Revised Flowchart of the New HCP Engagement Process



4. Checklist of Requirements of IHCPs Engaging with PhilHealth
5. Statement of Intent

#### D. EFFECTIVITY

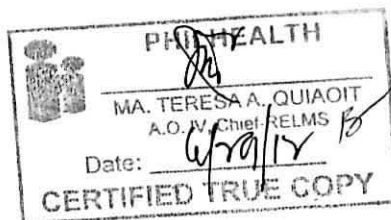
All PhilHealth Offices through the Corporate Communications Department, Public and Media Affairs Units and Health Care Delivery and Management Divisions of the PROs shall ensure appropriate and massive information campaign efforts regarding this issuance.

All other existing issuances inconsistent with this circular are hereby repealed and/or amended accordingly.

This circular shall apply to all applications, including those pending applications as of May 10, 2012.

Please be guided accordingly.

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**DR. EDUARDO F. BANCION**  
President and CEO 6/25/12



## **Annex 1. Guidelines for the Implementation of the Performance Commitment**

1. There are 3 performance commitment (PC) documents as of June 26, 2012:
  - a. Performance Commitment for Health Care Providers (PC for HCP)
  - b. Performance Commitment for Health System Providers (PC for HSP)
  - c. Performance Commitment for Primary Care Benefit Providers (PC for PCBP)
2. The PC for HCP or PC for HSP already covers the commitments for the other outpatient benefit packages, which means there will be no specific provisions for them (TB-DOTS, MCP, NCP, OHAT, Malaria package, ABP).
3. All three PCs will be made available in the PhilHealth website as a restricted word document. Only certain portions of the uploaded documents may be edited. Guidelines for accomplishing the Performance Commitment are found in Annex A.
4. HCPs may download the appropriate PC they need from the website ([www.philhealth.gov.ph](http://www.philhealth.gov.ph)). The HCP will need to:
  - a. Edit the unrestricted portions appropriate to their facility
  - b. Print two copies of the document
  - c. Have the documents signed by the owner/LCE and medical director/head of facility
  - d. Submit one document to PhilHealth and have the other marked as received but keep as their copy
5. HCPs that do not have access to the internet may ask for a copy of the appropriate PC from the nearest PhilHealth office.
6. Providers for PCB1 need to sign both the PC for HCP or PC for HSP and the PC for PCB.
7. Hospitals that also opt to be Primary Care Benefit Providers have to accomplish, sign and submit both the PC for HCP and PC for PCBP.
8. Local government units that opt to commit their entire health system to the National Health Insurance Program (NHIP) should sign the PC for HSP. Facilities within the health system that also opt to provide primary care benefits should submit the PC for PCBP separately.
9. Upon receipt of the performance commitment/s, the PRO/LHIO should make sure that the provisions in the performance commitment/s submitted are complete and that the forms are properly accomplished.

A properly accomplished PC should have the following:

- i. The first three pages are initialed by the LCE/owner and head/s of the facility.
- ii. The letterhead of the facility/LGU is reflected on the top portion of the first page.
- iii. The names of the owner and head of facility and their signatures are reflected in the last page. For PC for HSP, all the heads of facilities listed in item#1 should affix their signature on the last page.
- iv. All 43 provisions are complete and unaltered.
- v. Items 1, 2 and 13 of the PC for HCP or items 1 and 12 of the PC for HSP have been edited to reflect the information of the HCP/HSP.
- vi. For PCB providers, names of the local chief executive and head of facility and their signatures are reflected at the bottom of the page.

## Annex 1.1 Accomplishing the Performance Commitment for Health Care Providers (PC for HCP)

{{Letterhead of Healthcare Provider}}	
<div style="border: 1px solid black; display: inline-block; padding: 2px 10px;">A</div>	
 16 May 2012	
PHILIPPINE HEALTH INSURANCE CORPORATION 17 <sup>th</sup> Flr., City State Centre Bldg., Shaw Blvd., Pasig City	
 SUBJECT : <u>Performance Commitment</u>	
 Sir/Madam:	
 To guarantee our commitment to the National Health Insurance Program (NHIF), we respectfully submit this Performance Commitment.	
 And for the purposes of this Performance Commitment, we hereby warrant the following representations:	
<ol style="list-style-type: none"><li>1. That we are {{only registered and licensed by the DOH}} / {{non-regulated health care facility}} capable of delivering the services expected from the type of healthcare provider that we are applying for.</li><li>2. That we are owned by {{_____}} and managed by {{_____}} and doing business under the name of {{_____}} {{with license/certificate number}} {{_____}}.</li><li>3. That all professional health care providers in our facility have proper credentials and given appropriate privileges in accordance with our policies and procedures.</li><li>4. That our officers, employees, other personnel and staff are members in good standing of the NHIF.</li></ol>	
 Further, we hereby commit ourselves to the following:	
<ol style="list-style-type: none"><li>5. That as responsible owner(s) and/or manager(s) of the institution, we shall be jointly and severally liable for all violations committed against the provisions of R.A. 7675 including its</li></ol>	

Editing of the document has been restricted. There are only some parts (highlighted) that are editable

- I. Part A is for the letterhead of the HCP.
- II. In item #1, the HCP should indicate whether they are a facility that is regulated (or licensed) by the Department of Health or not.

- III. In item #2, HCP should indicate the name/s of its owner/s in the **first blank**. For government facilities, the name of the local chief executive is indicated here. The **second blank** is for the head of the facility otherwise known as the manager or medical director. The **third blank** is for the official name of the HCP as reflected in the business registration and DOH license (if applicable). The **fourth blank** applies only for those facilities that are licensed by DOH. These facilities should indicate their license number in the blank. Facilities that are not regulated by the DOH, should delete the highlighted part (in grey).

11. That we shall adhere to pertinent statutory laws affecting the operations of IHCPs including but not limited to the Expanded Senior Citizens Act of 2003 (R.A. 9257), the Breastfeeding Act (R.A. 7600), the Newborn Screening Act (R.A. 9288), the Cheaper Medicines Act (R.A. 9502), the Pharmacy Law (R.A. 5921), the Magna Carta for Disabled Persons (R.A. 9442) and all other laws, rules and regulations that may hereafter be passed by the Congress of the Philippines or any other authorized instrumentalities of the government.

12. That we shall promptly submit reports as may be required by PhilHealth, DOH and all other government agencies and instrumentalities governing the operations of IHCPs.

13. That we are duly capable to deliver the following services [as provided in our DOH license] for the duration of the validity of this commitment *(please check appropriate boxes)*:

- ☐ Level 1 hospital services
- ☐ Level 2 hospital services
- ☐ Level 3 hospital services
- ☐ Level 4 hospital services
- ☐ Specialized services
  - ☐ Radiotherapy
  - ☐ Hemodialysis/Peritoneal Dialysis
  - ☐ Others (please specify) \_\_\_\_\_
- ☐ Benefit package and other services
  - ☐ Tuberculosis Directly Observed Treatment System (TB DOTS)
  - ☐ Maternity Care Package
  - ☐ Newborn Care Package
  - ☐ Malaria Package
  - ☐ Primary Care Benefit Package 1 (For government hospitals only)
  - ☐ Outpatient HIV/AIDS Package (for DOH-identified hospitals only)
  - ☐ Animal Bite Package
  - ☐ Others (please specify) \_\_\_\_\_

14. That we shall provide and charge to the PhilHealth benefit of the client the necessary services including but not limited to drugs, medicines, supplies, devices, and diagnostic and treatment procedures for our PhilHealth clients.

- IV. In item #13, the highlighted phrase “as provided in our DOH license” should be deleted by facilities that are not regulated by the DOH. This should be retained as part of the PC for facilities that are regulated by DOH.

Other services that the facility is committing may be enumerated in the blank under ‘specialized services’

Other benefit packages that the facility is committing may be enumerated in the blank space under ‘Benefit package and other services’

- V. Edit part B and input the name of the owner or Local Chief Executive if LGU-owned. In the other blank, input the name of the head of the facility/medical director/manager.

