



Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
ACCREDITATION DEPARTMENT
12th Floor City State Centre Bldg., 709 Shaw Blvd. Oranbo, Pasig City
Tel No. 637-62-65 Trunk line 637-99-99 loc 1215, 1216, Telefax. 637-25-27

CHECKLIST OF REQUIREMENTS FOR HOSPITAL ACCREDITATION

PHIC - PRIMARY

DOH - LEVEL I

NAME OF HOSPITAL: _____
ADDRESS: _____

- _____ 1. PhilHealth application form properly accomplished.
- _____ 2. Duly notarized Warranties of Accreditation.
- _____ 3. Current DOH License.
- _____ 4. Current PHA Certificate of Membership.
- _____ 5. List of functional / serviceable equipment signed by the Medical Director/
Administrator (Annex A).
- _____ 6. List of current hospital's room rates (Annex B).
- _____ 7. List of current hospital service charges (Annex C).
- _____ 8. Certificate of Affiliation or Memorandum of Agreement with a licensed clinical
laboratory and radiology facility within the locality.

- a.) * Laboratory
- b.) * X-ray
- c.) * Pharmacy

*** Optional. If ancillary service/s is/are present, DOH license/s should be submitted.**

- _____ 9. List of available emergency drugs.
- _____ 10. Complete list of hospital staff with respective designation and signature
(Annex D).
- _____ 11. Accreditation fee by PMO payable to PHIC or cash paid directly to cashier and /
or photocopy of OR from PRO. Accreditation fee is non-refundable.

Renewal	- P2,000.00
Initial	- P3,000.00
Re-accreditation	- P3,000.00

(see attached PhilHealth Circular No. 29, s.2004 and Payment Scheme)

- _____ 12. Quality Assurance Program.
- _____ 13. Photocopy of Remittance Form 1 (RF1) for the last quarter (for Private hospitals
only).
- _____ 14. Updated Health Certificate of Kitchen personnel.

- _____ 15. Sanitary Permit for the current year.
- _____ 16. Fire Safety Inspection Certificate for the current year.
- _____ 17. International Classification of Diseases (ICD-10) Training Certificate.
- _____ 18. Financial Statement of the previous year.

Additional Requirements for Initial Accreditation:

- _____ 1. Current photograph of hospital facade and other available facilities.
- _____ 2. Organizational Chart.
- _____ 3. Current standard operating procedures.
- _____ 4. SEC License / DTI certificate / CDA certificate.
- _____ 5. DOH licenses of three (3) previous successive years.

DOCUMENTS SUBMITTED:

PRO / SO / Central Office: _____
 Date Received: _____
 Received By: _____
 Date Re-filed: _____

Assessed / Evaluated By:

Receiving Clerk _____ Date _____
 AQAO / MO _____ Date _____
 Returned By _____ Date _____

PRO / SO / Central Office staff are advised to strictly indicate the above data.

IMPORTANT: Applications not completely filled-in and/or lacking in requirements shall be returned.



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PhilHealth ACCREDITATION FORM
APPLICATION FOR ACCREDITATION (PRIMARY)
DOH CATEGORY - LEVEL I

1 P

_____, 20__

THE PRESIDENT
Philippine Health Insurance Corporation
Pasig City, Philippines

SIR :

I, _____, Filipino of legal age, _____
 (Position / Designation)

with address at _____ and the duly authorized
 representative to act for and in behalf of _____,
 (Health Care Institution)

hereby applies for accreditation under Sec. 16 L of R.A. 7875 and its Implementing Rules
 and Regulations thereto. For this purpose, I hereby submit the following pertinent information
 and documentary requirements.

PART I - GENERAL INFORMATION

Name of Hospital : _____ TIN: _____

Complete Address : _____ Postal Code : _____

E-Mail Address : _____

PhilHealth Code No. : _____ Tel No.: _____ Fax No.: _____

Date established : _____ Date of Last Accreditation : _____

Chief / Medical Director : _____ Administrator : _____

DOH License No. _____ valid from _____ to _____ issued on
 _____, 20__

PERSON PRIMARILY RESPONSIBLE FOR ALL PHILHEALTH ISSUES: NAME: _____
 DESIGNATION: _____

Ownership / Management

- | | |
|---|--|
| Private
<input type="checkbox"/> Single Proprietorship
<input type="checkbox"/> Partnership
<input type="checkbox"/> Cooperative
<input type="checkbox"/> Corporation
<input type="checkbox"/> Foundation | Government
<input type="checkbox"/> Local Government Unit
<input type="checkbox"/> National
<input type="checkbox"/> DND
<input type="checkbox"/> Others, specify _____ |
|---|--|

For LGU hospital, please indicate the name of Mayor or Governor, office address, telephone nos. and e-mail address (if available).

