

Draft

**THE
REVISED
IMPLEMENTING
RULES AND REGULATIONS (IRR)**

of

Republic Act 7875 As Amended

otherwise known as the

**NATIONAL HEALTH INSURANCE ACT
of 2013**

TABLE OF CONTENTS

TITLE 1	GUIDING PRINCIPLES AND OBJECTIVES	
Section 1	Declaration of Principles	1
Section 2	General Objectives	2
TITLE II	DEFINITION OF TERMS	
Section 3	Definition of Terms	2
TITLE III	MEMBERSHIP AND CONTRIBUTIONS	
Rule I	Coverage	6
Section 4	Objective	6
Section 5	Nature and Scope	6
Section 6	Functions	8
Rule II	General Provisions Concerning All Members	8
Section 7	PhilHealth Identification Number and Health Insurance ID Card	8
Section 8	Replacement of Health Insurance ID Card	8
Section 9	Requirements for Registration of Members and Dependents	8
Section 10	Emancipated Individual or Single Parent	9
Section 11	Remittance of Premium Contribution	9
Section 12	Effectivity	9
Rule III	Specific Provisions Concerning Members in the Formal Sector	9
Section 13	Registration of Employers	9
Section 14	Requirements for Registration of Employers	9
Section 15	Employer Data Amendment and Revision	9
Section 16	Obligations of the Employer	10
Section 17	Rates of Premium Contributions	10
Section 18	Mandatory Appropriation of Premium Contribution for Government Agencies	10
Section 19	Payment of Premium Contributions	10
Section 20	Remittance of Premiums for Employees with Income Gaps	11
Section 21	Premium Payment of the Government and Private Sectors with Multiple Employment	11
Rule IV	Specific Provisions Concerning the Kasambahays	11

Section 22	Obligations of the Employer of Household Help or Kasambahays	11
Section 23	Premium Payment of Household Help	11
Rule V	Specific Provisions Concerning Members in the Informal Sector	11
Section 24	Payment of Premium Contributions	11
Section 25	Cost Sharing of Contributions from the Lower Income Segment	11
Section 26	Cessation from Formal Employment or Coverage as Indigent, Sponsored Member or as Migrant Workers	12
Section 27	Retroactive Payment of Premium Contribution	12
Section 28	Enrollment of Citizens of Other Countries	12
Rule VI	Specific Provisions Concerning Indigents	12
Section 29	Identification and Enrollment of Indigents	12
Section 30	Payment of Premium Contributions	12
Section 31	Women as Primary Members	12
Section 32	Data Sharing on the List of Indigents and their Dependents	12
Rule VII	Specific Provisions Concerning Sponsored Members	12
Section 33	Payment for Sponsored Members' Contributions	12
Rule VIII	Specific Provisions Concerning Lifetime Members	13
Section 34	Required Number of Monthly Contributions to Qualify as Lifetime Member	13
Section 35	Lifetime Member with Current Source of Income	13
Rule IX	Provision on Making PhilHealth a Requisite for Issuance / Renewal of License / Permits	13
Section 36	Requisite for Issuance or Renewal of License / Permits	13
TITLE IV	BENEFIT ENTITLEMENTS	
Rule 1	Benefits	13
Section 37	Objective	13
Section 38	Functions	13
Section 39	Benefit Package	14
Section 40	Excluded Personal Health Services	14
Section 41	Entitlement to Benefits	14
Section 42	Continuation of Entitlement to Benefits in Case of Death of Member	14
Section 43	Benefits of Members and their Dependents Confined Abroad	14
Rule II	Payment of Claims	15

Section 44	Provider Payment Mechanisms	15
Section 45	No Balance Billing for Indigents and Sponsored Members in Government Health Care Institutions	15
Section 46	Payment for Health Care Professionals in Health Care Institutions	15
Section 47	Income Retention by Government Health Care Institutions	15
Section 48	Reimbursement and Period to File Claims	15
Section 49	Guidelines on Claims Payment	15
Section 50	Capitation Arrangement	17
Section 51	Disposition of Capitation Payments	17
TITLE V	QUALITY ASSURANCE AND ACCREDITATION	
Rule I	Quality Assurance	17
Section 52	Objective	17
Section 53	Functions	17
Section 54	Health Finance Policy Research	18
Rule II	Accreditation	18
Section 55	Types of Accreditation	18
Section 56	Participation to the Program	19
Section 57	Health Care Providers	19
Section 58	Accreditation Requirements for Health Care Institutions	20
Section 59	Exemptions from Three-Year Operation Requirement	20
Section 60	Accreditation Requirements for Group Health Care Institutions, Health System Providers, Pharmacies and Retail Drug Outlets, Health Maintenance Organizations, and Community-Based Health Care Organizations	20
Section 61	Guidelines on the Accreditation of Health Care Institutions	20
Section 62	Third Party Accreditation through the Hospital Accreditation Commission	21
Section 63	Accreditation Requirements for Physicians, Dentists, Nurses, Midwives, Pharmacists, and other Licensed Health Care Professionals	21
Section 64	Process of Accreditation for Health Care Professionals	21
Section 65	Grounds for Denial / Non-Reinstatement of Accreditation	22
Rule III	Performance Monitoring of Health Care Providers	22
Section 66	Performance Monitoring System for Health Care Providers	22
Rule IV	Outcomes Assessment	22
Section 67	System of Outcomes Assessment	22

Rule V	Mechanism for Feedback	23
Section 68	Mechanism for Feedback	23
Rule VI	Health Technology Assessment	23
Section 69	Health Technology Assessment	23
Rule VII	Policy Formulation and Review	23
Section 70	Policy Formulation	23
Section 71	Policy Review	23
Section 74	Remedial Measures	23
TITLE VI	CREATION OF THE NATIONAL HEALTH INSURANCE FUND	
Rule I	National Health Insurance Fund	23
Section 73	Creation of the National Health Insurance Fund	23
Section 74	Financial Management	24
Rule II	Reserve Funds	24
Section 75	Reserve Funds	24
Section 76	Investible Funds	24
Section 77	Funds for Lifetime Members and Supplemental Benefits	25
Section 78	Provident Fund	25
TITLE VII	QUASI-JUDICIAL POWERS OF THE CORPORATION	
Rule I	Quasi-Judicial Powers	26
Section 79	Quasi-Judicial Powers	26
Rule II	The Board as a Quasi-Judicial Body	26
Section 80	The Board as a Quasi-Judicial Body	26
Section 81	Quorum and Votes Required	27
Rule III	The Prosecutors, Arbiters and Investigating Officers of the Corporation	27
Section 82	Jurisdiction and Qualifications of the Prosecutors and Arbiters of the Corporation	27
Section 83	Authority of the Investigating Officers of the Corporation	27
TITLE VIII	RULES OF PROCEDURE ON ADMINISTRATIVE CASES AGAINST HEALTH CARE PROVIDERS AND MEMBERS	
Rule I	Complaints, Grounds, Venue and Parties	27
Section 84	Who May File	27
Section 85	Grounds for a Complaint Against a Health Care Provider	27
Section 86	Grounds for a Complaint Against a Member	28

Section 87	Where To File	28
Rule II	Fact-Finding Investigation	28
Section 88	Complaints Filed Before The Fact-Finding Investigation and Enforcement Department	28
Section 89	Complaints Filed Before the Legal Office of the PRO	28
Rule III	Preliminary Investigation Before the Prosecution Department	28
Section 90	Duty of the Prosecutor	28
Section 91	Directive to Answer	28
Section 92	Finding of a Prima Facie Case	29
Section 93	Period for Approval of the Senior Vice President for Legal Sector	29
Section 94	Finality of Resolutions	29
Rule IV	Contents of the Formal Complaint	29
Section 95	Caption and Title	29
Section 96	Contents of Formal Complaint	29
Rule V	Procedure Before the Arbitration Office	30
Section 97	Docket Number	30
Section 98	Service of Summons	30
Section 99	Proof of Service	30
Section 100	Verified Answer	30
Section 101	Default	30
Section 102	Pre-Hearing and Formal Hearing	30
Section 103	Affidavits and Position Papers	31
Section 104	Rendition of Judgment	31
Section 105	Procedure of Trial	31
Section 106	Role of Arbiter in Proceedings	31
Section 107	Powers of the Arbiter	31
Section 108	Non-Appearance of Parties at Hearings	31
Section 109	Postponement of Hearing	32
Section 110	Records of Proceedings	32
Section 111	Contents of Decisions	32
Section 112	Motion for Reconsideration	32
Rule VI	Appeal to the Board	32

Section 113	Grounds	32
Section 114	Filing of Appeal (Notice and Memorandum of Appeal)	32
Section 115	Who May File An Appeal	32
Section 116	Appeal Fee and Appeal Bond	33
Section 117	Period of Appeal	33
Section 118	No Extension of Appeal Period	33
Section 119	Perfection of Appeal	33
Section 120	Memorandum of Appeal of Appellant	33
Section 121	Transmittal of the Records of the Case on Appeal	33
Rule VII	Review of Appealed Administrative Cases	33
Section 122	Jurisdiction	33
Section 123	Delegation of Review	33
Section 124	Composition of CAAC	34
Section 125	Review and Recommendation by CAAC	34
Section 126	Decision En Banc	34
Section 127	Inhibition	34
Rule VIII	Procedure Before The Board on Appealed Cases	34
Section 128	Functions of the Clerk of the Board	34
Section 129	Comment / Answer or Reply of Appellee	34
Section 130	Rejoinder	35
Rule IX	Decision Process	35
Section 131	Reply / Deliberation of Appealed Cases	35
Section 132	Substantial Evidence	35
Section 133	Assignment of the Appealed Case	35
Section 134	Decision or Resolution on Appeal	35
Section 135	Form of Decision or Resolution	35
Section 136	Promulgation of Decisions and Resolutions	35
Rule X	Entry of Judgment	36
Section 137	Entry of Judgment and Final Resolution	36
Section 138	Form	36
Rule XI	Execution of a Decision	36

Section 139	Execution of a Decision	36
Rule XII	Writ of Execution on Health Care Institutions	36
Section 140	Writ of Execution on Health Care Institutions	36
Section 141	Directive to Execute Writ	36
Section 142	Notice of Suspension / Revocation	37
Section 143	Report	37
Section 144	Deduction of Fines from Benefit Claims	37
Rule XIII	Writ of Execution on Health Care Professionals	38
Section 145	Writ of Execution on Health Care Professionals	38
Section 146	Directive to Execute Writ	38
Section 147	Claims Filed with Suspended Professional	38
Section 148	Report	38
Section 149	Deductions of Fines from Benefit Claims	39
Rule XIV	Writ of Execution on Members	39
Section 150	Writ of Execution on Members	39
Section 151	Claims Filed by Suspended Member	39
Section 152	Report	39
Rule XV	Appeal to the Court of Appeals	40
Section 153	Appeal to Court of Appeals of Board Decisions	40
TITLE IX	DEFINITION OF ADMINISTRATIVE OFFENSES AND PENALTIES	
Rule I	Offenses of Health Care Institutions	40
Section 154	Padding of Claims	40
Section 155	Claims for Non-Admitted or Non-Treated Patients	40
Section 156	Extending Period of Confinement	40
Section 157	Post-Dating of Claims	40
Section 158	Misrepresentation by Furnishing False or Incorrect Information	40
Section 159	Filing of Multiple Claims	41
Section 160	Unjustified Admission Beyond Accredited Bed Capacity	41
Section 161	Unauthorized Operations Beyond Service Capability	41
Section 162	Fabrication or Possession of Fabricated Forms and Supporting Documents	41
Section 163	Other Fraudulent Acts	41

Section 164	Breach of the Warranties of Accreditation / Performance Commitment	41
Section 165	Criminal Liability	41
Rule II	Offenses of Health Care Professionals	42
Section 166	Misrepresentation by False or Incorrect Information	42
Section 167	Breach of the Warranties of Accreditation / Performance Commitment	42
Section 168	Other Violations	42
Section 169	Criminal Liability	42
Rule III	Offenses of Members	42
Section 170	Fraudulent Acts	42
Section 171	Criminal Liability	42
Rule IV	Classification of Administrative Offenses	42
Section 172	Non-Fraudulent Offenses	42
Section 173	Fraudulent Offenses	43
Section 174	Scale of Administrative Penalties	43
Section 175	Cumulative Application of Penalties/Recidivists	43
Rule V	General Provisions	44
Section 176	Mitigating and Aggravating Circumstances	44
Section 177	Application of Circumstances in the Imposition of Penalties	44
Section 178	Application of Suspension and Revocation of Accreditation	44
TITLE X	PENAL OFFENSES AND PENALTIES	
Rule I	Offenses of Officers and Employees of the Corporation	44
Section 179	Infidelity in the Custody of Property	44
Section 180	Other Violations Involving Funds	45
Section 181	Connivance	45
Rule II	Offenses of Employers	45
Section 182	Failure or Refusal to Register / Deduct Contributions	45
Section 183	Failure or Refusal to Remit Contributions	45
Section 184	Unlawful Deductions	45
Section 185	Institution as Offender	45
Section 186	Reports on Penal Violations by Employers	45
Section 187	Affidavit-Complaint and Complainant in Penal Actions	45

Section 188	Preparation and Filing of Affidavit-Complaint	46
Rule III	Final Provisions	46
Section 189	Prosecution of Offenses	46
Section 190	Filing of Complaint	46
Section 191	Execution of Penalty	46
Section 192	Applicability of This Rules	46
TITLE XI	ADMINISTRATIVE REMEDIES OF HEALTH CARE PROVIDERS AND MEMBERS	
Rule I	Common Provisions	47
Section 193	Jurisdiction	47
Section 194	Grievance and Protests Not Covered	47
Rule II	Grievance Against Program Implementors	47
Section 195	Grounds for Grievances	47
Section 196	Who May File	47
Section 197	Venue	47
Section 198	Contents of Grievance	47
Section 199	Investigation	48
Rule III	The Grievance and Appeals Review Committee	48
Section 200	Grievance and Appeals Review Committee (GARC)	48
Section 201	Quorum and Votes Required	48
Section 202	Preliminary Determination	48
Section 203	Judgment by Default	48
Section 204	Position Papers	48
Section 205	Clarificatory Hearing	49
Section 206	Contents of the Decision	49
Section 207	Finality of Judgment	49
Section 208	Administrative Sanctions	49
Section 209	Constructive and Suppletory Application of the Rules of Court	49
Section 210	Powers of the GARC	49
Rule IV	Review of GARC Decision	49
Section 211	Appellate Jurisdiction of the Board Over Grievance Cases	49
Section 212	Period to File Petition for Review	49

Section 213	Who May File Petition for Review	49
Section 214	Decision of the Board	50
Rule V	Administrative Protests	50
Section 215	Original Jurisdiction of the PRO	50
Section 216	Claims Subject to Protest	50
Section 217	Forms and Period to File	50
Section 218	Procedure Before the PRO	50
Section 219	Action on Protests	50
Section 220	Appeal Before the Protests and Appeals Review Department (PARD)	50
Rule VI	Construction and Application	50
Section 221	Title of This Rules	50
Section 222	Application of This Rules	51
Section 223	Construction	51
Section 224	Suppletory Application of the Rules of Court and Jurisprudence	51
TITLE XII	VISITORIAL POWERS OF THE CORPORATION	
Section 225	Visitorial Powers	51
TITLE XIII	TRANSITORY PROVISION	
Section 226	PhilHealth Identification Card	51
TITLE XIV	MISCELLANEOUS PROVISIONS	
Section 227	Nine (9) Months Contribution Within Twelve (12) Months	51
Section 228	Repealing Clause	51
Section 229	Separability Clause	52
Section 230	Effectivity	52

IMPLEMENTING RULES AND REGULATIONS
of Republic Act 7875 As Amended
Otherwise Known As
the National Health Insurance Act of 2013

Title I
GUIDING PRINCIPLES AND OBJECTIVES

SECTION 1. Declaration of Principles

Section 11, Article XIII of the 1987 Constitution of the Republic of the Philippines declares that the State shall adopt an integrated and comprehensive approach to health development, which shall endeavor to make essential goods, health and other social services available to all the people at affordable cost. Priority for the needs of the underprivileged, sick, elderly, disabled, women and children shall be recognized. Likewise, it shall be the policy of the State to provide free medical care to paupers.