DOH license, suspension of accreditation, etc, downgrading of level, loss of license for certain services including any and all other fees due to be paid to PhilHealth.

Furthermore, recognizing PhilHealth's indispensable role in the NHIP, we hereby acknowledge the power and authority of PhilHealth to do the following:

41. To suspend, shorten, pre-terminate and/or revoke our privilege of participating in the NHIP including the appurtenant benefits and opportunities at any time during the validity of the commitment for any violation of any provision of this Performance Commitment.
42. To suspend, shorten, pre-terminate and/or revoke our accreditation including the appurtenant benefits and opportunities incident thereto at any time during the term of the commitment due to verified adverse reports/findings of pattern or any other similar incidents which may be indicative of any illegal, irregular or improper and/or unethical conduct of our operations.
43. To deny our accreditation and consequently participation in the NHIP should there be a case, regardless of the nature thereof, filed by us against PhilHealth, its Officers and/or any of its Personnel. Provided that, if in the discretion of PhilHealth, the specific nature of the case is such that it will not directly or indirectly affect a healthy business relationship with us, PhilHealth, upon the recommendation of the Accreditation Committee, may favorably consider the approval of our accreditation.

We commit to extend our full support in sharing PhilHealth's vision in achieving this noble objective of providing accessible quality health insurance coverage for all Filipinos.

\_\_\_\_\_  
[Local Chief Executive (if LGU-owned)/Owner]

\_\_\_\_\_  
[Head of Facility/Medical Director/Manager]

- VI. After accomplishing the form, the HCP has to print 2 copies. The owner/LCE and the head of facility/medical director/manager should sign in the blanks provided on the last page and affix their initials in the first three pages.
- VII. One of the signed copies should be submitted and left with PhilHealth. The other copy should be marked by PhilHealth as received and should be kept safe by the facility.

## Annex 1.2 Accomplishing the Performance Commitment for Health System Providers (PC for HSP)

(Letterhead of LGU)		<b>A</b>																														
<p>17 May 2012</p> <p><b>PHILIPPINE HEALTH INSURANCE CORPORATION</b> 17<sup>th</sup> Flr., City State Centre Bldg., Shaw Blvd., Pasig City</p> <p><b>SUBJECT : <u>Performance Commitment</u></b></p> <p><b>Sir/Madam:</b></p> <p>To guarantee our commitment to the National Health Insurance Program (NHIP), we respectfully submit this Performance Commitment.</p> <p>And for the purposes of this Performance Commitment, we hereby warrant the following representations:</p> <p>1. That the following facilities, as guaranteed by the heads of facilities listed in the following table, are capable of delivering the services expected from the type of healthcare provider that we are applying for:</p> <table border="1" style="width: 100%; border-collapse: collapse;"><thead><tr><th style="width: 20%;">Name of Facility</th><th style="width: 25%;">Type of facility (hospital, RHU, HC, Lying-in, TB-DOTS, ABTCs, etc)</th><th style="width: 15%;">Hospital Level (if applicable)</th><th style="width: 20%;">License Number/Certificate Number (if applicable)</th><th style="width: 20%;">Management (if different from the LGU)</th></tr></thead><tbody><tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr></tbody></table> <p>2. That all professional healthcare providers in our facility have proper credentials and given appropriate privileges in accordance with our policies and procedures.</p> <p>3. That our officers, employees, other personnel and staff are members in good standing of the NHIP.</p>			Name of Facility	Type of facility (hospital, RHU, HC, Lying-in, TB-DOTS, ABTCs, etc)	Hospital Level (if applicable)	License Number/Certificate Number (if applicable)	Management (if different from the LGU)																									
Name of Facility	Type of facility (hospital, RHU, HC, Lying-in, TB-DOTS, ABTCs, etc)	Hospital Level (if applicable)	License Number/Certificate Number (if applicable)	Management (if different from the LGU)																												

Editing of the document has been restricted. There are only some parts (highlighted) that are editable

- I. Part A is for the letterhead of the Local Government Unit.
- II. In item #1, the LGU should enumerate ALL the facilities included in the health system – hospitals, RHUs, birthing homes, DOTS facilities, animal bite treatment centers, etc. The corresponding columns should be filled out appropriately.

Pharmacy Law (R.A. 5921), the Magna Carta for Disabled Persons (R.A. 5442) and all other laws, rules and regulations that may hereafter be passed by the Congress of the Philippines or any other authorized instrumentalities of the government.

11. That we shall promptly submit reports as may be required by PhilHealth, DOH and all other government agencies and instrumentalities governing the operations of IHCPs.
12. That we shall deliver the following services for the duration of the validity of this commitment:

Name of Facility	Committed Services (choose from the enumerated services below; e.g. 1, 6a, 6b, 6c)

1. Level 1 hospital services
2. Level 2 hospital services
3. Level 3 hospital services
4. Level 4 hospital services
5. Specialized services
  - a. Radiotherapy
  - b. Hemodialysis/Peritoneal Dialysis
  - c. Others (please specify in table)
6. Benefit package and other services
  - a. Tuberculosis Directly Observed Treatment System (TB DOTS)
  - b. Maternity Care Package
  - c. Newborn Care Package
  - d. Outpatient Malaria Package
  - e. Primary Care Benefit Package 1 (For government hospitals only)
  - f. Outpatient HIV/AIDS Package (for DOH identified hospitals only)
  - g. Animal Bite Package
  - h. Others (please specify in table)

- III. In item #12, the LGU should list down the same facilities enumerated in table 1 of item #1. The committed services for each facility should be enumerated using the numbers opposite the services listed below the table. An example may be found in the succeeding figure.

- government agencies and instrumentalities governing the operations of IHCPs.
12. That we shall deliver the following services for the duration of the validity of this commitment:

Name of Facility	Committed Services (choose from the enumerated services below; e.g. 1, 6a, 6b, 6c)
EPB Hospital	4, 5a, 5b, 6e, 6g
FZS Rural Health Unit	6e
NJS Lying in	6b, 6c

EPB hospital commits the following: level 4 hospital services, radiotherapy, hemodialysis, primary care benefit (PCB) and animal bite package. FZS RHU commits PCB. NJS Lying in commits MCP and NCP.

- IV. Edit part B and input the names of the heads of facilities. In the other blank, input the name of the local chief executive.

41. To suspend, shorten, pre-terminate and/or revoke our privilege of participating in the NHIP including the appurtenant benefits and opportunities at any time during the validity of the commitment for any violation of any provision of this Performance Commitment.
42. To suspend, shorten, pre-terminate and/or revoke our accreditation including the appurtenant benefits and opportunities incident thereto at any time during the term of the commitment due to verified adverse reports/findings of pattern or any other similar incidents which may be indicative of any illegal, irregular or improper and/or unethical conduct of our operations.
43. To deny our accreditation and consequently participation in the NHIP should there be a case, regardless of the nature thereof, filed by us against PhilHealth, its Officers and/or any of its Personnel. Provided that, if in the discretion of PhilHealth, the specific nature of the case is such that it will not directly or indirectly affect a healthy business relationship with us, PhilHealth, upon the recommendation of the Accreditation Committee, may favorably consider the approval of our accreditation.

We commit to extend our full support in sharing PhilHealth's vision in achieving this noble objective of providing accessible quality health insurance coverage for all Filipinos.

\_\_\_\_\_  
Head of Facility/Medical Director/Manager

B

With my express conformity,

\_\_\_\_\_  
Local Chief Executive

- V. After accomplishing the form, the LGU has to print 2 copies. The LCE and the heads of facility/medical director/manager should sign in the blanks provided on the last page and affix their initials in the first three pages.
- VI. One of the signed copies should be submitted and left with PhilHealth. The other copy should be marked by PhilHealth as received and should be kept safe by the facility.