Name: _____
 Office address: _____
 Telephone no.: _____ e-mail address: _____

A. PHYSICAL PLANT & ENVIRONMENT

1. **Building**

<input type="checkbox"/> Concrete	<input type="checkbox"/> Old structure
<input type="checkbox"/> Semi-concrete	<input type="checkbox"/> Renovated
<input type="checkbox"/> Wood	<input type="checkbox"/> New structure

2. **Sanitation and Safety Standard**
 - a. **Water supply** _____
 (Please attach the current Water Analysis Report)
 - b. **Electric Power** _____
 Stand by generator Yes No
 - c. **Sewage Disposal**
 Solid waste by _____
 Liquid waste by _____
 Pathological waste by _____
 - d. **Fire escape** Yes No
 - e. **Fire extinguisher** Yes No
 - f. **Toilet facilities** Yes No

3. **Has there been any change in ownership or management ?**
 Yes No If yes, when ? _____

4. **Has the Health Care Institution transferred to another location ?**
 Yes No If yes, where ? _____
(complete address)

5. **Has there been any change in category or authorized bed capacity since last accreditation ?**
 Yes No If yes, when ? _____ What ? _____

B. HOSPITAL BEDS Submit complete list of hospital's bed per room and current rates. (See Annex B)

C. MANPOWER COMPLEMENT (Indicate the Number)

1. Medical Service

a. Consultants:	Full Time	Part Time	Visiting
General Surgery	_____	_____	_____
OB-Gyn	_____	_____	_____
Pediatrics	_____	_____	_____
Internal Medicine	_____	_____	_____
Pathology	_____	_____	_____
Radiology	_____	_____	_____
Dental	_____	_____	_____
Others _____	_____	_____	_____

b. Residents _____

2. Nursing Service

a. Registered Nurse	_____	_____
b. Registered Midwives	_____	_____
c. Nursing Aides	_____	_____

3. * Pharmacist (optional) _____

4. Laboratory & X-ray

a. * Medical Technologist	_____	_____
b. * Radio Technologist	_____	_____

5. Dentist _____

6. * Cook _____

7. Food Handlers _____

7. Administrative Service _____

8. Others _____

** The personnel may be contracted out. A contract of service or memorandum of agreement with a service providers should be secured.*

NOTE : Submit complete list of hospital personnel. (See Annex D)

D. CLINICAL FACILITIES

- () Emergency room
- () Doctor's / Consultation office

- () * Clinical laboratory (optional)
 Laboratory Lic. No. _____ valid from _____ to _____
 Affiliation () Yes () No If yes, specify _____
- () * X-ray facility (optional)
 X-ray Lic. No. _____ valid from _____ to _____
 Affiliation () Yes () No If yes, specify _____
- () Drug Room
- () * Pharmacy (optional)
 Pharmacy Lic. No. _____ valid from _____ to _____
- () Dental room
- () Labor room
- () Delivery room
- () Recovery room
- () Medical Records room
- () * Kitchen
- () ** Transport Vehicle or Ambulance
- () Others, please specify _____

* *The services can be contracted out. A contract of service or memorandum of agreement with a service providers should be secured.*

** *The Patient Transport Service may be contracted out, but the vehicle used for patient transport must be available for 24 hours. There must be a mechanism to ensure that it is readily available whenever there is a need to transfer patients to a higher level of facility or to transport patients to diagnostic facilities.*

E. EQUIPMENT Submit complete list of existing functional or serviceable equipment under each facility. (Please see Annex A)

F. CLINICAL SERVICE

- () General Medicine
- () Obstetrics & Gynecology
- () Pediatrics
- () Others, specify _____

G. RECORDS

- () Admission Logbook
 - [] Prescribed logbook (Follow PhilHealth Cir. No. 25 s. 2005)
 - [] Computerized

Case No.	Date & Time of Admission	Name of Patient	Date of Birth	Sex	Address	Membership	Admitting Diagnosis	Attending Physician	Final Diagnosis	Disposition	Disposition Date & Time
----------	--------------------------	-----------------	---------------	-----	---------	------------	---------------------	---------------------	-----------------	-------------	-------------------------