In pursuit of this principle, the Implementing Rules and Regulations (IRR) of the National Health Insurance Program (NHIP) herein referred to as the Program, shall adopt the following guiding principles:

- a. **Allocation of National Resources for Health** – The Program shall underscore the importance for government to give priority to health as a strategy for bringing about faster economic development and improving quality of life;
- b. **Universality** – The Program shall provide all citizens with the mechanism to gain financial access to health services, in combination with other government health programs. The Program shall give the highest priority to achieving coverage of the entire population with at least a basic minimum package of health insurance benefits;
- c. **Equity** – The Program shall provide for uniform basic benefits. Access to care must be a function of a person's health needs rather than ability to pay;
- d. **Responsiveness** – The Program shall adequately meet the needs for personal health services at various stages of a member's life;
- e. **Social Solidarity** – The Program shall be guided by community spirit. It must enhance risk sharing among income groups, age groups, and persons of differing health status, and residing in different geographic areas;
- f. **Effectiveness** – The Program shall balance economical use of resources with quality of care;
- g. **Innovation** – The Program shall adapt to changes in medical technology, health service organizations, health care provider payment systems, scopes of professional practice, and other trends in the health sector. It must be cognizant of the appropriate roles and respective strengths of the public and private sectors in health care, including people's organizations and community-based health care organizations;
- h. **Devolution** – The Program shall be implemented in consultation with local government units, subject to the overall policy directions set by the National Government;
- i. **Fiduciary Responsibility** – The Program shall provide effective stewardship, funds management, and maintenance of reserves;
- j. **Informed Choice** – The Program shall encourage members to choose from among accredited health care providers. The Corporation's local offices shall objectively apprise its members of the full range of providers involved in the Program and of the services and privileges to which they are entitled as members. This explanation, which the members may use as a guide in selecting the appropriate and most suitable provider, shall be given in clear and simple Filipino and in the local languages that are comprehensible to the member;
- k. **Maximum Community Participation** – The Program shall build on existing community initiatives for its organization and human resource requirements;
- l. **Compulsory Coverage** – The Program shall enroll all citizens of the Philippines in order to avoid adverse selection and social inequity;
- m. **Cost-Sharing** – The Program shall continuously evaluate its cost-sharing schedule to ensure that costs borne by the members are fair and equitable and that the charges by health care providers are reasonable;

- n. **Professional Responsibility of Health Care Providers** – The Program shall assure that all participating health care providers are responsible and accountable in all their dealings with the Corporation and its members;
- o. **Public Health Services** – The Program shall focus on the provision of benefit packages for personal health services while the Government shall provide public health services for all groups such as women, children, indigenous people, displaced communities and communities in environmentally endangered areas, while the Program shall focus on the provision of personal health services. Preventive and promotive health services are essential for reducing the need and spending for personal health services;
- p. **Quality of Services** – The Program shall promote the improvement in the quality of health services provided through the institutionalization of programs of quality assurance at all levels of the health service delivery system. The satisfaction of the community, as well as individual beneficiaries, shall be a determinant of the quality of service delivery;
- q. **Cost Containment** – The Program shall incorporate features of cost containment in its design and operations and provide viable means of helping the people pay for health care services; and,
- r. **Care for the Indigent** – The Program shall provide a basic package of needed personal health services to indigents through premium subsidy or through direct supervision from the Government.

SECTION 2. General Objectives

This IRR seeks to attain the objectives of the Act which are to:

- a. Provide all citizens of the Philippines with the mechanism to gain financial access to health services;
- b. Establish the Program to serve as the means to help the people pay for health care services; and,
- c. Prioritize and accelerate the provision of health services to all Filipinos, especially that segment of the population who cannot afford these services.

Title II DEFINITION OF TERMS

SECTION 3. Definition of Terms

For the purposes of this Rules, the terms below shall be defined as follows:

- a. **Abandoned Children** – children who have no known family willing and capable to take care of them and are under the care of the Department of Social Welfare and Development (DSWD), orphanages, churches and other institutions.
- b. **Accreditation of Health Care Providers** – a process whereby the qualifications and capabilities of health care providers are verified in accordance with the guidelines, standards and procedures set by the Corporation for the purpose of conferring upon them the privilege of participating in the Program and assuring that health care services rendered by them are of the desired and expected quality. This may be done by the Corporation itself or may be contracted to third party accrediting organizations. Accreditation encompasses licensing or certification, as applicable, and participation in the Program.
- c. **Accredited Collecting Agent** – any person, natural or juridical, accredited by the Corporation to receive, account and remit premium contributions of members.
- d. **Act** – refers to Republic Act No. 7875 as amended, otherwise known as the National Health Insurance Act of 2013.
- e. **Automatic Accreditation** – is the state of health care institutions that are licensed or certified by Department of Health (DOH) or other certifying body duly recognized by the Philippine Health Insurance Corporation (PhilHealth) and has the opportunity to be accredited through basic participation with the Program. These institutions do not require Pre-Accreditation Survey (PAS). Automatic accreditation is likewise applicable to professional health care providers subject to compliance of requirements as determined by the Corporation.
- f. **Benefit Package** – services that the Program offers to members, subject to the classification and qualifications provided for in this Rules.
- g. **Board** – the Board of Directors of the Philippine Health Insurance Corporation.
- h. **Capitation** – a payment mechanism where a fixed rate, whether per person, family, household, or group, is negotiated with a health care provider who shall be responsible for delivering or arranging for the delivery of health services required by the covered person under the conditions of a health care provider contract.

- i. **Case Rate Payment** – a payment method, also known as Case-Based Payment, that reimburses health care institutions a predetermined fixed rate for each treated case or disease.
- j. **Contribution** – the amount paid by or in behalf of a member to the Program for coverage, based on salaries or wages in the case of members in the formal sector and on household earnings and assets, in the case of the informal sector, or on other criteria as may be defined by the Corporation in accordance with the guiding principles set forth in Article I of the Act.
- k. **Clinical Practice Guidelines (CPG)** – systematically developed statements based on best evidence, intended to assist practitioners in making decisions about appropriate management of specific clinical conditions or diseases.
- l. **Corporation** – refers to the Philippine Health Insurance Corporation (PHIC or PhilHealth), which is mandated by law to administer the Program.
- m. **Coverage** – the entitlement of an individual, as a member or as dependent, to the benefits of the Program.
- n. **Dependent** – the legal dependents of a member who are the:
 - 1. Legitimate spouse who is not a member;
 - 2. Unmarried and unemployed legitimate, legitimated, acknowledged, illegitimate children and legally adopted or stepchildren below twenty-one (21) years of age;
 - 3. Children who are twenty-one (21) years old or above but suffering from congenital disability, either physical or mental, or any disability acquired that renders them totally dependent on the member for support, as determined by the Corporation;
 - 4. Foster child as defined in Republic Act 10165 otherwise known as the Foster Act of 2012 ;
 - 5. Parents who are sixty (60) years old or above, not otherwise an enrolled member, whose monthly income is below an amount to be determined by the Corporation in accordance with the guiding principles set forth in the Act; and,
 - 6. Parents with permanent disability regardless of age as determined by the Corporation, that renders them totally dependent on the member for subsistence.
- g. **Employee** – any person who performs services for an employer in which either or both mental and physical efforts are used and who receives compensation for such services, the performance of which is under an employer-employee relationship.
- h. **Employer** – a natural or juridical person who pays or compensates for services rendered by one or more individuals.
- i. **Enrollment** – the process determined by the Corporation to enlist individuals as members or dependents covered by the Program.
- j. **Fee-for-Service** – a fee pre-determined by the Corporation for each service delivered by a health care provider based on the bill. The payment system shall be based on a pre-negotiated schedule promulgated by the Corporation.
- k. **Global Budget** – an approach in the purchase of medical services by which health care providers negotiate the cost of providing a specific package of medical benefits based solely on a pre-determined and fixed budget as determined by the Corporation.
- l. **Grievance** – is a remedy as provided for in this Rules where anyone aggrieved by any decision of the implementors of the Program can avail of redress.
- m. **Gross Negligence** – the utter lack of care and diligence expected of a reasonable person as evidenced by the respondent's indifference or being oblivious to the danger of the injury to the person or property of others.
- n. **Group Health Care Institutions** - refer to institutions that have been accredited by PhilHealth as a group/corporation under one management (e.g. hospitals or other health care institutions with branches, extensions).
- o. **Health Care Institution** - refers to health facilities that are accredited with PhilHealth which includes, among others, hospitals, ambulatory surgical clinics, TB-DOTS, freestanding dialysis clinics, primary care benefits facilities, and maternity care package providers.
- p. **Health Care Institution Extension or Branches** – a licensed facility of any category situated in another location that is owned and operated by a health care institution that has been accredited for at least two (2) years.
- q. **Health Care Provider** – refers to any of the following:
 - 1. A health care institution, which is duly licensed and/or accredited, devoted primarily to the maintenance and operation of facilities for health promotion, prevention, diagnosis, treatment and care of individuals suffering from illness, disease, injury, disability or deformity, drug addiction or in need of obstetrical or other medical and nursing care.

It shall also be construed as any institution, building or place where there are installed beds, cribs or bassinets for twenty-four (24) hour use or longer by patients in the treatment of disease, injuries, deformities or abnormal physical and mental states, maternity cases or sanitarial care; or infirmaries, nurseries, dispensaries, rehabilitation centers and such other similar names by which they may be designated; or,

2. A health care professional, who is any doctor of medicine, nurse, midwife, dentist, pharmacist or other health care professional or practitioner duly licensed to practice in the Philippines and accredited by the Corporation; or,
 3. A health maintenance organization (HMO), which is an entity that provides, offers or arranges for coverage of designated health services needed by plan members for a fixed pre-paid premium; or,
 4. A community-based health care organization (CBHCO), which is an association of members of the community organized for the purpose of improving the health status of that community through preventive, promotive and curative health services.
- r. **Health Education Package** – a set of informational services such as training and instruction on disease prevention, health promotion, rehabilitation and other health education packages that may be determined by the Corporation. These shall be made available by health care providers to provide members and their family with knowledge about an illness and its treatment, the means available to prevent the recurrence or aggravation of such illness and to promote health in general.
- s. **Health System Providers (HSP)** – the organization of people, institutions, and resources that deliver health care services to meet the health needs of target populations that may be accredited subject to the guidelines set by the Corporation. These include, among others, Inter-local Health Zones (ILHZ), health care facility network owned and managed by provincial, city and/or municipal governments.
- t. **Health Technology Assessment** – a field of science that investigates the value of a health technology such as procedure, process, products, or devices, specifically on their quality, relative cost-effectiveness and safety. It is usually related to the science of epidemiology and economics and has implications on policy, decision to adopt and invest in these technologies, or in health benefit coverage.
- u. **Home Care and Medical Rehabilitation Services** – skilled nursing care, which members get in their homes/clinics for the treatment of an illness or injury that severely affects their activities or daily living. Home care and rehabilitation services include hospice or palliative care for people who are terminally ill but does not include custodial and non-skilled personal care.
- v. **Indigent** – a person who has no visible means of income, or whose income is insufficient for family subsistence, as identified by the DSWD based on specific criteria set for this purpose in accordance with the guiding principles set forth in Article I of the Act.
- w. **Informal Sector** – units engaged in the production of goods and services with the primary objective of generating employment and income for the persons concerned. It consists of households, unincorporated enterprises that are market and non-market producers of goods, as well as market producers of services. These enterprises are operated by own-account workers, which may employ unpaid family workers as well as occasional, seasonally hired workers. To this sector belong, among others, street hawkers, market vendors, pedicab and tricycle drivers, small construction workers and home-based industries and services.
- x. **Late Remittance** – PhilHealth premium contribution remitted after the prescribed period as determined by the Corporation.
- y. **Local Government Units (LGUs)** – provinces, cities, municipalities, and barangays where an enrolled member resides.
- z. **Mechanism for Feedback** – the process devised to inform both the Corporation and health care providers of the data and results of the performance monitoring and outcomes assessment processes.
- aa. **Member** – any person whose premium contributions have been regularly paid to the Program who may be a paying member, an indigent member, a sponsored member or a lifetime member or otherwise known as covered member.
- bb. **National Health Insurance Program (NHIP)** – the compulsory health insurance program of the government as established in the Act, which shall provide universal health insurance coverage and ensure affordable, acceptable, available and accessible health care services for all citizens of the Philippines.
- cc. **Outcomes Assessment** – the process of monitoring and review of outcomes resulting from the health care services rendered by accredited providers. Information that can result from an outcome assessment includes knowledge and attitude changes, short-term or intermediate behavior shifts, reduction of morbidity and mortality, satisfaction of patients with care and cost, among others.
- dd. **Out-Patient Clinic** – an institution or facility with a basic team providing health services such as diagnostic consultation, examination, treatment, surgery and rehabilitation on an out-patient basis.