### Annex 1.3 (Letterhead of Healthcare Provider)

27 June 2012

**PHILIPPINE HEALTH INSURANCE CORPORATION**

17<sup>th</sup> Flr., City State Centre Bldg.,

Shaw Blvd., Pasig City

**SUBJECT : Performance Commitment**

**Sir/Madam:**

To guarantee our commitment to the National Health Insurance Program (NHIP), we respectfully submit this Performance Commitment.

And for the purposes of this Performance Commitment, we hereby warrant the following representations:

1. That we are [duly registered and licensed by the DOH] / [non-regulated health care facility] capable of delivering the services expected from the type of healthcare provider that we are applying for.
2. That we are owned by \_\_\_\_\_ and managed by \_\_\_\_\_ and doing business under the name of \_\_\_\_\_ [with license/certificate number \_\_\_\_\_].
3. That all professional health care providers in our facility have proper credentials and given appropriate privileges in accordance with our policies and procedures.
4. That our officers, employees, other personnel and staff are members in good standing of the NHIP.

Further, we hereby commit ourselves to the following:

5. That as responsible owner(s) and/or manager(s) of the institution, we shall be jointly and severally liable for all violations committed against the provisions of R.A 7875 including its Implementing Rules and Regulations and policies.
6. That we shall promptly inform PhilHealth prior to any change in the ownership and/or management of our institution.
7. That any change in ownership and/or management of our institution shall not operate to exempt the previous and/or present owner and/or manager from violations of R.A. 7875 including its Implementing Rules & Regulations and policies.
8. That we shall maintain active membership in the NHIP as an employer not only during the entire validity of our participation in the NHIP as an Institutional HealthCare Provider (IHCP) but also during the corporate existence of our institution.
9. That we shall abide with all the implementing rules and regulations, memorandum circulars, office orders, special orders and other administrative issuances by PhilHealth affecting us.
10. That we shall abide with all administrative orders, circulars and such other policies, rules and regulations issued by the Department of Health and all other related government agencies and instrumentalities governing the operations of IHCPs in participating in the NHIP.

11. That we shall adhere to pertinent statutory laws affecting the operations of IHCPs including but not limited to the Expanded Senior Citizens Act of 2003 (R.A. 9257), the Breastfeeding Act (R.A. 7600), the Newborn Screening Act (R.A. 9288), the Cheaper Medicines Act (R.A. 9502), the Pharmacy Law (R.A. 5921), the Magna Carta for Disabled Persons (R.A. 9442) and all other laws, rules and regulations that may hereafter be passed by the Congress of the Philippines or any other authorized instrumentalities of the government.
12. That we shall promptly submit reports as may be required by PhilHealth, DOH and all other government agencies and instrumentalities governing the operations of IHCPs.
13. That we are duly capable to deliver the following services [as provided in our DOH license] for the duration of the validity of this commitment (*please check appropriate boxes*):

- ☐ Level 1 hospital services
- ☐ Level 2 hospital services
- ☐ Level 3 hospital services
- ☐ Level 4 hospital services
- ☐ Specialized services
  - ☐ Radiotherapy
  - ☐ Hemodialysis/Peritoneal Dialysis
  - ☐ Others (please specify) \_\_\_\_\_
- ☐ Benefit package and other services
  - ☐ Tuberculosis Directly Observed Treatment System (TB DOTS)
  - ☐ Maternity Care Package
  - ☐ Newborn Care Package
  - ☐ Malaria Package
  - ☐ Primary Care Benefit Package 1 (For government hospitals only)
  - ☐ Outpatient HIV/AIDS Package (for DOH identified hospitals only)
  - ☐ Animal Bite Package
  - ☐ Others (please specify) \_\_\_\_\_

14. That we shall provide and charge to the PhilHealth benefit of the client the necessary services including but not limited to drugs, medicines, supplies, devices, and diagnostic and treatment procedures for our PhilHealth clients.
15. That we shall provide the necessary drugs, supplies and services with no out of-pocket expenses on the part of the members as contained in PhilHealth's 'No Balance Billing' (NBB) Policy.
16. That we shall maintain a high level of service satisfaction among PhilHealth clients including all their qualified beneficiaries.
17. That we shall be guided by PhilHealth-approved clinical practice guidelines or if not available, other established and accepted standards of practice.
18. That we shall provide a PhilHealth Bulletin Board for the posting of updated information of the NHIP (circulars, memoranda, IEC materials, price reference index, etc.) in conspicuous places accessible to patients, members and dependents of the NHIP within our healthcare facility.
19. That we shall always make available the necessary forms for patient's use.
20. That we shall treat clients with courtesy and respect, assist them in availing PhilHealth benefits and provide them with accurate information on PhilHealth policies and guidelines.
21. That we shall ensure that clients with needs beyond our service capability are referred to appropriate PhilHealth-accredited facilities.
22. That we shall maintain a registry of all our clients/patients (including newborns) including a database of all claims filed containing actual charges (board, drugs, labs, auxiliary, services and

professional fees), actual amount deducted/ by the facility as PhilHealth reimbursement and actual Philhealth reimbursement, which shall be made available to PhilHealth or any of its authorized personnel.

23. That we shall maintain and submit to PhilHealth an electronic registry of physicians including their fields of practice, official e-mail and mobile phone numbers.
24. That we shall electronically encode the drugs and supplies used in the care of the patient in our information system, which shall be made available for PhilHealth use.
25. That we shall ensure that true and accurate data are encoded in all patients' records.
26. That we shall only file legitimate claims recognizing the period of filing after the patient's discharge prescribed in PhilHealth circulars.
27. That we shall submit claims in the format required for our facility.
28. That we shall regularly submit PhilHealth monitoring reports as required in PhilHealth circulars and the PhilHealth Benchbook.
29. That we shall annually submit a copy of our audited financial statement/report.
30. That we shall extend full cooperation with duly recognized authorities of PhilHealth and any other authorized personnel and instrumentalities to provide access to patient records and submit to any assessment conducted by PhilHealth relative to any findings, adverse reports, pattern of utilization and/or any other acts indicative of any illegal, irregular and/or unethical practices in our operations as an accredited IHCP of the NHIP that may be prejudicial or tends to undermine the NHIP and make available all pertinent official records and documents including the provision of copies thereof.
31. That we shall ensure that our officers, employees and personnel extend full cooperation and due courtesy to all PhilHealth officers, employees and staff during the conduct of assessment/visitation/investigation/monitoring of our operations as an accredited IHCP of the NHIP.
32. That at any time during the period of our participation in the NHIP, upon request of PhilHealth, we shall voluntarily and unconditionally sign and execute a new 'Performance Commitment' to cover the remaining portion of our engagement or to renew our participation with the NHIP as the case may be, as a sign of our good faith and continuous commitment to support the NHIP.
33. That we shall take full responsibility for any inaccuracies and/or falsities entered into and/or reflected in our patients' records as well as in any omission, addition, inaccuracies and/or falsities entered into and/or reflected in claims submitted to PhilHealth by our institution.
34. That we shall comply with PhilHealth's summons, subpoena, subpoena 'duces tecum' and other legal or quality assurance processes and requirements.
35. That we shall recognize the authority of PhilHealth, its Officers and personnel and/or its duly authorized representatives to conduct regular surveys, domiciliary visits and/or conduct administrative assessment(s) at any time relative to the exercise of our privilege and conduct of our operations as an accredited IHCP of the NHIP.
36. That we shall comply with the corrective actions given after monitoring activities within the prescribed period.
37. That we shall protect the NHIP against abuse, violation and/or over-utilization of its funds and we shall not allow our institution to be a party to any act, scheme, plan, or contract that may directly or indirectly be prejudicial to the NHIP.
38. That we shall not directly or indirectly engage in any form of unethical or improper practices as an accredited provider such as, but not limited to, solicitation of patients for purposes of compensability under the NHIP, the purpose and/or the end consideration of which tends unnecessary financial gain rather than promotion of the NHIP.
39. That we shall immediately report to PhilHealth, its officers and/or to any of its personnel, any act(s) of illegal, improper and/or unethical practices of IHCP of the NHIP that may have come to our knowledge directly or indirectly.