() Emergency Room Logbook

Case No.	Date & Time of Admission	Name of Patient	Date of Birth	Sex	Address	Membership	Procedure Done (if applicable)	Admitting Diagnosis	Attending Physician
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() Diagnostic Radiology Logbook

Case No.	Date of Examination	Name of Patient	Date of Birth	Sex	Type of Examination
----------	---------------------	-----------------	---------------	-----	---------------------

() Laboratory Logbook

Case No.	Date of Examination	Name of Patient	Date of Birth	Sex	Type of Examination
----------	---------------------	-----------------	---------------	-----	---------------------

- () Patient's chart
- () Outpatient surgical logbook
- () Mandatory monthly hospital reports

H. QUALITY ASSURANCE PROGRAM OF THE INSTITUTION

1. Plan
2. Mission and Vision
3. Personnel Responsible for the Program
4. Activities
5. Minutes of Meeting

PART II – WARRANTIES OF ACCREDITATION

The undersigned, as representative to act for and on behalf of

_____ (Hospital)

located at _____
(complete address)

warrants the following :

1. ELIGIBILITY

- 1.1 That the aforementioned health care institution has been in operation for at least three years,
- 1.2 That it is duly licensed / accredited by the Department of Health,
- 1.3 That it shows a good track record in the provision of health care,
- 1.4 That it is a member of good standing of _____ duly recognized by
(association)
PhilHealth with its established standards and criteria,
- 1.5 That it has the human resources, equipment, physical structure and other requirements in conformity with standards established by the Corporation,
- 1.6 That it has an ongoing quality assurance program.

2. COMPLIANCE TO PERTINENT LAWS

- 2.1 That the aforementioned health care institution shall in the course of its participation with the NHI program by virtue of its accreditation comply with the provisions of the National Health Insurance Law (RA 7875), its Implementing Rules and Regulations, all administrative orders of the corporation,
- 2.2 **That it shall comply at all times with the provisions of the Hospital Licensure Act (RA 4226), its prevailing Implementing Rules and Regulations (A.O # 147, s.2004), Administrative Order # 183, s.2004 for ambulatory surgical clinics as well as other Administrative Orders,**
- 2.3 **That all DOH-retained hospitals shall comply with the provisions of Administrative Order # 137, s.2002 on the waiver of excess fees and charges for PhilHealth indigent patients,**
- 2.4 That it shall accept the formal program of Quality Assurance, payment mechanism and utilization review of the National Health Insurance Program,
- 2.5 That its personnel shall strictly adhere and comply at all times with the Codes of Ethics of the Medical and Nursing professions and other medical related professions of the Philippines,
- 2.6 That it shall strictly enforce a smoke-free policy within the premises of the health care institutions. Premises shall be understood to include all areas of a health care institution's compound regardless whether the same is inside or outside an enclosed structure.

2.7 That it shall strictly adhere and abide by the Expanded Senior Citizens Act of 2003 (R.A. 9257), A.O. # 177, s.2004 as implemented in PhilHealth Circular 2, s.2005.

3. CLINICAL SERVICES

- 3.1 That the aforementioned health care institution shall guarantee, safe adequate and standard medical care for all patients seeking medical care; and shall exercise observance of public health measures in case of communicable disease,
- 3.2 That it shall adopt referral protocols, strictly follow guidelines and health resource sharing arrangements of the Program,
- 3.3 That it shall extend without delay chargeable benefits due qualified members and beneficiaries,
- 3.4 That it shall not engage in unethical and illegal solicitation of patients for purposes of compensability under the NHI program,
- 3.5 That it shall maintain at all times the required personnel, serviceable equipment and facilities for use of patients.

4. CLINICAL RECORDS AND PREPARATION OF CLAIMS

- 4.1 That the aforementioned health care institution shall maintain and accomplish at all times accurate chronological records of all patients, services rendered and health outcomes resulting from such services and health expenditures on patient care,
- 4.2 That it shall keep a neat and systematic records file in a safe but accessible place for easy retrieval,
- 4.3 That it shall undertake measures to enter only true and correct data in all patients records and in the preparation of claims and ensure the filing of legitimate claims within the sixty (60) calendar days after the patients discharge,
- 4.4 That I, acting on behalf of this institution, together with the concerned personnel, shall take full responsibility for any omission or commission in the preparation of claims and in the entry of clinical records.