- ee. **Out-patient Services** – Health services such as diagnostic, consultation, examination, treatment, surgery and rehabilitation on an out-patient basis.
- ff. **Participation to the Program** – a process whereby a health care provider commits to provide quality health care services to Program members and dependents as stipulated in a performance commitment. All services provided shall receive reimbursement from PhilHealth.
- gg. **Peer Review** – a process by which the quality of health care provided to Program members or the performance of a health care professional is reviewed by professional colleagues of comparable training and experience either within the professional organization or hospital or within the Corporation itself when commissioned by the Corporation to undertake the same. The results of the said review can be utilized as basis for quality interventions and/or payment or non-payment of claims.
- hh. **Performance Commitment** – a document signed by health care institutions who intend to participate in the Program, which stipulate their undertakings to provide complete and quality health services to PhilHealth members and their dependents, and their willingness to comply with PhilHealth policies on benefits payment, information technology, data management and reporting and referral, among others.
- ii. **Performance Monitoring** – an ongoing measurement of a variety of indicators of health care quality in the health field to identify opportunities for improvement in health care delivery.
- jj. **PhilHealth Employer Number (PEN)** – the permanent and unique number issued by the Corporation to registered employers, who may either be juridical or natural persons.
- kk. **PhilHealth Identification Number (PIN)** - the permanent and unique number issued by the Corporation to individual members and to each and every dependent.
- ll. **PhilHealth Identification Card** – is the health insurance identification card issued by the Corporation to members and their dependents.
- mm. **PhilHealth Office** – the head office and other offices established by the Corporation in every province and chartered city, or wherever it is deemed practicable.
- nn. **Philippine National Formulary (PNF)** – the essential drugs list of the Philippines which is prepared by the Department of Health (DOH) in consultation with experts and specialists from organized professional medical societies, the academe and the pharmaceutical industry and which is updated regularly.
- oo. **Policy Review and Formulation** – the process of continuous research, development and evaluation of program policies that address health needs and ensure delivery of quality and cost-effective health services.
- pp. **Portability** – the enablement of a member and their dependents to avail of program benefits in an area outside the jurisdiction of the member’s PhilHealth office.
- qq. **Pre-Accreditation Survey (PAS)** - is a process of assessing health care institutions that are not automatically accredited as defined by the Corporation as well as those applying for advanced participation. This includes among others, on-site observation, evaluation of pertinent documents and interview of personnel and patients.
- rr. **Preferred Health Care Institution** - is a recognition conferred to a health facility that has been granted advanced participation for beyond compliance with PhilHealth policies, demonstrated higher financial risk protection, excellent quality of care and better service satisfaction to its clients/patients.
- ss. **Prescription Drug** – a drug which has been approved by the Food and Drug Administration (FDA) and which can only be dispensed pursuant to a prescription order from a provider who is duly licensed to do so.
- tt. **Professional Practitioners** – include doctors, lawyers, certified public accountants, and other practitioners required to pass government licensure examinations in order to practice their professions.
- uu. **Program Implementor** – any official and/or employee of the Corporation who, in the general conduct of the operations and management functions of the Corporation, is charged with the implementation of the Program and the enforcement of the provisions of the NHI Act of 1995 as amended, this Rules, and other administrative issuances related thereto, including officials and employees of other institutions who are duly authorized by virtue of a Memorandum of Agreement (MOA) to exercise any of the powers vested in the Corporation to implement the Program.
- vv. **Quality Assurance** – a formal set of activities to review and ensure the quality of services provided. It includes quality assessment and corrective actions to remedy any deficiency identified in the quality of patient care, administrative and support services.
- ww. **Residence** – the place where a member actually resides.
- xx. **Retiree** – refers to a member of the Program who has reached the age of retirement as provided by law or who was retired on account of permanent disability as certified by the employer and the Corporation.
- yy. **Salary** – the basic monthly compensation paid regularly for services rendered.

- zz. **Self-Employed** – a person who works for himself/herself and is therefore both employee and employer at the same time which includes but not limited to those belonging to the informal sector and self-earning individuals.
- aaa. **Sufficient Regularity of Premium Contribution** – is a pattern characterized by consistent remittance of premium contributions.
- bbb. **Traditional and Alternative Health Care** – the application of traditional knowledge, skills and practice of alternative health care or healing methods which include reflexology, acupuncture, massage, acupressure, chiropractics, nutritional therapy and other similar methods in accordance with the accreditation guidelines set forth by the Corporation and the Food and Drug Administration (FDA).
- ccc. **Third Party Accreditation** – is the accreditation of health care institutions by a third party duly recognized and authorized by PhilHealth exclusive of the decision-making function to grant or deny accreditation to Program.
- ddd. **Treatment Procedure** – any method used to remove or alleviate the signs and symptoms and/or causes of a disease.
- eee. **Utilization Review** - a formal review of health resource utilization or of the appropriateness of health care services on a prospective, concurrent, or retrospective basis.

Title III MEMBERSHIP AND CONTRIBUTIONS

Rule I COVERAGE

SECTION 4. Objective

All Filipinos shall be mandatorily covered under the Program. In accordance with the principles of universality and compulsory coverage enunciated in Section 2(b) and 2(l) of the Act, implementation of the Program shall ensure sustainability of coverage and continuous enhancement of the quality of service. The Program shall be compulsory in all provinces, cities and municipalities nationwide, notwithstanding the existence of LGU-based health insurance programs. The Corporation, DOH, LGUs, and other agencies including nongovernmental organizations (NGOs) and other national government agencies (NGAs) shall ensure that members in such localities shall have access to quality and cost-effective health care services.

SECTION 5. Nature and Scope

The Program shall cover the following members and their dependent/s:

- a. **Members in the Formal Sector** – those with formal contracts and fixed terms of employment including workers in the government and private sector, whose premium contribution payments are equally shared by the employee and the employer.
 - 1. **Government Employees** - an employee of the government, whether regular, casual or contractual, who renders services in any of the government branches, military or police force, political subdivisions, agencies or instrumentalities, including government-owned and-controlled corporations, financial institutions with original charter, Constitutional Commissions, and is occupying either an elective or appointive position, regardless of status of appointment or whether such rendition of service is regarded as government service or not.
 - 2. **Private Employees** - an employee who renders services in any of the following:
 - i. Corporations, partnerships, or single proprietorships, NGOs, cooperatives, non-profit organizations, social, civic, or professional or charitable institutions, organized and based in the Philippines including those foreign owned;
 - ii. Foreign governments or international organizations with quasi-state status based in the Philippines which entered into an agreement with the Corporation to cover their Filipino employees in PhilHealth;
 - iii. Foreign business organizations based abroad with agreement with the Corporation to cover their Filipino employees in PhilHealth;
 - 3. All other workers rendering services, whether in government or private offices, such as job order contractors, project-based contractors, and the like

3. **Household Help** – as defined in the Republic Act 10631 or “Kasambahay Law”
4. **Family Drivers**
- b. **Members in the Informal Sector** – those who are not covered by formal contracts or agreements and whose premium contributions are self-paid or subsidized by another person through a defined criteria set by the Corporation.
 1. **Individuals in the informal sector not identified as indigents by the DSWD;**
 - i. Own account workers, unpaid family workers;
 - ii. Occasional and seasonal workers;
 - iii. Micro-Entrepreneurs such as street hawkers and market vendors;
 - iv. Daily wage earners such as pedicab and tricycle drivers, and small construction workers; and,
 - v. Micro home-based industries and services.
 2. **Migrant Workers** – documented or undocumented Filipinos who are engaged in a remunerated activity in another country of which they are not citizens.
 3. **Self-Earning Individuals** – individuals who render services or sell goods as a means of livelihood outside of an employer-employee relationship, or as a career, but do not belong to the informal sector. These include professional practitioners including but not limited to doctors, lawyers, engineers, artists, architects and the like, businessmen, entrepreneurs, actors, actresses and other performers, news correspondents, professional athletes, coaches, trainers, and such other individuals.
 4. **Filipinos With Dual Citizenship** – Filipinos who are also citizens of other countries.
 5. **Naturalized Filipino Citizens** – those who have become Filipino citizens through naturalization as governed by Commonwealth Act No. 473 or the Revised Naturalization Law.
 6. **Citizens of other countries working and/or residing in the Philippines** – foreign citizens with valid working permits and/or Aliens Certificate of Registrations (ACRs) working and or residing in the Philippines.
- c. **Indigent** – a person who has no visible means of income, or whose income is insufficient for family subsistence, as identified by the DSWD based on specific criteria set for this purpose in accordance with the guiding principles set forth in Article I of the Act.
- d. **Sponsored Member** – a member whose contribution is being paid by another individual, government agency, or private entity according to the rules as may be prescribed by the Corporation.
- e. **Lifetime Members** – a member who has reached the age of retirement under the law and has paid at least one hundred twenty (120) monthly premium contributions. Lifetime members shall include but not limited to the following:
 1. Retirees/ Pensioners from the Government Sector
 - i. Old-age retirees and pensioners of the GSIS, including non-uniformed personnel of the AFP, PNP, BJMP and BFP who have reached the compulsory age of retirement before June 24, 1997, and retirees under Presidential Decree 408.
 - ii. GSIS Disability Pensioners prior to March 4, 1995.
 - iii. GSIS Retirees who have reached the age of retirement on or after March 4, 1995 and have at least 120 months PhilHealth premium contributions.
 - iv. Retirees and Pensioners who are members of the Judiciary who have reached the age of retirement and have at least 120 months PhilHealth contributions.
 - v. Retirees who are members of Constitutional Commissions and other Constitutional Offices who have reached the age of retirement and have at least 120 months PhilHealth contributions.
 2. Retirees/ Pensioners from the Private Sector
 - i. SSS Pensioners prior to March 4, 1995.
 - ii. SSS Permanent Total Disability Pensioners prior to March 4, 1995.
 - iii. SSS Death/ Survivorship Pensioners prior to March 4, 1995.
 - iv. SSS Old-age Retirees who have reached the age of retirement on or after March 4, 1995 and have at least 120 months PhilHealth premium contributions.
 3. Uniformed Members of the AFP, PNP, BJMP and BFP
 - i. Uniformed personnel of the AFP, PNP, BJMP and BFP who have reached the compulsory age of retirement before June 24, 1997, and retirees under Presidential Decree 408.
 - ii. Uniformed members of the AFP, PNP, BJMP and BFP who have reached the compulsory age of retirement on or after June 24, 1997, being the effectivity date of RA 8291 which excluded them in the compulsory membership of the GSIS and have at least 120 months PhilHealth premium contributions.

4. Members of PhilHealth who have reached the age of retirement age as provided by law and have met the required premium contributions of at least 120 months, regardless of their employer/s' or sponsor's arrears in contributions and is not included in the Sponsored program nor declared as dependent by their spouse or children.

SECTION 6. Functions

To achieve its objectives, the Corporation shall undertake the following:

- a. Require the enrollment and coverage of all citizens of the Philippines under the Program;
- b. Coordinate with the DSWD, DILG, DOH, LGUs and other stakeholders for the enrollment and coverage of identified indigents, sponsored members and those members in the informal sector from the lower segment who do not qualify for full subsidy under the means test rule of the DSWD;
- c. Ensure that all government entities including LGUs issuing professional or business license or permit shall require all applicants to submit certificate or proof of payment of PhilHealth premium contributions, prior to the issuance of renewal of such license or permit;
- d. Encourage associations, charitable institutions, cooperatives, private non-profit health insurance organizations/associations or individuals to mobilize funds for the enrollment of as many persons who cannot afford to pay premium contribution;
- e. Establish an efficient premium collection mechanism;
- f. Establish and maintain an updated membership and contribution database;
- g. Conduct information campaigns on the principles of the Program to the public and accredited health care providers. This campaign must include the current benefit packages provided by the Corporation, the mechanisms to avail of the current benefit packages, the list of accredited and dis-accredited health care providers, and the list of offices/branches where members can pay or check the status of paid health premiums; and,
- h. To establish an office, or where it is not feasible, designate a focal person in every Philippine Consular Office in all countries where there are Filipino citizens. The office or the focal person shall, among others, process, review and pay the claims of the migrant workers.

Rule II

GENERAL PROVISIONS CONCERNING ALL MEMBERS

SECTION 7. PhilHealth Identification Number and Health Insurance ID Card

Consistent with the mandate of enrolling Filipinos into the Program, the Corporation shall assign a permanent and unique PhilHealth Identification Number (PIN) to every member including each and every dependent of theirs. It shall facilitate the issuance of a Health Insurance ID Card containing the PIN for purposes of identification, eligibility verification and utilization recording. The issuance of this ID card shall be accompanied by a clear explanation on the rights, privileges and responsibilities of a PhilHealth member and the list of PhilHealth-accredited healthcare providers.

SECTION 8. Replacement of Health Insurance ID Card

A member may request for replacement of the Health Insurance ID Card due to loss or wear and tear upon payment of fees for the issuance of a new card.

SECTION 9. Requirements for Registration of Members and Dependents

A person intending to register with the Program regardless of membership category, shall submit to the Corporation a properly accomplished prescribed Membership Registration Form, whereby the member shall certify the truthfulness and accuracy of the information provided including the list of declared qualified legal dependents. The Corporation may require proof of supporting documents. The same process shall be maintained for amendments/revision to any submitted data of the member and/or dependents.

SECTION 10. Emancipated Individual or Single Parent

Any person below 21 years of age, married or unmarried but with a child, shall be enrolled as a member.

SECTION 11. Remittance of Premium Contribution

Remittance of contribution shall be mandatory to all members. It shall be made to PhilHealth offices or to any of the accredited collecting agents. Failure to timely remit the appropriate premium contribution shall be subject to interest and penalties as prescribed by the Corporation without prejudice to other applicable penalties herein provided.