40. We agree that PhilHealth may deduct from our future claims, all reimbursements paid to our institution during the period of its non-accredited status as a result of a gap in validity of our DOH license, suspension of accreditation, etc; downgrading of level, loss of license for certain services including any and all other fees due to be paid to PhilHealth.

Furthermore, recognizing PhilHealth's indispensable role in the NHIP, we hereby acknowledge the power and authority of PhilHealth to do the following:

41. To suspend, shorten, pre-terminate and/or revoke our privilege of participating in the NHIP including the appurtenant benefits and opportunities at any time during the validity of the commitment for any violation of any provision of this Performance Commitment.
42. To suspend, shorten, pre-terminate and/or revoke our accreditation including the appurtenant benefits and opportunities incident thereto at any time during the term of the commitment due to verified adverse reports/findings of pattern or any other similar incidents which may be indicative of any illegal, irregular or improper and/or unethical conduct of our operations.
43. To deny our accreditation and consequently participation in the NHIP should there be a case, regardless of the nature thereof, filed by us against PhilHealth, its Officers and/or any of its Personnel. Provided that, if in the discretion of PhilHealth, the specific nature of the case is such that it will not directly or indirectly affect a healthy business relationship with us, PhilHealth, upon the recommendation of the Accreditation Committee, may favorably consider the approval of our accreditation.

We commit to extend our full support in sharing PhilHealth's vision in achieving this noble objective of providing accessible quality health insurance coverage for all Filipinos.

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Local Chief Executive (if LGU-owned)/Owner

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Head of Facility/Medical Director/Manager

#### Annex 1.4 (Letterhead of LGU)

27 June 2012

**PHILIPPINE HEALTH INSURANCE CORPORATION**

17<sup>th</sup> Flr., City State Centre Bldg.,  
Shaw Blvd., Pasig City

**SUBJECT : Performance Commitment**

**Sir/Madam:**

To guarantee our commitment to the National Health Insurance Program (NHIP), we respectfully submit this Performance Commitment.

And for the purposes of this Performance Commitment, we hereby warrant the following representations:

1. That the following facilities, as guaranteed by the heads of facilities listed in the following table, are capable of delivering the services expected from the type of healthcare provider that we are applying for:

Name of Facility	Type of facility (hospital, RHU, HC, Lying-in, TB-DOTS, ABTCs, etc)	Hospital Level (if applicable)	License Number/Certificate Number (if applicable)	Management (if different from the LGU)

2. That all professional healthcare providers in our facility have proper credentials and given appropriate privileges in accordance with our policies and procedures.
3. That our officers, employees, other personnel and staff are members in good standing of the NHIP.

Further, we hereby commit ourselves to the following:

4. That as responsible owner(s) and/or manager(s) of the institution, we shall be jointly and severally liable for all violations committed against the provisions of R.A 7875 including its Implementing Rules and Regulations and policies.
5. That we shall promptly inform PhilHealth prior to any change in the ownership and/or management of our institution.
6. That any change in ownership and/or management of our institution shall not operate to exempt the previous and/or present owner and/or manager from violations of R.A. 7875 including its Implementing Rules & Regulations and policies.

7. That we shall maintain active membership in the NHIP as an employer not only during the entire validity of our participation in the NHIP as an Institutional HealthCare Provider (IHCP) but also during the corporate existence of our institution.
8. That we shall abide with all the implementing rules and regulations, memorandum circulars, office orders, special orders and other administrative issuances by PhilHealth affecting us.
9. That we shall abide with all administrative orders, circulars and such other policies, rules and regulations issued by the Department of Health and all other related government agencies and instrumentalities governing the operations of IHCPs in participating in the NHIP.
10. That we shall adhere to pertinent statutory laws affecting the operations of IHCPs including but not limited to the Expanded Senior Citizens Act of 2003 (R.A. 9257), the Breastfeeding Act (R.A. 7600), the Newborn Screening Act (R.A. 9288), the Cheaper Medicines Act (R.A. 9502), the Pharmacy Law (R.A. 5921), the Magna Carta for Disabled Persons (R.A. 9442) and all other laws, rules and regulations that may hereafter be passed by the Congress of the Philippines or any other authorized instrumentalities of the government.
11. That we shall promptly submit reports as may be required by PhilHealth, DOH and all other government agencies and instrumentalities governing the operations of IHCPs.
12. That we shall deliver the following services for the duration of the validity of this commitment:

Name of Facility	Committed Services (choose from the enumerated services below; e.g. 1, 6a, 6b, 6c)

1. Level 1 hospital services
2. Level 2 hospital services
3. Level 3 hospital services
4. Level 4 hospital services
5. Specialized services
  - a. Radiotherapy
  - b. Hemodialysis/Peritoneal Dialysis
  - c. Others (please specify in table)
6. Benefit package and other services
  - a. Tuberculosis Directly Observed Treatment System (TB DOTS)
  - b. Maternity Care Package
  - c. Newborn Care Package
  - d. Outpatient Malaria Package
  - e. Primary Care Benefit Package 1 (For government hospitals only)
  - f. Outpatient HIV/AIDS Package (for DOH identified hospitals only)
  - g. Animal Bite Package
  - h. Others (please specify in table)

13. That we shall provide and charge to the PhilHealth benefit of the client the necessary services including but not limited to drugs, medicines, supplies, devices, and diagnostic and treatment procedures for our PhilHealth clients.
14. That we shall provide the necessary drugs, supplies and services with no out-of-pocket expenses on the part of the members as contained in PhilHealth's 'No Balance Billing' (NBB) Policy.
15. That we shall maintain a high level of service satisfaction among PhilHealth clients including all their qualified beneficiaries.

16. That we shall be guided by PhilHealth-approved clinical practice guidelines or if not available, other established and accepted standards of practice.
17. That we shall provide a PhilHealth Bulletin Board for the posting of updated information of the NHIP (circulars, memoranda, IEC materials, price reference index, etc.) in conspicuous places accessible to patients, members and dependents of the NHIP within our healthcare facility.
18. That we shall always make available the necessary forms for patient's use.
19. That we shall treat clients with courtesy and respect, assist them in availing PhilHealth benefits and provide them with accurate information on PhilHealth policies and guidelines.
20. That a functional referral system, which will ensure that patients are managed in appropriate facilities, shall be established and institutionalized among the signatories of this Performance Commitment.
21. That we shall ensure that clients with needs beyond our service capability are referred to appropriate PhilHealth-accredited facilities.
22. That we shall maintain a registry of all our clients/patients (including newborns) including a database of all claims filed containing actual charges (board, drugs, labs, auxiliary, services and professional fees), actual amount deducted/ by the facility as PhilHealth reimbursement and actual Philhealth reimbursement, which shall be made available to PhilHealth or any of its authorized personnel.
23. That we shall maintain and submit to PhilHealth an electronic registry of physicians including their fields of practice, official e-mail and mobile phone numbers.
24. That we shall electronically encode the drugs and supplies used in the care of the patient in our information system, which shall be made available for PhilHealth use.
25. That we shall ensure that true and accurate data are encoded in all patients' records.
26. That we shall only file legitimate claims recognizing the period of filing after the patient's discharge prescribed in PhilHealth circulars.
27. That we shall submit claims in the format required for our facility.
28. That we shall regularly submit PhilHealth monitoring reports as required in PhilHealth circulars and the PhilHealth Benchbook.
29. That we shall annually submit a copy of our audited financial statement/report.
30. That we shall extend full cooperation with duly recognized authorities of PhilHealth and any other authorized personnel and instrumentalities to provide access to patient records and submit to any assessment conducted by PhilHealth relative to any findings, adverse reports, pattern of utilization and/or any other acts indicative of any illegal, irregular and/or unethical practices in our operations as an accredited IHCP of the NHIP that may be prejudicial or tends to undermine the NHIP and make available all pertinent official records and documents including the provision of copies thereof.
31. That we shall ensure that our officers, employees and personnel extend full cooperation and due courtesy to all PhilHealth officers, employees and staff during the conduct of assessment/visitation/investigation/monitoring of our operations as an accredited IHCP of the NHIP.
32. That at any time during the period of our participation in the NHIP, upon request of PhilHealth, we shall voluntarily and unconditionally sign and execute a new 'Performance Commitment' to cover the remaining portion of our engagement or to renew our participation with the NHIP as the case may be, as a sign of our good faith and continuous commitment to support the NHIP.
33. That we shall take full responsibility for any inaccuracies and/or falsities entered into and/or reflected in our patients' records as well as in any omission, addition, inaccuracies and/or falsities entered into and/or reflected in claims submitted to PhilHealth by our institution.
34. That we shall comply with PhilHealth's summons, subpoena, subpoena 'duces tecum' and other legal or quality assurance processes and requirements.
35. That we shall recognize the authority of PhilHealth, its Officers and personnel and/or its duly authorized representatives to conduct regular surveys, domiciliary visits and/or conduct