5. MANAGEMENT INFORMATION SYSTEM

- 5.1 That the aforementioned health care institution shall give proper information of its accreditation status by posting the PhilHealth certificate of accreditation in a very conspicuous place in the said institution,
- 5.2 That it shall post at its billing section updated information of the Program's benefits and procedural requirements and make available the necessary forms for patient's use,
- 5.3 That it shall inform the Department of Health all reportable cases confined in the aforementioned institution,
- 5.4 That it shall immediately inform the PhilHealth in writing of any of the following changes in the institution's (1) location (2) ownership or management, or (3) closure or temporary cessation of hospital operation.

6. HOSPITAL INSPECTION / VISITATION / INVESTIGATION

- 6.1 That the aforementioned health care institution recognizes the authority of the PhilHealth and its duly authorized representative or agents deputized by PhilHealth to conduct inspection, visitation or investigation of the institution at anytime,
- 6.2 That the PhilHealth's duly authorized representative shall be accorded with courtesy and respect by the hospital management and staff during inspection / visitation / investigation of the institution,
- 6.3 That it shall cooperate in the inspection / visitation / investigation by making ready and available all hospital records (medical & financial) and other pertinent documents,
- 6.4 That it shall obey without delay summons, subpoena or subpoena duces tecum from the Corporation or Local Health Insurance Office.

Finally, I hereby certify that I have read the provisions of these warranties and affirms that the PhilHealth, by virtue of its power under RA 7875 may suspend or revoke the accreditation of this institution if found to have violated any of the provisions of the National Health Insurance Act, or its Implementing Rules and Regulations and any of these Warranties of Accreditation.

MEDICAL DIRECTOR / ADMINISTRATOR
(Signature over Printed Name)

SUBSCRIBED AND SWORN TO, this _____ day of _____,
20____ at _____.

Notary Public

Until _____
PTR No. _____
Issued at _____
Issued on _____

Doc. No. _____
Book No. _____
Page No. _____
Series of 20____

**LEVEL 1
(PRIMARY)**

ANNEX A

LIST OF FUNCTIONAL / SERVICEABLE EQUIPMENT / APPARATUSES / INSTRUMENTS

**NAME OF
HOSPITAL:** _____

ADDRESS: _____

FACILITY	EQUIPMENT		REMARKS (Functional, For repair, etc.)
	TYPE	NUMBER	

I hereby declare under penalties of perjury that the answers given are true and correct to the best of my knowledge and belief.

Date Accomplished

Medical Director's / Administrator's Signature
over printed name

Res. Cert. No. _____

Issued at: _____

Issued on: _____

PRIMARY

Annex B

HOSPITAL'S ROOM RATES

NAME OF HOSPITAL : _____
 ADDRESS : _____
 CATEGORY : _____ ACCREDITATION NO.: _____
 DOH BED CAPACITY : _____ EFFECTIVITY OF ACCREDITATION: _____
 PHIC ACCREDITED BED : _____

TYPE OF ROOMS	ROOM NO/S.	NO. OF BEDS	ROOM RATES	AMENITIES
WARD MALE FEMALE				
SEMI - PRIVATE				
PRIVATE				
SUITE				
DELIVERY ROOM				
OTHERS				

I hereby declare under penalties of perjury that the answers given are true and correct to the best of my knowledge and belief.

Date Accomplished

Medical Director's / Administrator's Signature
over printed name

Res. Cert. No. _____
 Issued at _____
 Issued on _____

LIST OF CURRENT HOSPITAL SERVICE CHARGES

SERVICES	RATE
Laboratory procedure (Optional)	
X-ray & other Radiologic procedures (Optional)	
Other ancillary procedures (Optional)	

I hereby declare under penalties of perjury that the answers given are true and correct to the best of my knowledge and belief.

Date Accomplished

Medical Director's / Administrator's Signature
over printed name

Res. Cert. No. _____
Issued at _____
Issued on _____

LIST OF HOSPITAL PERSONNEL

NAME	POSITION / SPECIALTY	EMPLOYMENT STATUS				PRC NO. FOR PROFESSIONALS	PHILHEALTH NO.	SIGNATURE
		FULL TIME	PART TIME	VISITING	ON CALL			

NOTE : In case of resignation of any of the above listed employees, submit appointment of replacement properly attested and subscribed to.

I hereby declare under penalties of perjury that the answers given are true and correct to the best of my knowledge and belief.

Date Accomplished

Medical Director's / Administrator's Signature
over printed name

Res. Cert. No. _____
Issued at _____
Issued on _____