SECTION 12. Effectivity

Membership shall take effect upon enrollment and payment of the required premium contribution.

Rule III

SPECIFIC PROVISIONS CONCERNING MEMBERS IN THE FORMAL SECTOR

SECTION 13. Registration of Employers

All government and private sector employers are required to register with the Corporation and each shall be issued a permanent PhilHealth Employer Number (PEN).

Employers may similarly register through the Philippine Business Registry (PBR). Employers registering under the PBR are no longer required to submit documentary requirements.

SECTION 14. Requirements for Registration of Employers

All employers are required to submit an employer registration form. Private sector employers are required to submit a copy of their business permit/license to operate and/or any of the following whichever is applicable:

- a. For single proprietorships – Department of Trade and Industry (DTI) registration;
- b. For partnerships and corporations – Securities and Exchange Commission (SEC) registration;
- c. For foundations and other non-profit organizations – SEC registration;
- d. For cooperatives – Cooperative Development Authority (CDA) registration;
- e. For backyard industries/ventures and micro-business enterprises – Barangay Certification and/or Mayor's Permit.

SECTION 15. Employer Data Amendment and Revision

An employer shall update the Corporation on the revision/amendment in the data previously furnished the Corporation by accomplishing an amendment form and submitting documents to substantiate the same. The request may be due to any of the following:

- a. Correction/change of business name/legal personality – submit certificate of filing of business name with the DTI or Articles of Partnership/Incorporation;
- b. Temporary suspension of operation – if due to:
 1. Bankruptcy – submit Financial Statement, or Income Tax Return, or Board Resolution;
 2. Separation of employee/s – submit Separation paper of last employee;
 3. Fire/Demolition – submit Certification from the Fire Department of the municipality or city or Certification from the concerned municipality or city government; or
 4. Earthquake, declared calamities, and such other analogous circumstances.
- c. Termination/dissolution
 1. For single proprietorship – submit approved application for business retirement by the Municipal Treasurer's Office
 2. For partnership or corporation – submit Deed of Dissolution approved by SEC or Minutes of the Meeting certified by the corporate secretary
 3. For cooperatives – Certificate/Order of Dissolution/ Cancellation issued by the CDA

4. Under fortuitous events as defined by law – submit applicable supporting documents as may be determined by the Corporation;
- d. Change of ownership – submit Deed of Sale/Transfer/ Assignment;
- e. Resumption of operation – submit prescribed PhilHealth form reporting newly-hired or re-hired employees. In case of closure due to fortuitous events, submit supporting documents as determined by the Corporation.

SECTION 16. Obligations of the Employer

All government and private employers are required to:

- a. Register their employees and their qualified dependents by submitting a list of their employees complete with their salary base and other documents as may be required.
- b. Report to the Corporation its newly-hired employees within thirty (30) calendar days from assumption to office.
- c. Give notice to the Corporation of an employee's separation within thirty (30) calendar days from separation.
- d. Keep true and accurate work records for such period and containing such information as the Corporation may prescribe.
- e. Allow the inspection of its premises including its books and other pertinent records.

SECTION 17. Rates of Premium Contributions

Members in the formal sector shall continue paying the monthly contributions to be shared equally by the employer and employee at a prescribed rate set by the Corporation not exceeding five percent (5%) of their respective monthly salaries.

SECTION 18. Mandatory Appropriation of Premium Contribution for Government Agencies

It shall be mandatory for all government agencies to include the payment of premium contribution in their respective annual appropriations. Any increase in the premium contribution of the national government as employer shall only become effective upon inclusion of said amount in the annual General Appropriation Act (GAA).

SECTION 19. Payment of Premium Contributions

- a. The member's monthly contribution shall be deducted and withheld automatically by the employer from the former's salary, wage or earnings. The premium contributed shall be divided equally between the employer and the employee. The employer's counterpart shall not, in any manner be charged to the employee.
- b. The monthly premium contribution of employed members shall be remitted by the employer on or before the tenth (10th) calendar day of the month following the applicable month for which the payment is due and applicable.
- c. The remittance of premium contribution by the employer shall be supported by a monthly Remittance List to be submitted regularly to the Corporation.
- d. The failure of the employer to remit the required contribution and to submit the required remittance list shall make the employer liable for reimbursement of payment of a properly filed claim in case the concerned employee or his/her dependent/s avails of Program benefits, without prejudice to the imposition of other penalties as provided for in this Rules.
- e. For government agencies, it shall be mandatory and compulsory for the employers to include the payment of contributions in their annual appropriations. The use of said funds other than for the purpose of remitting Program contributions will hold the erring government employers liable under the pertinent provisions of the Revised Penal Code.
- f. Failure and/or refusal of the employer to deduct or remit the complete employees' and employer's premium contribution shall not be a basis for denial of a properly filed claim. In such a case, the Corporation shall be entitled to reimbursement of claims paid from the erring or negligent employer, without prejudice to the latter's prosecution and other liabilities, as may hereafter be provided by this Rules.
- g. The last complete record of monthly contributions paid by the employer or the average of the monthly contributions paid during the past three (3) years as of the date of filing of the action for collection shall

be presumed to be the monthly contributions payable by and due from the employer to the Corporation for each of the unpaid month, unless contradicted and overcome by other evidence: *Provided*, that the Corporation shall neither be barred from determining and collecting the true and correct contributions due it even after full payment pursuant to this provision, nor shall the employer be relieved of his/her liability.

SECTION 20. Remittance of Premiums for Employees with Income Gaps

Employees with no income for particular month/s due to non- rendition of service or for such other reasons such as those who are on leave without pay or on extended leave, including members engaged in seasonal employment, shall continue to pay premiums to the Program to ensure continuous entitlement to benefits.

SECTION 21. Premium Payment of the Government and Private Sectors with Multiple Employment

Members engaged in multiple employment in the government and private sectors whose aggregate monthly premium contribution exceeds the maximum rate in the prescribed premium contribution schedule may request for adjustment of personal share subject to the guidelines to be issued by the Corporation.

Rule IV SPECIFIC PROVISIONS CONCERNING THE KASAMBAHAYS

SECTION 22. Obligations of the Employer of Household Help or Kasambahay

To ensure that PhilHealth membership of the household help or kasambahay is sustained, employers are required to:

- a. Register their kasambahay with the Corporation and the kasambahay's qualified dependents under their PIN;
- b. Report to the Corporation their kasambahay within thirty (30) calendar days upon employment; and,
- c. Give notice to the Corporation upon separation of the kasambahay and pay the corresponding PhilHealth Premium contributions for the rendered services until the date of separation.

Employers of household-help who have registered with the SSS prior to July 1, 1999, are considered automatically registered. They shall be required to update their records with the Corporation.

SECTION 23. Premium Payment of Household Help

The annual premium contributions of household helps shall be fully paid in accordance with the provisions of Republic Act No. 10361 or the 'Kasambahay Law'.

Rule V SPECIFIC PROVISIONS CONCERNING MEMBERS IN THE INFORMAL SECTOR

SECTION 24. Payment of Premium Contributions

Contributions of members in the informal sector shall be based primarily on household earnings and assets.

SECTION 25. Cost Sharing of Contributions from the Lower Income Segment

Members in the informal sector from the lower income segment who do not qualify for full subsidy under the means test rule of the DSWD shall be entirely subsidized by the LGUs or through cost sharing mechanisms between/among LGUs, and/or legislative sponsors, and/or other sponsors and/or the member, including the National Government.

SECTION 26. Cessation from Formal Employment or Coverage as Indigent, Sponsored Member or as Migrant Workers

A member separated from formal employment or whose coverage as a Sponsored member or an Indigent or as migrant workers has ceased should pay the required premium as a member in the Informal Sector to ensure continuous entitlement to benefits.

SECTION 27. Retroactive Payment of Premium Contribution

A member who has missed/unpaid premium contribution shall be allowed to pay retroactively as prescribed by the Corporation.

SECTION 28. Enrollment of Citizens of Other Countries

Citizens of other countries working in the Philippines may be allowed coverage in the Program provided that their countries have existing reciprocity agreements with the Philippines, subject to additional guidelines as may be prescribed by the Corporation.

**Rule VI
SPECIFIC PROVISIONS CONCERNING INDIGENTS**

SECTION 29. Identification and Enrollment of Indigents

All indigents identified by the DSWD under the NHTS and other such acceptable methods, shall automatically be enrolled and covered under the Program.

SECTION 30. Payment for Premium Contributions

Premium contributions for indigent members shall be fully subsidized by the National Government. The amount necessary shall be included in the appropriations for the DOH under the annual GAA.

SECTION 31. Women as Primary Members

The female spouse of the families identified by DSWD may be designated as the primary member of the Program.

SECTION 32. Data Sharing on the List of Indigents and their Dependents

The DSWD shall regularly provide the Corporation with the list of indigent families and their dependents including their personal data and other pertinent information required for their enrollment to the Program. Likewise, the Corporation shall provide DSWD any updates on the personal data and information of the indigent families. This data sharing arrangement shall be at no cost to DSWD and PhilHealth.

**Rule VII
SPECIFIC PROVISIONS CONCERNING SPONSORED MEMBERS**

SECTION 33. Payment for Sponsored Members' Contributions

The premium payment for Sponsored Members shall be as follows:

- a. The premium contributions of orphans, abandoned and abused minors, out-of-school youths, street children, persons with disability (PWD), senior citizens and battered women under the care of the DSWD, or any of its accredited institutions run by NGOs or any nonprofit private organizations, shall be paid by the DSWD and the funds necessary for their inclusion in the Program shall be included in the annual budget of the DSWD;

- b. The needed premium contributions of all barangay health workers, nutrition scholars, barangay tanods, and other barangay workers and volunteers shall be fully borne by the LGUs concerned;
- c. The annual required premium for the coverage of un-enrolled women who are about to give birth shall be fully borne by the National Government and/or LGUs and/or legislative sponsors or the DSWD if such woman is an indigent as determined by it through the means test.

Rule VIII
SPECIFIC PROVISIONS CONCERNING LIFETIME MEMBERS

SECTION 34. Required Number of Monthly Premium Contributions to Qualify as Lifetime Member

Any person who has reached the age of retirement and has paid at least 120 monthly contributions shall be qualified as a Lifetime Member. The number of monthly contributions required as a Lifetime Member may be increased in accordance with an actuarial study to sustain the financial viability of the Program.

SECTION 35. Lifetime Member with Current Source of Income

A Lifetime Member who obtains a regular source of income from employment, practice of profession and other means shall resume paying the required monthly premium contribution until finally ceasing to earn, provided that said income is above the poverty threshold.

Rule IX
**PROVISION ON MAKING PHILHEALTH A REQUISITE FOR
ISSUANCE / RENEWAL OF LICENSE / PERMITS**

SECTION 36. Requisite for Issuance or Renewal of License / Permits

Among the powers and functions of the Corporation and notwithstanding any law to the contrary, all government entities including LGUs issuing professional or business license or permits, shall require all applicants to submit a certificate or proof of payment of PhilHealth premium contributions as a pre-requisite to the issuance or renewal of such license or permit.

Title IV
BENEFIT ENTITLEMENTS

Rule I
BENEFITS

SECTION 37. Objective

The Program aims to provide its members with responsive benefit packages. In view of this, the Corporation shall continuously endeavor to improve its benefit package to meet the needs of its members.

SECTION 38. Functions

To achieve the above objective, the Corporation shall undertake the following:

- a. Introduce additional benefit items and improve those already being provided;
- b. Develop the appropriate provider payment mechanisms;
- c. Continuously improve the system for benefit availment; and,
- d. Strictly monitor the implementation of benefit availment.

SECTION 39. Benefit Package

Members and their dependents are entitled to the following minimum services, subject to the limitations specified in the Act and as may be determined by the Corporation:

- a. In-patient care:
 1. Room and board;
 2. Services of health care professionals;
 3. Diagnostic, laboratory, and other medical examination services;
 4. Use of surgical or medical equipment and facilities;
 5. Prescription drugs and biologicals, subject to the limitations of the Act; and,
 6. Health Education.
- b. Out-patient medical and surgical care:
 1. Services of health care professionals;
 2. Diagnostic, laboratory and other medical services;
 3. Personal preventive services;
 4. Prescription drugs and biologicals, subject to the limitations of the Act; and,
 5. Health Education.
- c. Emergency and transfer services;
- d. Health Education Packages; and,
- e. Such other health care services that the Corporation and the DOH shall determine to be appropriate and cost-effective.

These services and packages shall be reviewed annually to determine its financial sustainability and relevance to health innovations, with the end in view of quality assurance, increased benefits and reduced out-of-pocket expenditure. Such review shall include actuarial studies.

SECTION 40. Excluded Personal Health Services

The Corporation shall not cover expenses for health services, which the Corporation and the DOH consider cost-ineffective through health technology assessment. The Corporation may institute additional exclusions and limitations as it may deem reasonable in keeping with its protection objectives and financial sustainability.

SECTION 41. Entitlement to Benefits

Members and/or their dependents are entitled to avail of the benefits if either of the following is met:

- a. Have paid premium contribution for at least three (3) months within the six (6) months prior to the first day of availment; or,
- b. Have paid the full premium for the calendar year.

In addition, the member is not currently subject to legal penalty of suspension as provided for in Section 44 of the Act and has paid the premium with sufficient regularity.

The following need not pay the monthly contributions to be entitled to the Program's benefits

- a. Retirees and pensioners of the SSS and GSIS prior to March 4, 1995;
- b. Members of PhilHealth who have reached the age of retirement as provided for by law, not gainfully employed or continuing their practice as professional and have met the required premium contributions of at least 120 months; and,
- c. Enrolled indigents and sponsored members.

SECTION 42. Continuation of Entitlement to Benefits in Case of Death of Member

In case of death of the member, the dependents of the deceased member shall continue to avail of the benefits for the unexpired portion of the coverage or until the end of the calendar year, whichever comes first.

SECTION 43. Benefits of Members and their Dependents Confined Abroad

Members and/or their dependents shall be eligible to avail of benefits for confinement/s outside the country: *Provided*, that the conditions for entitlement under this Rules are met and the following requirements are submitted within one hundred eighty (180) calendar days from the date of discharge:

- a. Official receipt or any proof of payment and/or statement of account from the health care institution

- where the member/dependent was confined; and,
- b. Certification of the attending physician as to the final diagnosis, period of confinement and services rendered.