administrative assessment(s) at any time relative to the exercise of our privilege and conduct of our operations as an accredited IHCP of the NHIP.

36. That we shall comply with the corrective actions given after monitoring activities within the prescribed period.
37. That we shall protect the NHIP against abuse, violation and/or over-utilization of its funds and we shall not allow our institution to be a party to any act, scheme, plan, or contract that may directly or indirectly be prejudicial to the NHIP.
38. That we shall not directly or indirectly engage in any form of unethical or improper practices as an accredited provider such as, but not limited to, solicitation of patients for purposes of compensability under the NHIP, the purpose and/or the end consideration of which tends unnecessary financial gain rather than promotion of the NHIP.
39. That we shall immediately report to PhilHealth, its officers and/or to any of its personnel, any act(s) of illegal, improper and/or unethical practices of IHCP of the NHIP that may have come to our knowledge directly or indirectly.
40. We agree that PhilHealth may deduct from our future claims, all reimbursements paid to our institution during the period of its non-accredited status as a result of a gap in validity of our DOH license, suspension of accreditation, etc; downgrading of level, loss of license for certain services including any and all other fees due to be paid to PhilHealth.

Furthermore, recognizing PhilHealth's indispensable role in the NHIP, we hereby acknowledge the power and authority of PhilHealth to do the following:

41. To suspend, shorten, pre-terminate and/or revoke our privilege of participating in the NHIP including the appurtenant benefits and opportunities at any time during the validity of the commitment for any violation of any provision of this Performance Commitment.
42. To suspend, shorten, pre-terminate and/or revoke our accreditation including the appurtenant benefits and opportunities incident thereto at any time during the term of the commitment due to verified adverse reports/findings of pattern or any other similar incidents which may be indicative of any illegal, irregular or improper and/or unethical conduct of our operations.
43. To deny our accreditation and consequently participation in the NHIP should there be a case, regardless of the nature thereof, filed by us against PhilHealth, its Officers and/or any of its Personnel. Provided that, if in the discretion of PhilHealth, the specific nature of the case is such that it will not directly or indirectly affect a healthy business relationship with us, PhilHealth, upon the recommendation of the Accreditation Committee, may favorably consider the approval of our accreditation.

We commit to extend our full support in sharing PhilHealth's vision in achieving this noble objective of providing accessible quality health insurance coverage for all Filipinos.

---

**Head of Facility/Medical Director/Manager**

With my express conformity,

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**Local Chief Executive**

## **ANNEX 1.5: Specific Provisions for Primary Care Benefit 1 Providers (PC for PCB)**

That we shall deliver the Primary Care Benefit Package services for the duration of the validity of this commitment.

As **PCB1 provider**,

That we shall be responsible to seek and enlist eligible members and their qualified dependents in our community assigned to our facility.

That we shall establish a baseline health profile of all PhilHealth members and qualified dependents, which shall be kept and updated regularly by our facility.

That we shall submit a consolidated profile of our clientele using PCB Clientele Profile as a documentary requirement for the release of Per Family Payment Rate (PFPR).

That we shall deliver the services covered by the PCB1 package to respond to the health needs of the clientele of our facility.

That in case there is/are diagnostic examination(s) outsourced from another facility, we shall forge a Memorandum of Agreement (MOA) to ensure quality checks and appropriate processes are provided.

That we shall abide by the performance targets on the minimum obligated services for all members assigned in our facility set by the corporation.

That we shall create/maintain a trust fund for PFPR fund.

That we shall abide by the prescribed disposition and allocation of the PFPR as follows:

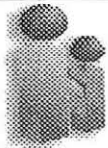
- A. Eighty percent (80%) of PFPR is for operational cost and shall cover:
  - a. Minimum of forty percent (40%) for drugs & medicines (PNDF) (to be dispensed at the facility) including drugs & medicines for asthma, acute gastroenteritis, & pneumonia;
  - b. Maximum of forty percent (40%) for reagents, medical supplies, equipment (i.e. ambulance, ambubag, stretcher, etc), information technology (IT equipment specific to the needs of facility for it to facilitate reporting and building up of its database), capacity building for staff, infrastructure or any other use related, necessary for the delivery of required service including referral fees for diagnostic services if not available in the facility.
- B. The remaining twenty percent (20%) shall be exclusively utilized as honoraria of the staff of the health facility and in the improvement of their capabilities to be able to provide better health services:
  - a. Ten percent (10%) for the physician;
  - b. Five percent (5%) for other health professional staff of the facility
  - c. Five percent (5%) for non-health professional/staff, including volunteers.

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**Local Chief Executive (if LGU-owned)/Owner**

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**Head of Facility/Medical Director/Manager**



Republic of the Philippines  
**PHILIPPINE HEALTH INSURANCE CORPORATION**  
 City State Bldg., 709 Shaw Blvd., Pasig City  
 Health line 441-7444; www.philhealth.gov.ph



## PROVIDER DATA RECORD INSTITUTIONAL HEALTH CARE PROVIDER (IHCP)

### THE PRESIDENT & CEO

Philippine Health Insurance Corporation  
 Pasig City, Philippines

Sir/Madam:

I, \_\_\_\_\_, of legal age, \_\_\_\_\_ with  
 (Position/Designation)  
 address at \_\_\_\_\_ and the duly authorized representative to act for and  
 in behalf of \_\_\_\_\_, hereby submits the following pertinent information and  
 (name of Health Care Institution)  
 documentary requirements under Sec. 52 L of R.A. 7875 as amended by RA 9241 and its Implementing Rules and  
 Regulations thereto.

### Type of Institution: (Please shade the appropriate box)

#### Hospital:

#### Award Applied For: Self-assessment Scores:

- |   |                                    |         |
|---|------------------------------------|---------|
| <input type="checkbox"/> Center of Safety     | Pt. Rights & Organizational Ethics | _____ % |
| <input type="checkbox"/> Center of Quality    | Patient Care                       | _____ % |
| <input type="checkbox"/> Center of Excellence | Leadership and Management          | _____ % |
| <b>Hospital Level:</b>                        | Human Resource Management          | _____ % |
| <input type="checkbox"/> Level 1              | Information Management             | _____ % |
| <input type="checkbox"/> Level 2              | Safe Practice and Environment      | _____ % |
| <input type="checkbox"/> Level 3              | Improving Performance              | _____ % |
| <input type="checkbox"/> Level 4              | Core indicator                     | _____ % |

#### Outpatient Clinic:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Single service                   | <input type="checkbox"/> 2-in-1                              | <input type="checkbox"/> 3-in-1                                 | <input type="checkbox"/> Multiple                                |
| <input type="checkbox"/> Ambulatory Surgical Clinic (ASC) | <input type="checkbox"/> Freestanding Dialysis Clinic (FDC)  | <input type="checkbox"/> Primary Care Benefit Provider          | <input type="checkbox"/> Maternity Care Package Provider         |
| <input type="checkbox"/> Anti-TB/DOTS Package Provider    | <input type="checkbox"/> Outpatient Malaria Package Provider | <input type="checkbox"/> Animal Bite Treatment Package Provider | <input type="checkbox"/> Other Package Provider (Specify): _____ |

### Facility Ownership (Please shade the appropriate box)

- |  |  |
|--|--|
| <input type="checkbox"/> Government            | <input type="checkbox"/> Private         |
| <input type="checkbox"/> Province              | <input type="checkbox"/> DOH             |
| <input type="checkbox"/> City/Municipality     | <input type="checkbox"/> Military/Police |
| <input type="checkbox"/> University            | <input type="checkbox"/> Others          |
| <input type="checkbox"/> Single Proprietorship | <input type="checkbox"/> Foundation      |
| <input type="checkbox"/> Partnership           | <input type="checkbox"/> Cooperative     |
| <input type="checkbox"/> Corporation           | <input type="checkbox"/> Others          |

### Type of Application: (Please shade the appropriate box)

- |                                     |  |   |
|-------------------------------------|--|---|
| <input type="checkbox"/> Initial    | <input type="checkbox"/> Re-accreditation          | <input type="checkbox"/> Change in location/ownership |
| <input type="checkbox"/> Renewal    | <input type="checkbox"/> with gap in accreditation | <input type="checkbox"/> Upgrading/add'l services     |
| <input type="checkbox"/> Late Filer | <input type="checkbox"/> Upgrading/add'l services  |   |

Accreditation No. \_\_\_\_\_

### Name of Institution: (Please print legibly and provide appropriate spaces)

### Mailing/Billing Address:

No. / St. / Brgy.

Municipality / City

Province

Zip Code

### Other Contact Information

Contact No. \_\_\_\_\_ Fax No. \_\_\_\_\_ Email Address: \_\_\_\_\_

Medical Director/Chief of Hospital

Accreditation Number (If applicable)

Head of Facility

Administrator (If applicable)

Owner of the Institution

### For PhilHealth Use Only

Date Evaluated:

SO  
PhRO

By:

SO

Date Received:

SO  
PhRO

By:

SO  
PhRO

Date Encoded:

SO/PhRO(Receiving Module)  
PhRO (Data Entry)

By:

SO  
PhRO

Control No.

OR No.