The benefits to be granted shall be paid to the member in the equivalent local rate based on the Level Three (3) hospital category with the applicable case-rate payment.

Rule II PAYMENT OF CLAIMS

SECTION 44. Provider Payment Mechanisms

The following provider payment mechanisms shall be allowed in the Program:

- a. Fee-for-Service payments;
- b. Case Rate payments;
- c. Capitation of health care professionals and institutions, or networks of the same including HMOs, medical cooperatives, and other legally formed health service groups;
- d. Global budget; and,
- e. Such other provider payment mechanisms that may be determined and adopted by the Corporation.

SECTION 45. No Balance Billing for Indigents and Sponsored Members in Government Health Care Institutions

No other fee or expense shall be charged to indigent or sponsored patient in government health care institutions, subject to the guidelines issued by the Corporation. All necessary services and complete quality care to attain the best possible health outcomes shall be provided to them.

Health care institutions must give indigent members preferential access to their social welfare funds, which may be used to augment the benefit package provided, in case of insufficiency to fully cover all confinement charges.

Health care professionals must not charge over and above the professional fees provided by the Program for members admitted to a service bed.

SECTION 46. Payment for Health Care Professionals in Health Care Institutions

All payments for professional services rendered by salaried public providers shall be allowed to be retained by the health facility in which services are rendered and be pooled and distributed among health personnel. Charges paid to public facilities shall be retained by the individual facility in which services were rendered and for which payment was made. Such revenues shall be used to primarily defray operating costs other than salaries, to maintain or upgrade equipment, plant or facility, and to maintain or improve the quality of service in the public sector.

SECTION 47. Income Retention by Government Health Care Institutions

Reimbursements paid to public facilities shall be retained by the individual facility in which services were rendered and for which payment was made. Such revenues shall be used to primarily defray operating costs other than salaries, to maintain or upgrade equipment, plant or facility, and to maintain or improve the quality of service in the public sector.

SECTION 48. Reimbursement and Period to File Claims

All claims for reimbursement or payment for services rendered shall be filed within a period of sixty (60) calendar days from the date of discharge of the patient from the health care provider. The period to file the claim may be extended for such reasonable causes as may be determined by the Corporation.

SECTION 49. Guidelines on Claims Payment

The following are the guidelines for the claims payment:

- a. The health care provider shall submit the prescribed and completely filled up PhilHealth claim forms and

other documents required for processing.

1. The claim sent through mail or courier, the date of mailing as stamped by the post office of origin or date received by the courier service shall be considered as the date of filing.
 2. If the delay in the filing of claims is due to natural calamities or other fortuitous events, the health care provider shall be accorded an extension period of sixty (60) calendar days.
 3. If the delay in the filing of claim is caused by the health care provider and the benefits had already been deducted, the claim will not be paid. If the benefits are not yet deducted, it will be paid to the member chargeable to the future claims of the health care provider.
 4. For any other means of filing of claims, such as but not limited to electronic submission, the Corporation shall issue specific guidelines for the purpose.
- b. The health care provider shall deduct from the total charges all expenses reimbursable by the Corporation upon discharge of the patient. The payment of benefits shall be made directly to the health care provider.
- c. Health care providers are not allowed to charge for PhilHealth forms and processing fees from the member when claiming reimbursement from the Corporation.
- d. Direct filing of claims and payment to the member shall be allowed only for confinements abroad or such other conditions as may be determined by the Corporation.
- e. The Corporation shall penalize health care providers for claims attended by any but not limited to the following circumstances:
1. Over-utilization of services;
 2. Unnecessary diagnostic and therapeutic procedures and intervention;
 3. Irrational medication and prescriptions;
 4. Fraudulent, false or incorrect information as determined by the appropriate office;
 5. Gross, unjustified deviations from currently accepted standards of practice and/or treatment protocols;
 6. Inappropriate referral practices;
 7. Use of fake, adulterated or misbranded pharmaceuticals, or unregistered drugs;
 8. Use of drugs other than those recognized in the latest PNF and those for which exemptions were granted by the Board; and,
 9. Failure to comply without justifiable cause with the pertinent provisions of the law, IRR and any issuances of the Corporation.
- f. When the claim is denied, the amount of claim shall not be recovered from the member.
- g. All claim applications for drugs and medicines shall be in generic terminology in conformity with DOH regulations and the law.
- h. When the claims filed by a private health care institution indicate that its bed occupancy rate exceeds its accredited bed capacity, such claims must be justified in a notarized document, the contents of which shall be prescribed by the Corporation. Otherwise, the same shall not be processed.
- i. Any operation performed beyond the accredited capability shall be considered a violation and a claim for such shall be denied by the Corporation, except when the same is done in an emergency case or when referral to a higher category health care institution is physically impossible.
- j. Primary care facilities shall be compensated only for certain medical and simple surgical operations as determined by the Corporation.
- k. All claims for services filed by a health care institution after its category is downgraded/upgraded pursuant to this Rules shall be paid based on rates for such downgraded/upgraded category.
- l. All completed claims, except those under investigation, shall be paid within sixty (60) calendar days from receipt of the Corporation.
- m. Confinements of less than twenty-four (24) hours shall only be compensated under the following instances:
1. If the patient is transferred to another health care institution;
 2. In emergency cases as defined by the Corporation;
 3. If the patient expired; or,
 4. Other cases as may be determined by the Corporation.
- n. Claims of members confined in a non-participating health care institution shall be compensated; *Provided*, that all of the following conditions are met:
1. The health care institution is licensed by DOH;
 2. The case is emergency as determined by the Corporation; and,
 3. When physical transfer/referral to an accredited health care institution is impossible as determined by the Corporation.

SECTION 50. Capitation Arrangement

All capitation arrangement shall be covered by a performance commitment by and between the Corporation and the concerned accredited health care provider.

SECTION 51. Disposition of Capitation Payments

Consistent with the mandates for each political subdivision under Republic Act No. 7160 or 'The Local Government Code of 1991', LGUs shall provide basic health care services. LGUs shall invest the capitation payments given to them by the Corporation on health infrastructures or equipment, professional fees, drugs and supplies, or health information technology and database: *Provided*, that basic health care services, as defined by the DOH and the Corporation, shall be ensured especially with the end in view of improving maternal, infant and child health. *Provided, further*, that the capitation payments shall be segregated and placed into a special trust fund created by LGUs and be accessed for the use of such mandated purpose.

**Title V
QUALITY ASSURANCE AND ACCREDITATION**

**Rule I
QUALITY ASSURANCE**

SECTION 52. Objective

The Corporation shall implement a Quality Assurance Program applicable to all health care providers for the delivery of health services nationwide. This program shall ensure that the health services rendered to the members by accredited health care providers are of the quality necessary to achieve the desired health outcomes and member satisfaction.

Thus, the Corporation is specifically mandated to ensure that:

- a. The personal health services delivered, measured in terms of inputs, processes, and outcomes, are of desired and expected quality;
- b. The health care standards are uniform throughout the nation;
- c. Acquisition and use of scarce and expensive medical technologies and equipment are consistent with actual needs and standards of medical practice and that the performance of medical procedures and the administration of drugs are appropriate, necessary and consistent with accepted standards of medical practice and ethics and respectful of the local culture. Drugs for which payments will be made shall be those included in the PNF, unless explicit exception is granted by the Corporation; and,
- d. Health care professionals of the accredited health care institutions possess the proper training and credentials to render quality health care services to members of the Program.

SECTION 53. Functions

To achieve the above objectives and ensure the quality of health care services provided to its members the Corporation shall undertake the following:

- a. Verify, through the accreditation process, the qualifications and capabilities of health care providers for the purpose of conferring upon them the privilege of participating in the Program and assuring that the health care services they render meet the desired and expected quality;
- b. Monitor on a periodic basis, the services rendered to members by health care providers through surveys, utilization review, peer review and patient satisfaction review or index;
- c. Monitor and review, through outcomes assessment, the outcomes resulting from the health care services rendered by health care providers both from the standpoint of effects on health and member satisfaction;
- d. Initiate and impose changes and corrective actions based on the results of performance monitoring and outcomes assessment to ensure quality health service by using mechanisms for feedback;
- e. Formulate and review program policies on health insurance based on data gathered from the conduct of the above activities;

- f. Translate and implement quality assurance standards in the medical evaluation of claim applications for reimbursement of services rendered to members; and,
- g. Undertake studies/researches that would gauge the effectiveness of the program.

In the same manner, the program shall include, among others, the following functions that will ascertain quality standards of its providers:

- a. Review the credentials of individual health care professionals working in the health care institution;
- b. Provide referral and practice guidelines for the health care providers;
- c. Establish utilization review and monitoring scheme for the performance of health care providers;
- d. Institutionalize a mechanism to measure health outcomes and patient satisfaction including mortality, morbidity, infection rates and other related activities;
- e. Set-up a data gathering and retrieval system from the health and financial records to support performance monitoring and outcomes measurement activities;
- f. Establish a system for peer review and feedback to the health care professionals and mechanism for change in practice patterns as needed;
- g. The appointment of a specific person responsible for quality assurance in the institution;
- h. Implement remedial measures to correct deficiencies in the quality of the health services that have been identified through utilization review, peer review, performance assessment of health care institutions; and,
- i. Document meetings of quality circles or Quality Assurance Committee

SECTION 54. Health Finance Policy Research

The Corporation shall establish the Health Finance Policy Research Department, which shall have the following duties and functions:

- a. Develop broad conceptual framework for implementation of the Program through a national health finance master plan to ensure sustained investments in health care and to provide guidance for additional appropriations from the National Government;
- b. Conduct researches and studies toward the development of policies necessary to ensure the viability, adequacy and responsiveness of the Program;
- c. Review, evaluate, and assess the Program's impact on the access as well as to the quality and cost of health care in the country;
- d. Conduct periodic review of fees, charges, compensation rates, capitation rates, medical standards, health outcomes and satisfaction of members, benefits, and other matters pertinent to the operations of the Program;
- e. Analyze the delivery, quality, use and cost of health care services of the different offices;
- f. Submit for consideration a program of quality assurance, utilization review, and technology assessment;
- g. Submission of recommendations on policy and operational issues that will help the Corporation meet the objectives of the Act; and,
- h. Conduct client-satisfaction surveys and research in order to assess outcomes of service rendered by health care providers.

Rule II ACCREDITATION

SECTION 55. Types of Accreditation

Accreditation shall be of the following types:

- a. **Initial Accreditation** – This shall be given to qualified health care providers that are applying for the first time. The accreditation shall take effect upon compliance of the requirements. If the facilities of a revoked institutional health care provider are transferred either by sale or lease or such other modes of transfer, such will be treated as an application for initial accreditation.
- b. **Continuous Accreditation** – This shall be given to accredited health care providers that applied through basic participation and who complied with the requirements prescribed by the Corporation that qualify them for uninterrupted participation to the Program, until their accreditation is withdrawn based on rules set by the Corporation.
- c. **Re-accreditation** – the accreditation that shall be given to health care providers under any of the following conditions, or any other conditions as determined by the Corporation:

1. Health care institutions whose previous accreditation has lapsed or whose subsequent application was denied;
2. Health care institutions that failed to submit the requirements for continuous participation within the prescribed period;
3. Acquisition of additional service capability that would require change in license/certificate, as applicable, issued by the relevant authority;
4. Transfer of location. The health care institution must first secure a license to operate from the DOH for the new facility prior to the date of transfer and apply for re-accreditation within ninety (90) calendar days from the date of transfer. Beyond this period, the accreditation shall automatically lapse and all claims filed with the Corporation shall not be paid. The health care institution must inform the Corporation of the planned transfer indicating the exact date of transfer and address of the new site. The ninety (90) day grace period shall not apply to the new site if it is not licensed.
5. Upgrading of facility level or category
6. Change in the classification of health care institution
7. Change in ownership. The health care institution in good standing must apply within the ninety (90) calendar days from actual change of ownership.
8. Resumption of operation after closure/cessation of operation.

Professionals whose previous accreditation has lapsed or whose subsequent application was denied shall be re-accredited.

When the accreditation of a health care institution lapsed due to the voluntary act of a health care provider to evade the consequences of a previous violation or adverse findings indicating fraud, as determined by the Corporation, the application for re-accreditation shall be denied.

- d. **Reinstatement of Accreditation** – the restoration of accreditation after compliance to conditions following a suspension imposed by the Corporation.

SECTION 56. Participation to the Program

A process whereby a health care provider commits to provide quality health care services to the Program members and their dependents as articulated in its performance commitment. In return, it shall receive reimbursement from PhilHealth for services provided.

There are two levels of participation for Health Care Institutions (HCI):

- a. **Basic Participation** – is the minimum level of participation granted by PhilHealth to all HCIs that comply with all the requirements including the performance commitment (e.g. license or certificate, as applicable) and pass the accreditation survey, when applicable. Health care institutions shall be granted continuous basic participation with PhilHealth until withdrawn based on the rules set by the Corporation.
- b. **Advanced Participation** – a higher level of participation granted by PhilHealth to HCIs already engaged for basic participation that are able to comply with all the requirements set by PhilHealth and pass the mandatory survey for Advanced Participation.

SECTION 57. Health Care Providers

The following health care providers shall be accredited before they can participate in the Program:

- a. Health Care Institutions
 1. Hospitals
 2. Primary care facilities
 - i. Rural health units/health centers
 - ii. Dispensaries
 - iii. Birthing homes/facilities
 - iv. Medical Out-patient Clinics
 - v. Other Primary Care Facilities licensed by the DOH
 - vi. Free-Standing Dialysis Clinics
 - vii. Ambulatory Surgical Clinics
 - viii. Health Maintenance Organizations (HMOs)
 - ix. Community-Based Health Care Organizations (CBHCOs)
 - x. Pharmacies
 - xi. Other health care institutions licensed by the DOH
- a. Health Care Professionals

1. Physicians
2. Dentists
3. Nurses
4. Midwives
5. Pharmacists
6. Other duly licensed health care professionals

SECTION 58. Accreditation Requirements for Health Care Institutions

The following requirements shall apply to Health Care Institutions in appropriate cases:

- a. They must have been operating for at least three (3) years prior to initial application for accreditation, with a good track record in the provision of health care services. The date of reckoning of the three-year operation requirement shall be the effectivity date of either the initial license, clearance to operate, certificate, or other proof of operation issued by the DOH or other pertinent government agencies if applicable. HCI that have temporarily stopped operation due to upgrading, expansion, change of ownership or any other causes shall have their length of operation computed on a cumulative basis from the date of the initial operation of the former institution.
- b. They must be licensed / certified by the DOH, as applicable;
- c. They must comply with the provisions of the performance commitment. They must have their own ongoing formal program of quality assurance that satisfy the Corporation's standards;
- d. Any other requirements that may be determined by the Corporation.

SECTION 59. Exemptions from Three-Year Operation Requirement

A HCI that does not qualify for the provision of the three- year operation requirement may still apply and qualify for initial accreditation if it meets any of the following conditions:

- a. Its managing health care professional has a working experience in another accredited health care institution for at least three (3) years or a graduate of hospital administration or any related degree. If the managing health care professional leaves the accredited health care institution within the initial year of accreditation the accreditation shall be withdrawn effective on the date of vacancy;
- b. It operates as a tertiary facility or its equivalent;
- c. It operates in an LGU where the accredited HCI cannot adequately or fully service its population;
- d. Its service capability is not currently available in the LGU;
- e. It is an extension or branch of a health care institution that has been accredited for at least two (2) years; and,
- f. Other conditions as may be determined by the Corporation.

The following health care institutions shall be exempted from the three (3) year operation requirement:

- a. Primary Care Benefit Providers;
- b. TB DOTS providers;
- c. Non-hospital maternity care package providers;
- d. Malaria outpatient clinics;
- e. Animal bite treatment providers; and,
- f. Such other health facilities as may be determined by the Corporation

SECTION 60. Accreditation Requirements for Group Health Care Institutions, Health System Providers, Pharmacies and Retail Drug Outlets, Health Maintenance Organizations, and Community-Based Health Care Organizations

The Corporation shall prescribe the requirements for the accreditation of group health care institutions, health system providers, pharmacies and retail drug outlets, health maintenance organizations, and community-based health care organizations.

SECTION 61. Guidelines on the Accreditation of Health Care Institutions

The accreditation of HCIs shall be guided by the following:

- a. The Corporation shall prescribe the requirements for the accreditation of HCIs applying for basic and advanced participation.
- b. The HCI shall apply for accreditation through basic participation and advanced participation by

submitting the duly accomplished forms and documents and upon payment of the required fees as prescribed by the Corporation. Such documents shall be subject to verification and authentication at the discretion of the Corporation.

- c. The HCI shall submit the requirements for accreditation to its respective PhilHealth Regional Offices (PRO) for evaluation and processing.
- d. The accreditation of HICs through the basic participation shall be continuous unless withdrawn, suspended or revoked based on the rules set by the Corporation.
- e. HCIs shall be visited and inspected as often and as necessary to determine compliance with the requirements and conditions for accreditation.
- f. The Corporation shall determine the period of accreditation within a reasonable period of time from receipt of application and reserves the right to issue, deny or withdraw the accreditation after an evaluation of the capability and integrity of the health care institution.
- g. All matters pertaining to accreditation shall be decided by the Accreditation Committee whose decision shall become effective upon approval by the President and CEO. Only decisions on application for basic participation may be the subject of a motion for reconsideration to be filed with the Accreditation Committee. Only one motion for reconsideration shall be entertained.
- h. Accreditation shall take effect prospectively. Claims for services before the effectivity of accreditation and after the withdrawal of accreditation shall be denied.

SECTION 62. Third Party Accreditation through the Hospital Accreditation Commission

The Corporation shall develop a policy for the implementation of third party accreditation through the Hospital Accreditation Commission.

SECTION 63. Accreditation requirements for Physicians, Dentists, Nurses, Midwives, Pharmacists and other Licensed Health Care Professionals

Physicians, dentists, nurses, midwives, pharmacists and other licensed health care professionals shall comply with the following requirements to be accredited:

- a. They must be duly licensed to practice in the Philippines by the PRC;
- b. They must be members of the Program with qualifying premium contributions;
- c. They must comply with the provisions set forth in the performance commitment for professionals;
- d. They must comply with any other requirements that may be determined by the Corporation.

No accreditation fees shall be imposed by the Corporation for health care professionals and shall not require a certificate of good standing or such other analogous certification for them to be accredited.

Findings on ethical issues by disciplinary bodies of accredited professional organizations of the Professional Regulation Commission (PRC) or specialty societies recognized by the Philippine Medical Association (PMA) in the case of medical specialists, shall be considered in assessing the performance of health care professionals. Suspension of membership in such professional organizations shall be given due consideration in assessing the continued accreditation of such professionals.

SECTION 64. Process of Accreditation for Health Care Professionals

The following is the process for all health care professionals for them to be accredited:

- a. The health care professional shall apply for accreditation by submitting duly accomplished forms and documents as required by the Corporation. Such documents shall be subject to verification and authentication at the discretion of the Corporation.
- b. The health care professional shall submit all requirements for accreditation for evaluation and processing.
- c. The Corporation shall determine the period of accreditation and reserves the right to issue or deny accreditation after an evaluation of the capability and integrity of the health care professional.
- d. Accreditation shall take effect prospectively.
- e. The Corporation may limit accreditation to health care professionals performing specific health care services, as applicable, depending on training, experience, capability, and specialty certification.
- f. All matters pertaining to accreditation shall be decided by the Accreditation Committee whose decision shall become effective upon approval by the President and CEO. Such decision may be the subject of a motion for reconsideration to be filed with the Accreditation Committee. Only one motion for reconsideration shall be entertained.

SECTION 65. Grounds for Denial/Non-Reinstatement of Accreditation

Any of the following shall be grounds for the denial/non-reinstatement of accreditation:

- a. Non-compliance with any or all of the requirements of accreditation;
- b. Revocation, non-renewal or non-issuance of license/ accreditation/ clearance to operate or practice of the health care provider by the DOH, PRC or government regulatory office or institution;
- c. Conviction due to fraudulent acts as determined by the Corporation until such time that the decision is reversed by the Appellate Court or the penalty has been fully served;
- d. Change in the ownership, management or any form of transfer either by lease, mortgage or any other transfer of a health care institution without prior notice to the Corporation; or,
- e. Such other grounds as the Corporation may determine.

Rule III PERFORMANCE MONITORING OF HEALTH CARE PROVIDERS

SECTION 66. Performance Monitoring System for Health Care Providers

The Corporation shall develop and implement a performance monitoring system for all health care providers. The monitoring system shall provide for, among others:

- a. Periodic actual inspection of facilities and offices when necessary and appropriate;
- b. Analysis of mandatory monthly hospital reports and other reportorial requirements as determined by the Corporation;
- c. Periodic review of health facility data and patient's chart review for purposes of determining quality and cost-effectiveness as well as adherence to practice guidelines by health care providers;
- d. Conduct of utilization review;
- e. Peer review, adverse reports and other pertinent information;
- f. Conduct of patient satisfaction surveys;
- g. Periodic assessment of the performance of all health care providers based on performance commitment and standards;
- h. Inspection and audit of books, records, billing statements, medical charts, doctor's notes, and other documents and processes deemed important by the Corporation to complete a thorough review;
- i. Inspection of books of accounts, ledgers, invoices, receipts and other accountable forms deemed relevant by the Corporation; and,
- j. Other mechanism or analogous process, as may be determined by the Corporation that would be necessary to conduct a complete audit and investigation.

Rule IV OUTCOMES ASSESSMENT

SECTION 67. System of Outcomes Assessment

The Corporation shall implement a system of assessing outcomes of services rendered by health care providers to include the following:

- a. Review of mortality and morbidity rates, post-surgical infection rates and other health outcome indicators;
- b. Conduct of outcomes research projects; and,
- c. Conduct of client satisfaction surveys.

A periodic report of outcomes assessment shall be submitted to the President/CEO and to the Board.

**Rule V
MECHANISM FOR FEEDBACK**

SECTION 68. Mechanism for Feedback

The Corporation shall establish a mechanism aimed at improving quality of service and to periodically inform health care providers, program administrators and the public of the performance of accredited health care providers. The Corporation shall make known to the general public information on the performance of accredited health care providers—as well as those whose accreditation has been suspended or revoked by the Corporation.

**Rule VI
HEALTH TECHNOLOGY ASSESSMENT**

SECTION 69. Health Technology Assessment – The Corporation shall use Health Technology Assessment (HTA) to examine the medical, economic, social and ethical implications of use of health technology in order to support its benefit and quality assurance policies within the context of actual needs, current standards of medical practice and national health objectives. The Corporation shall do this in partnership with the DOH, academe, government, medical professional organizations and other stakeholders. The outputs of HTA shall be one of the bases for inclusion or non-inclusion of health technologies in the benefit package.

**Rule VII
POLICY FORMULATION AND REVIEW**

SECTION 70. Policy Formulation

In formulating and designing policies to pursue the principles and objectives of the Program, the Corporation shall utilize and incorporate data, research results, reports and other information derived from the conduct of the preceding formal set of activities to ensure quality health care.

SECTION 71. Policy Review

The Corporation shall continuously evaluate and validate the relevance, efficacy and acceptability of existing policies in the light of the outcomes and results derived from the conduct of the Quality Assurance Program.

SECTION 72. Remedial Measures

As the need arises and based on data obtained from performance monitoring, remedial measures shall be imposed by the Corporation on particular health care providers found to be deficient in the delivery of cost-efficient and quality services.

**Title VI
CREATION OF THE NATIONAL HEALTH INSURANCE FUND**

**Rule I
NATIONAL HEALTH INSURANCE FUND**

SECTION 73. Creation of the National Health Insurance Fund

There is hereby created a National Health Insurance Fund, hereinafter referred to as the Fund, that shall consist of:

- a. Contribution from Program members;

- b. Other appropriations earmarked by the national and local governments purposely for the implementation of the Program;
- c. Subsequent appropriations provided for under Sections 46 and 47 of the Act;
- d. Donations and grants-in-aid; and,
- e. All accruals thereof.

SECTION 74. Financial Management

The use, disposition, investment, disbursement, administration and management of the Fund, including any subsidy, grant or donation received for program operations shall be governed by applicable laws and in the absence thereof, existing resolutions of the Board of Directors of the Corporation, subject to the following limitations:

- a. All funds under the management and control of the Corporation shall be subject to all rules and regulations applicable to public funds.
- b. The Corporation is authorized to charge to the various funds under its control the costs of administering the Program. Such costs may include administration, monitoring, marketing and promotion, research and development, audit and evaluation, information services, and other necessary activities for the effective management of the Program.

For the first five (5) years from the effectivity of the Act, the total annual cost shall not exceed the sum total of the following:

- a. Five percent (5%) of the total contributions;
- b. Five percent (5%) of the total reimbursements; and,
- c. Five percent (5%) of the investment earnings generated during the immediately preceding year.

Subsequently, the total annual costs for these shall not exceed the sum total of the following:

- a. Four percent (4%) of the total premium contributions collected during the immediately preceding year;
- b. Four percent (4%) of the total reimbursements or total cost of health services paid by the Corporation in the immediately preceding year; and,
- c. Five percent (5%) of the investment earnings generated during the immediately preceding year.

Rule II RESERVE FUNDS

SECTION 75. Reserve Funds

The Corporation shall set aside a portion of its accumulated revenues not needed to meet the cost of the current year's expenditures as reserve funds: *Provided*, That the total amount of reserves shall not exceed a ceiling equivalent to the amount actuarially estimated for two (2) years' projected Program reimbursements: *Provided further*, that whenever actual reserves exceed the required ceiling at the end of the Corporation's fiscal year, the excess of the Corporation's reserve fund shall be used to increase the Program's benefits, decrease the members contributions, and augment the health facilities enhancement program of the DOH.

SECTION 76. Investible Funds

The remaining portion of the reserve fund that are not needed to meet the current expenditure obligations or used for the above-mentioned programs shall be placed in investments to earn an average annual income at prevailing rates of interest and shall be known as the "Investment Reserve Fund" which shall be invested in any or all of the following:

- a. In interest-bearing bonds, securities or other evidences of indebtedness of the Government of the Philippines, or in bonds, securities, promissory notes and other evidences of indebtedness to which full faith and credit and unconditional guarantee of the Republic of the Philippines is pledged;
- b. In debt, securities and corporate bonds issuances: *Provided*, That such securities and bonds are rated triple "A" by authorized accredited domestic rating agencies: *Provided*, further, That the issuing or assuming entity or its predecessor shall not have defaulted in the payment of interest on any of its securities and that during each of any three (3) including last two (2) of the five (5) fiscal years next preceding the date of acquisition by the Corporation of such bonds, securities or other evidences of indebtedness, the net earnings of the issuing or assuming institution available for its recurring expenses, such as amortization of

debt discount and rentals for leased properties, including interest on funded and unfunded debt, shall have been not less than one and one quarter (1 ¼) times the total of the recurring expenses for such year: *Provided, further*, That such investment shall not exceed fifteen percent (15%) of the investment reserve fund;

- c. In interest-bearing deposits and loans to or securities in any domestic bank doing business in the Philippines: *Provided*, That in the case of such deposits, this shall not exceed at any time the unimpaired capital and surplus or total private deposits of the depository bank, whichever is smaller: *Provided, further*, that said bank shall first have been designated as a depository for this purpose by the Monetary Board of the Bangko Sentral ng Pilipinas;
- d. In preferred stocks of any solvent corporation or institution created or existing under the laws of the Philippines: *Provided*, that the issuing, assuming, or guaranteeing entity or its predecessor has paid regular dividends upon its preferred or guaranteed stocks for a period of at least three (3) years immediately preceding the date of investment in such preferred or guaranteed stocks: *Provided, further*, That if the stocks are guaranteed the amount of stocks so guaranteed is not in excess of fifty percent (50%) of the amount of the preferred common stocks as the case may be of the issuing corporation: *Provided, furthermore*, that if the corporation or institution has not paid dividends upon its preferred stocks, the corporation or institution has sufficient retained earnings to declare dividends for at least two (2) years on such preferred stocks and in common stocks of any solvent corporation or institution created or existing under the laws of the Philippines in the stock exchange with proven track record of profitability and payment of dividends over the last three (3) years; and,
- e. In bonds, securities, promissory notes or other evidence of indebtedness of accredited and financially sound medical institutions exclusively to finance the construction, improvement and maintenance of hospitals and other medical facilities: *Provided*, that such securities and instruments are backed up by the guarantee of the Republic of the Philippines or the issuing medical institution and the issued securities and bonds are both rated triple 'A' by authorized accredited domestic rating agencies: *Provided, further*, that said investments shall not exceed ten percent (10%) of the total investment reserve fund.