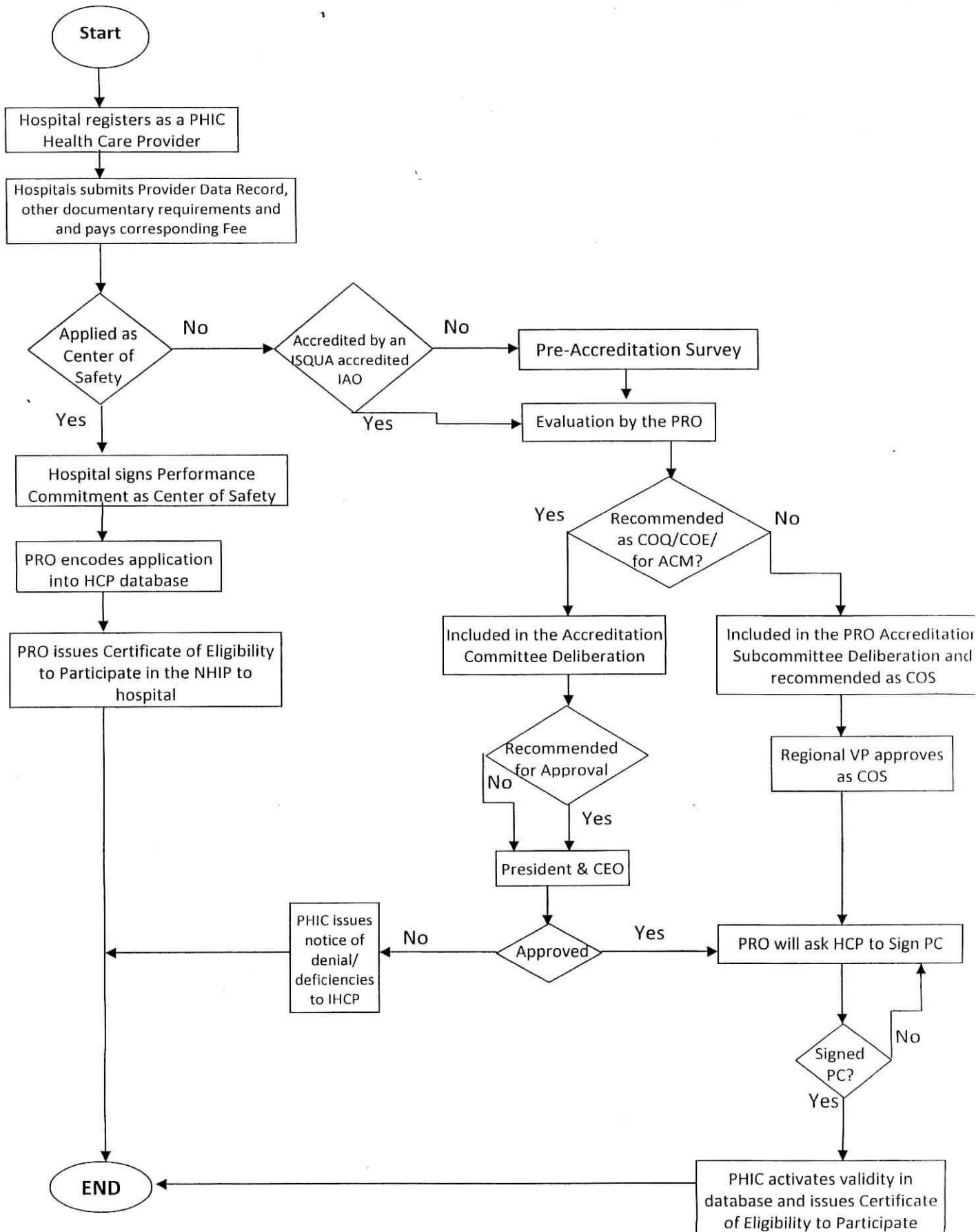
Date Paid: \_\_\_\_\_

Amt Paid: \_\_\_\_\_

# Annex 3. Flowchart for new HCP Engagement Process for Institutional Health Care Providers

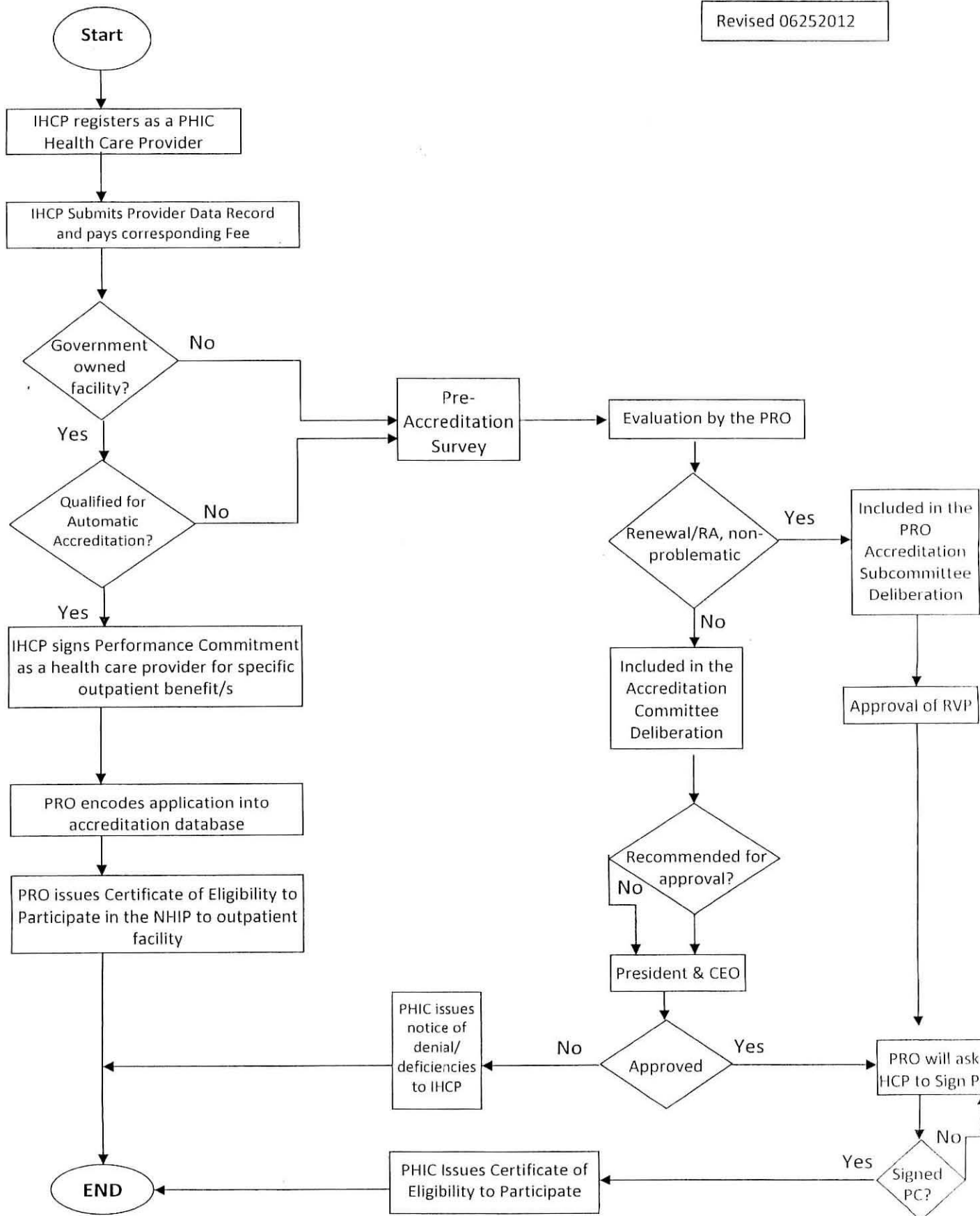
## A. Hospitals

Revised 06252012



**Outpatient facilities** (Primary Care Benefit Providers including hospitals, Maternity Care Providers, Anti-TB/DOTS Providers, Outpatient Malaria Providers, Animal Bite Treatment Centers, Ambulatory Surgical Clinics, Freestanding Dialysis Clinics, and other outpatient package providers)

Revised 06252012



## **Annex 4. CHECKLIST OF REQUIREMENTS FOR IHCPs ENGAGING WITH PHILHEALTH**

### **I. General Requirements:**

- ☐ 1. Provider Data Sheet (PDR)- properly accomplished
- ☐ 2. Performance Commitment – duly signed by the Local Chief Executive/owner and the head of the facility/ Medical Director/ Chief of Hospital
  - Submitted with the PDR – for automatically accredited providers
  - Submitted within thirty (30) days from receipt of notice of approval of participation – for providers under the regular engagement process
- ☐ 3. Electronic copies (in JPEG format) of recent photos of the facility, Internal and external area labeled with the name of the facility and date photo was taken
- ☐ 4. Statement of Intent (SOI) – **if applicable**
  - a. For Hospitals applying for initial/re-accreditation from January to April regarding to validity of accreditation, and/or
  - b. For hospitals applying as Centers of Quality/Excellence
  - c. For outpatient package providers applying for initial/re-accreditation from September to December regarding to validity of accreditation
- ☐ 5. Participation fee - proof of payment, if applicable (see back for appropriate fee schedule).

### **II. Specific Requirements:** (in addition to the above, the following are specific requirements per type of institution)

#### **A. Hospitals (Levels 1, 2, 3 and 4)**

- ☐ 1. DOH License – with validity applicable to the accreditation period applied for
- ☐ 2. Latest audited financial statement/ report (as applicable)
- ☐ 3. Certificate of Accreditation issued by an ISQUA-accredited organization – if applicable
- ☐ 4. DOH licenses for 3 previous years or its required alternative document – for **initial** participation

#### **B. Ambulatory Surgical Clinics & Freestanding Dialysis Clinics**

- ☐ 1. DOH License – with validity applicable to the accreditation period applied for
- ☐ 2. Latest audited financial statement/ report (as applicable)
- ☐ 3. DOH licenses for 3 previous years or its required alternative document – for initial participation

#### **C. Primary Care Benefit Providers**

- ☐ 1. MOA with referral facilities – if applicable
- ☐ 2. Location map

#### **D. Outpatient Malaria Package Providers**

- ☐ Certificate of Training in Malaria issued by DOH/CHDs

#### **E. Maternity Care Package Providers**

- ☐ 1. DOH certificate as BEmONC facility (for automatic accreditation)
- ☐ 2. Certificate as Newborn Screening Facility issued by the CHD or NIH – optional for initial accreditation and 2<sup>nd</sup> year of participation, required for renewal on the 3<sup>rd</sup> year of participation
- ☐ 3. Any of the following for applicable referral system:
  - a. Proof of Affiliation/MOA with at least a Level 2 PhilHealth Accredited Hospital
  - b. MOA with referral physician/s for OB and Pedia cases – as applicable
  - c. MOA with a DOH-certified Bemonc-CEmonc network (if the facility is not BEmONC Certified)
- ☐ 4. Location map

#### **F. Anti-TB/DOTS**

- ☐ 1. DOH - PhilCAT Certificate (optional for initial participation)
- ☐ 2. Location map

**G. Animal Bite Package Providers:**

- \_\_\_\_ 1. Certification as an Animal Bite Treatment Center (ABTC/ABC) from the DOH - National Rabies Prevention and Control Program Office
- \_\_\_\_ 2. Location map

**III. Schedule of Participation Fees:**

INSTITUTIONS	INITIAL & REACCREDITATION (PRIVATE/ GOVERNMENT)	RENEWAL		RENEWAL (LATE FILERS)	
		BEFORE THE PRESCRIBED FILING PERIOD (WITH 10% INCENTIVES)	PRESCRIBED FILING PERIOD	APPLICATIONS FILED AFTER THE PRESCRIBED FILING PERIOD (additional fee)	
				31 – 90 days prior to expiration	1 – 30 days prior to expiration
Level I Hospitals	P 3,000.00	P 1,800.00	P 2,000.00	P 4,000.00	P 8,000.00
Level II Hospitals	P 5,000.00	P 3,600.00	P 4,000.00	P 8,000.00	P 16,000.00
Level III Hospitals	P 8,000.00	P 7,200.00	P 8,000.00	P 16,000.00	P 32,000.00
Level IV Hospitals ( <i>with training programs</i> )	P 10,000.00	P 9,000.00	P 10,000.00	P 20,000.00	P 40,000.00
Ambulatory Surgical Centers (ASCs)	P 5,000.00	P 3,600.00	P 4,000.00	P 8,000.00	P 16,000.00
Free Standing Dialysis Centers (FSDCs)- <b>HD and PD</b>	P 5,000.00	P 4,500.00	P 5,000.00	P 10,000.00	P 20,000.00
Primary Care Benefit Providers (PCB) - formerly OPB	P 1,000.00	P 900.00	P 1,000.00	P 2,000.00	P 4,000.00
TB-DOTS Provider	P 1,000.00	P 900.00	P 1,000.00	P 2,000.00	P 4,000.00
Non-Hospital Maternity Care Providers	P 1,500.00	P 900.00	P 1,000.00	P 2,000.00	P 4,000.00
3-in-1 Providers	P 1,000.00	P 900.00	P 1,000.00	P 2,000.00	P 4,000.00
PCB (OPB) and DOTS Providers	P 1,000.00	P 900.00	P 1,000.00	P 2,000.00	P 4,000.00
PCB (OPB) and MCP Providers	P 1,500.00	P 1,350.00	P 1,500.00	P 3,000.00	P 6,000.00
MCP and DOTS Providers	P 1,500.00	P 1,350.00	P 1,500.00	P 3,000.00	P 6,000.00
Animal Bite Package Providers (Rabies Post-exposure Benefit)	P 1,000.00	P 900.00	P 1,000.00	P 2,000.00	P 4,000.00