As part of its investments operations, the Corporation may hire institutions with valid trust licenses as its external local fund managers to manage the investment reserve fund, as it may deem appropriate, through public bidding. The fund managers shall submit annual reports on investment performance to the Corporation.

SECTION 77. Funds for Lifetime Members and Supplemental Benefits

The Corporation shall set up, at the appropriate time, the following funds:

- a. A fund to secure benefit payouts to members prior to their becoming lifetime members;
- b. A fund to secure payouts to lifetime members; and,
- c. A fund for any optional supplemental benefits that are subject to additional contributions.

A portion of each of the above funds shall be identified as current and kept in liquid instruments. In no case shall said portion be considered part of invested assets.

Another portion of the said funds shall be allocated for Lifetime Members within six (6) months after the effectivity of the Act. Said amount shall be determined by an actuary or pre-calculated based on the most recent valuation of liabilities.

The Corporation shall allocate a portion of all contributions to the fund for Lifetime Members based on an allocation to be determined by the PhilHealth actuary based on a pre-determined percentage using the current average age of members and the current life expectancy and morbidity curve of filipinos.

The Corporation shall manage the supplemental benefits and the lifetime members' fund in an actuarially sound manner.

The Corporation shall manage the supplemental benefits fund to the minimum required to ensure that the supplemental benefit payments are secure.

SECTION 78. Provident Fund

The Corporation shall set up a provident fund in accordance with law.

Title VII QUASI-JUDICIAL POWERS OF THE CORPORATION

Rule I QUASI-JUDICIAL POWERS

SECTION 79. Quasi-Judicial Powers

The Corporation, to carry out its tasks more effectively, shall be vested with the following powers:

- a. Subject to the respondent's right to due process, to conduct investigations for the determination of a question, controversy, complaint, or unresolved grievance brought to its attention, and render decisions, orders, or resolutions thereon. It shall proceed to hear and determine the case even in the absence of any party who has been properly served with notice to appear. It shall conduct its proceedings or any part thereof in public or in executive session; adjourn its hearings to any time and place; refer technical matters or accounts to an expert and to accept his reports as evidence; direct parties to be joined in or excluded from the proceedings; and give all such directions as it may deem necessary or expedient in the determination of the dispute before it;
- b. To summon the parties to a controversy, issue subpoenas requiring the attendance and testimony of witnesses or the production of documents and other materials necessary to a just determination of the case under investigation;
- c. Subject to the respondent's right to due process, to suspend temporarily, revoke permanently, or restore the accreditation of a health care provider or the right to benefits of a member and/or impose fines after due notice and hearing. The decision shall immediately be executory, even pending appeal, when the public interest so requires and as may be provided for in this Rules. Suspension of accreditation shall not exceed six (6) months. Suspension of the rights of members shall not exceed six (6) months.

The revocation of a health care provider's accreditation shall operate to disqualify him from obtaining another accreditation in his own name, under a different name, or through another person, whether natural or juridical.

Rule II THE BOARD AS A QUASI-JUDICIAL BODY

SECTION 80. The Board as Quasi-Judicial Body

The Board, as a quasi-judicial body, may sit en banc or in divisions in all cases brought before it for review.

The Corporation shall be governed by the Board, which shall be composed of the following members:

- The Secretary of Health;
- The Secretary of Labor and Employment or a permanent representative;
- The Secretary of the Interior and Local Government or a permanent representative;
- The Secretary of Social Welfare and Development or a permanent representative;
- The Secretary of the Department of Finance (DOF) or a permanent representative;
- The President and Chief Executive Officer (CEO) of the Corporation;
- The SSS Administrator (President & Chief Executive Officer) or a permanent representative;
- The GSIS General Manager (President and General Manager) or a permanent representative;
- The Vice-Chairperson for the basic sector of the National Anti-Poverty Commission or a permanent representative;
- The Chairperson of the Civil Service Commission (CSC) or a permanent representative;
- A permanent representative of Filipino Migrant Workers;
- A permanent representative of the members in the Informal Economy;
- A permanent representative of the members in the Formal Economy;
- A representative of employers;
- A representative of health care providers to be endorsed by their national associations of health care institutions and medical health professionals;

A permanent representative of the elected Local Chief Executives to be endorsed by the League of Provinces, League of Cities and League of Municipalities; and,
An independent Director to be appointed by the Monetary Board.

The Secretary of Health shall be the ex-officio Chairperson of the Board while the President and CEO shall be the Vice-Chairperson.

SECTION 81. Quorum and Votes Required

When sitting en banc or in divisions, the concurrence of the majority of all the members thereof shall be required to render a decision in all cases.

Rule III

THE PROSECUTORS, ARBITERS AND INVESTIGATING OFFICERS OF THE CORPORATION

SECTION 82. Jurisdiction and Qualifications of the Prosecutors and Arbiters of the Corporation

Prosecutors of the Corporation shall have the power and authority to conduct fact-finding investigation on complaints filed by any person or by the Corporation against health care providers and/or members, and if a prima facie case exists, to file and prosecute the complaint before the Arbiter. The Prosecutor may also administer oath in accordance with Chapter X, Section 41, paragraph 2 of Executive Order No. 292. A Prosecutor must be a bona fide member of the Philippine Bar and must have been engaged in the practice of law for at least three (3) years prior to appointment.

Arbiters shall exercise original and exclusive jurisdiction over all complaints filed with the Corporation in accordance with R.A. 7875 as amended and this Rules. They shall have the power to administer oaths, issue subpoenas, (ad testificandum and duces tecum) and such other powers vested in them by R.A. 7875 and this Rules. An Arbiter must be a bona fide member of the Philippine Bar and must have been engaged in the practice of law for at least three (3) years prior to appointment.

SECTION 83. Authority of the Investigating Officers of the Corporation

Investigating Officers shall exercise, among others, the powers and functions enumerated under Section 10 (m) of R.A. 7875 as amended and to administer oath in the performance of their official functions and duties.

Title VIII

**RULES OF PROCEDURE ON ADMINISTRATIVE CASES AGAINST
HEALTH CARE PROVIDERS AND MEMBERS**

Rule I

COMPLAINTS, GROUNDS, VENUE AND PARTIES

SECTION 84. Who May File

Any person, natural or juridical, may file a complaint against health care providers and/or members. The Corporation shall however have the authority to motu proprio direct the conduct of a fact-finding investigation and the filing of a case against HCPs and/or members.

SECTION 85. Grounds for a Complaint Against a Health Care Provider

A written complaint against a health care provider may be filed for the commission of any of the offenses enumerated in Rules I and II, Title IX (Definition of Administrative Offenses and Penalties) of this Rules.

SECTION 86. Grounds for a Complaint Against a Member

A written complaint against a member may be filed for the commission of any of the offenses enumerated in Rule III, Title IX (Definition of Administrative Offenses and Penalties) of this Rules.

SECTION 87. Where To File

The written complaint against a health care provider and/or member may be filed with any PhilHealth Regional Office (PRO) - Legal Office or directly with the Fact-Finding Investigation and Enforcement Department (FFIED) – Central Office .

**Rule II
FACT-FINDING INVESTIGATION**

SECTION 88. Complaints Filed Before the Fact-Finding Investigation and Enforcement Department

For complaints filed before the FFIED, the following procedure shall be observed. Upon receipt of the complaint, the FFIED shall:

- a. Immediately docket the complaint;
- b. Conduct the necessary fact-finding investigation and issue the Fact-Finding Investigation Report (FFIR) within sixty (60) days;
- c. File the affidavit -complaint with the Prosecution Department within ten (10) days from the issuance of the FFIR if warranted by the same.

SECTION 89. Complaints Filed Before the Legal Office of the PRO

For complaints filed before the PRO Legal Office the following procedure shall be observed. Upon receipt of the complaint, the PRO Legal Office shall:

- a. Conduct the necessary fact-finding investigation, issue the FFIR along with its recommendation on whether to dismiss the complaint or file a case, and transmit the same to the FFIED within a period of sixty (60) days;
- b. Upon receipt of the FFIR, the FFIED shall immediately docket the same and, within ten (10) days, file the affidavit-complaint with the Prosecution Department, if warranted by the FFIR.

**Rule III
PRELIMINARY INVESTIGATION BEFORE THE PROSECUTION DEPARTMENT**

SECTION 90. Duty of the Prosecutor

After receipt of an affidavit-complaint, the investigating prosecutor shall immediately conduct the preliminary investigation. The investigating prosecutor may, from an examination of the allegations in the affidavit-complaint and such evidence as may be attached thereto, dismiss the same outright on any of the following grounds:

- a. Lack of jurisdiction over the subject matter;
- b. Failure to state a cause of action; or,
- c. Insufficiency of evidence.

SECTION 91. Directive to Answer

If no ground for dismissal is found, the investigating prosecutor shall issue the corresponding directive to the respondent health care provider and/or member directing the respondent/s to file their verified answer in three (3) copies to the affidavit-complaint within five (5) calendar days from receipt of the directive.

SECTION 92. Finding of a Prima Facie Case

If from an evaluation of the affidavit-complaint, answer and other evidence attached thereto, the investigating prosecutor finds a prima facie case against the respondent health care provider/member, the investigating prosecutor shall submit the resolution together with the formal complaint for the approval of the Senior Vice-President for Legal Sector (SVP-LS) within thirty (30) days from receipt of the answer or from the expiration of the period to file the same.

SECTION 93. Period for Approval of the Senior Vice-President for Legal Sector

The SVP-LS shall have five (5) days from receipt of the formal complaint and resolution to act on the same. If no action is taken within the given period, the formal complaint and resolution shall be deemed approved.

SECTION 94. Finality of Resolutions

The resolution of the prosecutor duly approved by the SVP-LS shall be final. No motion for reconsideration (MR) or similar pleadings shall be allowed and entertained.

**Rule IV
CONTENTS OF THE FORMAL COMPLAINT**

SECTION 95. Caption and Title

The formal complaint shall be filed in accordance with the following caption:

**REPUBLIC OF THE PHILIPPINES
PHILIPPINE HEALTH INSURANCE CORPORATION
(PLACE)
ARBITRATION OFFICE**

PHIC Case No. _____
(I.S. NO. _____)

Philippine Health Insurance Corporation,
Complainant,
-versus-
Respondent/s.
x- ----- x

SECTION 96. Contents of Formal Complaint

A formal complaint shall contain, among others, the following:

- a. The name and address of the complainant;
- b. The name/s and address/es of the respondent/s health care provider/s and/or member/s;
- c. A clear and concise statement of the cause/s of action; and,
- d. The relief/s sought.

Rule V
PROCEDURE BEFORE THE ARBITRATION OFFICE

SECTION 97. Docket Number

A formal complaint shall be filed by the Prosecution Department with the docket clerk of the Arbitration Office in three (3) copies with annexes. The docket clerk shall then assign a docket number to the formal complaint in the order of the date and time of filing and shall immediately endorse the complaint to the Arbiter for appropriate action.

SECTION 98. Service of Summons

Upon receipt of the docketed formal complaint, the Arbiter shall then issue the summons to the respondent/s, directing them to file their verified answers in three (3) copies, furnishing the Prosecution Department with another copy, with a notice that unless the respondent/s so answers, the complainant will take judgment by default and demand from the Arbiter the relief/s applied for. A copy of the complaint with the supporting documents shall be attached to the original copy of the summons. Service of summons shall be made either personally or by registered mail.

SECTION 99. Proof of Service

The proof of personal service of the summons shall be made in the form of an affidavit of service executed by the server who shall state the manner, place, and date of service and shall specify any papers which have been served with the process and the name of the person who received the same.

Service of summons by registered mail may be proved by a certificate of the server attesting that a copy of the summons and papers attached thereto, enclosed in an envelope and addressed to the respondent, with postage prepaid, has been mailed to which certificate the registry receipt and return card shall be attached to the certificate.

SECTION 100. Verified Answer

Within fifteen (15) calendar days from service of the summons and a copy of the complaint with supporting documents, respondent shall file a verified answer and serve a copy thereof to the complainant. Affirmative and negative defenses not pleaded therein shall be deemed waived except lack of jurisdiction over the subject matter. Failure to specifically deny any of the material allegations in the complaint shall be deemed an admission thereof.

No motion to dismiss shall be entertained, except one filed on the ground of lack of jurisdiction over the subject matter or failure to state a cause of action.

SECTION 101. Default

Should the respondent/s fails to file a verified answer to the complaint within the prescribed period, the Arbiter may, motu proprio or on motion of the complainant, render judgment as may be warranted by the facts and evidence alleged in the complaint.

SECTION 102. Pre-Hearing and Formal Hearing

Should the Arbiter find it necessary to conduct a formal hearing, an order setting the pre-hearing shall be issued. Such order shall further set the date or dates of the hearings and specify the witnesses who will be called to testify therein. All formal hearings shall be terminated as soon as possible.

SECTION 103. Affidavits and Position Papers

After a verified answer is filed and the issues are joined, the Arbiter shall issue an order requiring the parties to simultaneously submit their respective position paper within fifteen (15) calendar days from receipt of the order. The position paper shall contain a brief statement of the positions of the parties, setting forth the law and the facts relied upon them, including the affidavits of the witnesses and other evidence on the factual issues defined therein.

SECTION 104. Rendition of Judgment

The Arbiter shall have a period of one hundred twenty (120) days, upon receipt from the Prosecution Department of the formal complaint with complete supporting documents in three (3) copies, within which to render judgment.

SECTION 105. Procedure of Trial

Whenever the conduct of a hearing is deemed necessary by the Arbiter, the affidavits submitted by the parties shall constitute the testimonies of the witnesses who executed the same. Witnesses who testify may be subjected to clarificatory questions by the Arbiter. No witness shall be allowed to testify unless a corresponding affidavit was previously submitted to the Arbiter.