(Pro-forma)  
**STATEMENT OF INTENT  
 AUTOMATIC ACCREDITATION**

**Hospitals, Ambulatory Surgical Clinics (ASCs), and Freestanding Dialysis Clinics (FDCs)**

Date: \_\_\_\_\_

Name of Health Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Sign the applicable items if you agree with the statements below:

**1. For applications for Initial Participation or Re-accreditation that are filed from January to April of the current year:**

**OPTION A: I agree with the following provisions:**

1. To pay for the registration fees equivalent to two (2) accreditation cycles.
2. That the start date of participation of our health facility shall be before May 1 of the current year when it has complied with the requirements for registration and participation. The 2<sup>nd</sup> registration fee shall cover for the next accreditation cycle which is from May 1 of the current year up to April 30 of the succeeding year.
3. That in case my application for initial participation/re-accreditation is denied, the registration fee for the 2<sup>nd</sup> accreditation cycle may be used as payment when we file for the next registration for participation in the NHIP. Further, I understand that failure to register within one (1) year from receipt of notice of denial of participation shall forfeit the said registration fee in favor of the Corporation.

\_\_\_\_\_  
 Signature over Printed Name of the  
 Authorized Person

**OPTION B: I agree with the following provisions:**

1. To pay the registration fee equivalent to one (1) accreditation cycle.
2. That the start date of participation of our health facility shall be on or after May 1 of the current year when it has complied with the requirements for registration and participation.

\_\_\_\_\_  
 Signature over Printed Name of the  
 Authorized Person

**2. Downgrading of Accreditation Award (for hospitals only)**

I agree that, in case my hospital does not qualify for the accreditation award it applied for, the hospital shall be granted the Accreditation Award it is compliant with.

\_\_\_\_\_  
 Signature over Printed Name of the  
 Authorized Person

*(Pro-forma)*  
**STATEMENT OF INTENT  
AUTOMATIC ACCREDITATION  
PCB, OMP, MCP, DOTS, ABTCs  
(filed from September to December of the current year)**

Date: \_\_\_\_\_

Name of Health Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Sign the applicable items if you agree with the statements below:

**FOR INITIAL PARTICIPATION AND RE-ACCREDITATION**

**OPTION A: I agree with the following provisions:**

1. To pay for the registration fees equivalent to two (2) accreditation cycles.
2. That the start date of participation of our health facility shall be before January 1 of the succeeding year when it has complied with the requirements for registration and participation. The 2<sup>nd</sup> registration fee shall cover for the next accreditation cycle which is from January 1 up to December 31 of the succeeding year.
3. That in case my application for initial participation/re-accreditation is denied, the registration fee for the 2<sup>nd</sup> accreditation cycle may be used as payment for its next registration for participation in the NHIP. Failure to register within one (1) year from receipt of notice of denial of participation shall forfeit the said registration fee in favor of the Corporation.

\_\_\_\_\_  
Signature over Printed Name of the  
Authorized Person

**OPTION B: I agree with the following provisions:**

1. To pay the registration fee equivalent to one (1) accreditation cycle.
2. That the start date of participation of our health facility shall be on or after January 1 of the succeeding year when it has complied with the requirements for registration and participation.

\_\_\_\_\_  
Signature over Printed Name of the  
Authorized Person

(Pro-forma)  
**STATEMENT OF INTENT**  
**REGULAR ENGAGEMENT PROCESS OR NON-AUTOMATIC ACCREDITATION**  
**Hospitals, Ambulatory Surgical Clinics (ASCs), and Freestanding Dialysis Clinics (FDCs)**

Date: \_\_\_\_\_

Name of Health Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Sign the applicable items if you agree with the statements below:

**1. For applications for Initial Participation or Re-accreditation that are filed from January to April of the current year:**

**a. OPTION A: I agree with the following provisions:**

1. To pay for the registration fees equivalent to two (2) accreditation cycles.
2. That the start date of participation of the health facility shall be on or before April 30 in case the pre-accreditation survey is conducted in the health facility on or before April 30 of the current year and the application is approved before May 1 of the current year. The 2<sup>nd</sup> registration fee shall cover for the next accreditation cycle which is from May 1 of the current year up to April 30 of the succeeding year.

However, if the pre-accreditation survey of the health facility is conducted after May 1 and/or the application is approved after May 1, the start date of my accreditation shall be on the date when the facility has complied with all the standards and requirements of accreditation.

3. That in case my application for initial participation/re-accreditation is denied, the registration fee for the 2<sup>nd</sup> accreditation cycle may be used as payment when we file for the next registration for participation in the NHIP. Further, I understand that failure to register within one (1) year from receipt of notice of denial of participation shall forfeit the said registration fee in favor of the Corporation.
4. That if I submit the performance commitment of the health facility beyond thirty (30) days from receipt of notice of approval of participation, **the start date shall be on the day when the PHIC receives our signed performance commitment.**

\_\_\_\_\_  
 Signature over Printed Name of the  
 Authorized Person

**b. OPTION B: I agree with the following provisions:**

1. To pay for the registration fees equivalent to one (1) accreditation cycle.
2. That the start date of participation of our health facility shall be on or after May 1 of the current year when it has complied with the requirements for registration and participation.
3. That if I submit the performance commitment of the health facility beyond thirty (30) days from receipt of notice of approval of participation, **the start date shall be on the day when the PHIC receives our signed performance commitment.**

\_\_\_\_\_  
 Signature over Printed Name of the  
 Authorized Person

## **2. Downgrading of Accreditation Award (for hospitals only)**

I agree that, in case my hospital does not qualify for the accreditation award it applied for, the hospital shall be granted the Accreditation Award it is compliant with.

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Signature over Printed Name of the  
Authorized Person

(Pro-forma)  
**STATEMENT OF INTENT**  
**REGULAR ENGAGEMENT PROCESS OR NON-AUTOMATIC ACCREDITATION**  
**PCB, OMP, MCP, DOTS, ABTCs**  
**(filed from September to December of the current year)**

Date: \_\_\_\_\_

Name of Health Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Sign the applicable items if you agree with the statements below:

**FOR INITIAL PARTICIPATION AND RE-ACCREDITATION**

**OPTION A: I agree with the following provisions:**

1. To pay for the registration fees equivalent to two (2) accreditation cycles.
2. That the start date of participation of our facility shall be before January 1 of the succeeding year when it has complied with the requirements for registration and participation. The 2<sup>nd</sup> registration fee shall cover for the next accreditation cycle which is from January 1 up to December 31 of the succeeding year.
3. That in case my application for initial participation/re-accreditation is denied, the registration fee for the 2<sup>nd</sup> accreditation cycle may be used as payment for its next registration for participation in the NHIP. Failure to register within one (1) year from receipt of notice of denial of participation shall forfeit the said registration fee in favor of the Corporation.
4. That if I submit the performance commitment of the health facility beyond thirty (30) days from receipt of notice of approval of participation, **the start date shall be on the day when the PHIC receives our signed performance commitment**

\_\_\_\_\_  
 Signature over Printed Name of the  
 Authorized Person

**OPTION B: I agree with the following provisions:**

1. To pay the registration fee equivalent to one (1) accreditation cycle.
2. That the start date of participation of our facility shall be on or after January 1 of the succeeding year when it has complied with the requirements for registration and participation.
3. That if I submit the performance commitment of the health facility beyond thirty (30) days from receipt of notice of approval of participation, **the start date shall be on the day when the PHIC receives our signed performance commitment**

\_\_\_\_\_  
 Signature over Printed Name of the  
 Authorized Person