SECTION 106. Role of Arbiter in Proceedings

The Arbiter shall:

- a. Personally conduct the hearings and determine the order of presentation of evidence by the parties;
- b. Take full control of the proceedings and as becomes necessary, ask clarificatory questions to the parties and their witnesses with respect to the matters at issue; and,
- c. Limit the presentation of evidence to matters relevant to the issue/s.

SECTION 107. Powers of the Arbiter

The Arbiter shall:

- a. Conduct proceedings or any part thereof in public or in executive session;
- b. Adjourn hearings to any time and place;
- c. Refer technical matters or accounts to an expert and to accept the report as evidence;
- d. Direct parties to be joined or excluded from the proceedings;
- e. Give such directions as may be deemed necessary or expedient in the resolution of the dispute at hand;
- f. Summon the parties to a controversy;
- g. Issue subpoenas requiring the attendance and testimony of witnesses or the production of documents and other necessary material/s;
- h. Administer oaths; and,
- i. Certify official acts.

Whenever a person, without lawful excuse, fails or refuses to take an oath or to produce documents for examination or to testify, in disobedience to a lawful subpoena issued by the Arbiter, the latter may invoke the aid of the Regional Trial Court within whose territorial jurisdiction the case is being heard to cite such person in contempt, pursuant to Section 14, Chapter 3, Book VII of the Revised Administrative Code.

SECTION 108. Non-Appearance of Parties at Hearings

When the complainant or respondent fails to appear at the trial on two (2) successive occasions, despite due notice thereof, the Arbiter may motu proprio or upon motion of the opposing party, dismiss the case or deem the case submitted for resolution based on the records on hand, respectively. The complainant may, by proper motion with proper justification and within ten (10) calendar days after the resolution is received, ask for the reopening of the case.

The withdrawal or desistance of the complainant shall not bar the Arbiter from proceeding with the hearing of the complaint against the respondent. The Arbiter shall act on the complaint as may be merited by the complaint and evidence on record and impose such penalties on the erring respondent as may be deemed appropriate.

SECTION 109. Postponement of Hearing

The parties and their counsel or representative appearing before an Arbiter shall be prepared for continuous hearing. Postponements or continuances of hearing shall not be allowed by the Arbiter except upon meritorious grounds and subject always to the requirement of expeditious disposition of cases.

SECTION 110. Records of Proceedings

Except when any or both of the parties request that the proceedings be duly transcribed, the proceedings before an Arbiter need not be recorded by stenographers. The Arbiter shall make a written summary of the proceedings, including the substance of the evidence presented, in consultation with the parties. The written summary shall be signed by the parties and shall form part of the records.

SECTION 111. Contents of Decisions

The decision of the Arbiter shall be clear and concise and shall include a brief statement of the following:

- a. Facts of the case;
- b. Issue/s involved;
- c. Applicable laws or rules;
- d. Conclusions and the reasons therefor; and,
- e. Specific remedy or relief granted.

SECTION 112. Motion For Reconsideration

No motion for reconsideration (MR) or similar pleadings shall be allowed and entertained on the decision of the Arbitration Office. The filing of such pleading shall not toll or interrupt the period for filing an appeal to the Board.

**Rule VI
APPEAL TO THE BOARD**

SECTION 113. Grounds

The decision of the Arbitration Office may be appealed to the Board on any of the following grounds:

- a. The existence of a prima facie evidence of abuse of discretion on the part of the Arbiter, due to a misappreciation of facts or misapplication of law, or both;
- b. The decision was secured through fraud or coercion, including graft and corruption;
- c. The appeal is grounded on questions of law;
- d. Serious errors in the finding of facts which, if not corrected, would cause grave or irreparable damage or injury to the appellant.

SECTION 114. Filing of Appeal (Notice and Memorandum of Appeal)

A notice of appeal accompanied by a memorandum of appeal shall be filed through the Arbitration Office in at least three (3) copies.

SECTION 115. Who May File an Appeal

Any party to the case may appeal from a decision of the Arbitration Office.

SECTION 116. Appeal Fee and Appeal Bond

Except when the appellant is the Corporation or a member of the sponsored program, the appellant shall pay an appeal fee in an amount of ten percent (10%) of the imposed fine but not exceeding ten thousand pesos (P10,000.00) and shall post an appeal bond in the form of cash or surety bond in the amount equivalent to the fine imposed in the decision appealed from. Proof of such payment and posting shall be attached to the notice of appeal.

SECTION 117. Period of Appeal

The decision of the Arbitration Office shall be final and executory unless validly appealed to the Board within fifteen (15) calendar days from receipt of such decision in accordance with this Rules. If the last day falls on a Saturday, Sunday, holiday, or declared a non- working day due to force majeure, the last day to file and perfect the appeal shall be the next working day.

SECTION 118. No Extension of Appeal Period

No motion or request for extension of the period within which to file an appeal shall be allowed and entertained.

SECTION 119. Perfection of Appeal

An appeal shall be perfected and valid only upon the filing with the Arbitration Office of the following within the prescribed fifteen (15)-day period:

- a. Notice of appeal;
- b. Memorandum of appeal;
- c. Proof of payment of the appeal fee; and,
- d. Proof of posting of appeal bond.

Non-perfection of the appeal as provided in this Rules shall be a valid ground for the immediate dismissal by the Arbitration Office of the appeal and renders the decision final and executory.

SECTION 120. Memorandum of Appeal of Appellant

A memorandum of appeal shall state the date when the appellant received the appealed decision, the grounds relied upon, the arguments in support thereof, the relief prayed for, and shall be accompanied by an affidavit of service on the other party of such memorandum.

SECTION 121. Transmittal of the Records of the Case on Appeal

The Arbitration Office shall transmit the entire records of the case to the Board within five (5) calendar days from receipt of a perfected appeal.

**Rule VII
REVIEW OF APPEALED ADMINISTRATIVE CASES**

SECTION 122. Jurisdiction

The Board en banc shall have exclusive appellate jurisdiction to act, determine, review and decide all perfected appeals of health care providers and members involving decisions on administrative cases promulgated by the Arbitration Office.

SECTION 123. Delegation of Review

The Board en banc shall delegate to a division thereof the study and review of the decisions on administrative cases brought before it on appeal and the division shall submit its report and recommendation to the Board en banc. Such division shall be named as the Committee on Appealed Administrative Cases (CAAC) against health care providers and members.

SECTION 124. Composition of CAAC

The CAAC shall be composed of five (5) Board Members designated as such by the Board en banc. The members of the CAAC shall elect among themselves its Chairperson and Vice-Chairperson. The Chairperson, or in his/her absence, the Vice-Chairperson, shall preside over all meetings of CAAC.

SECTION 125. Review and Recommendation by CAAC

The CAAC shall study and review the decisions on administrative cases brought before the Board on appeal. It shall have the power to study and report the appellant's compliance with all the requirements of appeal, review the grounds of appeal, and provide reports and recommendations to the Board en banc. With the concurrence and approval of the majority of all its members, the CAAC shall elevate its written report and draft decision to the Board en banc for the latter's consideration and approval.

SECTION 126. Decision En Banc

The concurrence of the majority of the members of the Board constituting a quorum during the en banc session shall be required to approve the written reports, recommendations and draft decisions of the CAAC and to promulgate the decisions on the appealed administrative cases.

If the report and recommendation of the CAAC is not approved by the Board en banc, then the Chairperson of the Board will designate one of its members, who was part of the majority who voted not to approve such report and recommendation, to draft the decision for the consideration and approval of the Board en banc.

SECTION 127. Inhibition

Any Board Member may inhibit himself/herself from the consideration and resolution of any case/matter before the Board and shall so state in writing the grounds therefor.

**Rule VIII
PROCEDURE BEFORE THE BOARD ON APPEALED CASES**

SECTION 128. Functions of the Clerk of the Board

The Corporate Secretary shall act as the Clerk of the Board and the CAAC and shall assign one of its personnel to perform the following functions:

- a. Receive all pleadings, motions, and other papers required to be filed with the Board and CAAC in connection with any appeal pending therewith and to legibly stamp the date and hour of the filing thereof duly signed by the receiving personnel. If the filing is by registered mail, the Office of the Corporate Secretary shall legibly stamp or indicate on the first page of the pleading, motion or other paper the date of receipt thereof, the fact that the same was received by registered mail and the date of posting thereof, duly signed by the receiving personnel. The corresponding envelope or portion thereof showing the date of posting and registry stamp shall be attached to the rollo;
- b. Keep such books as may be necessary for recording all the proceedings of the Board and the CAAC;
- c. Send notices to the appellant as regards the filing of the verified memorandum of appeal and the submission of the appeal bond;
- d. Require the parties to submit the necessary pleadings, required number of copies of their pleadings, and/or legible copies of the assailed decision or order; and,
- e. Enter judgment upon finality of a decision or final resolution.

SECTION 129. Comment/Answer or Reply of Appellee

The appellee may file its comment/answer or reply to appellant's memorandum of appeal with the Clerk of the Board within a period of fifteen (15) calendar days from receipt of the memorandum of appeal. Failure to file such comment/answer within the said period shall be construed as a waiver to file the same.

SECTION 130. Rejoinder

The appellant may file its rejoinder to the comment/answer filed by the appellee within a period of ten (10) calendar days from receipt of such comment/answer. Failure to file such rejoinder within the said period shall be construed as a waiver to file the same.

Rule IX DECISION PROCESS

SECTION 131. Reply/Deliberation of Appealed Case

The CAAC shall deliberate and make a study and written report on the appealed case within sixty (60) calendar days from the time of the submission of the appellant's rejoinder or upon the expiration of the period to file the same.

SECTION 132. Substantial Evidence

The CAAC shall determine whether or not there exists substantial evidence in deliberating on and studying the appealed case. Substantial evidence is that amount of relevant evidence which a reasonable mind might accept as adequate to justify a conclusion.

In determining whether or not to affirm the decision of the Arbitration Office, the CAAC shall take into account the presence or absence of mitigating, aggravating circumstances and prior violations, if any, of the respondent health care provider or member, and the possible impact to the community/members of imposing administrative penalties against the appealing respondent.

SECTION 133. Assignment of the Appealed Case

The CAAC Chairperson shall assign to its member to write the report and recommendation and draft decision based on the deliberations conducted by the CAAC. Thereafter, the Clerk of the Board shall present the report and draft decision for the consideration and approval of the Board en banc.

SECTION 134. Decision or Resolution on Appeal

The Board en banc shall resolve the appeal within sixty (60) calendar days from receipt of the entire records of the case.

SECTION 135. Form of Decision or Resolution

The decision or resolution of the Board en banc shall state clearly and distinctly the findings of facts, issues and conclusions of law on which it is based and the relief/s granted, if any.

SECTION 136. Promulgation of Decisions and Resolutions

Promulgation of decisions or resolutions shall be the direct responsibility of the Clerk of the Board.

- a. Promulgation is made by filing the decision or resolution with the Clerk of the Board, who shall forthwith annotate the date and time thereof and attest to it by his/her signature thereon.
- b. The Clerk of the Board shall record in the promulgation book the docket number, title of the case, nature of the document (whether decision or resolution), and the action taken by the Board en banc. The promulgation book shall be under his/her care and custody.
- c. Immediately after promulgation of a decision or resolution, the Clerk of the Board shall forward the original and two (2) copies thereof to the Arbitration Office for proper action.
- d. Within seven (7) working days from the promulgation of a decision or resolution, the Clerk of the Board shall send notices and copies thereof in sealed envelopes to the parties through their counsel, either personally or by registered mail.

**Rule X
ENTRY OF JUDGMENT**

SECTION 137. Entry of Judgment and Final Resolution

If no appeal or motion for reconsideration is filed within the time provided in this Rules, the decision or final resolution shall forthwith be entered by the Clerk of the Board in the book of entries of judgments. The date when the judgment or final resolution becomes executory shall be deemed as the date of its entry. The record shall contain the dispositive part of the decision or final resolution and shall be signed by the Clerk of the Board, with a certificate that such decision or final resolution has become final and executory.

SECTION 138. Form

Entry of judgment shall be made in the prescribed form, signed by the Clerk of the Board, who shall certify the date when the decision or resolution was promulgated and the date it became final and executory.

**Rule XI
EXECUTION OF A DECISION**

SECTION 139. Execution of a Decision

Any decision of an Arbiter or of the Board in a complaint filed against a health care provider or member shall be executed after the same shall have become final and executory; *Provided that*, the penalty of fine shall first be satisfied or paid from the forfeiture of the appeal bond if applicable. The decision may be enforced and executed in the same manner as decisions of the Regional Trial Court. The Board shall have the power to issue to the City or Provincial Sheriff or the Sheriff whom it may appoint such needed writs of execution. Any person who shall fail or refuse to comply with such decision or writ after being required to do so shall, upon application by the Board, be punished by the proper court for contempt. The decision of the Board shall immediately be executory even pending appeal when the public interest so requires and unless such decision expressly states otherwise.

**Rule XII
WRIT OF EXECUTION ON HEALTH CARE INSTITUTIONS**

SECTION 140. Writ of Execution on Health Care Institutions

After the lapse of the fifteen (15) day period to appeal decisions of the Arbiter wherein the penalty imposed is suspension or revocation of accreditation, or after the decision of the Board on appealed cases affirming the imposition of the penalty of suspension or revocation has become final and executory and upon motion of the prosecution, an order granting the issuance of a writ of execution (“writ” for brevity) shall be issued by the Arbiter. The writ shall state therein the exact date of implementation and effectivity of the suspension or revocation, as the case may be, which in no case shall be earlier than sixty (60) days from the date of issuance of the writ. No motion for reconsideration, opposition or any other similar pleading shall be allowed and entertained by the Arbitration Office except on the ground that the decision is not yet final and executory or that the penalties imposed therein have already been fully satisfied.

SECTION 141. Directive to Execute Writ

Attached to the order granting the issuance of the writ is the directive to the Legal Office under whose regional jurisdiction the respondent health care institution is situated to execute and implement it. Copies of the said directive shall likewise be furnished to the Office of the Regional Vice-President or Head of the receiving PRO, the Accreditation and Prosecution Departments of the Central Office.

- a. After receipt of the directive to execute, the respective Legal Office shall personally serve the writ to the respondent health care institution within seven (7) days. The Legal Office shall also coordinate and

inform the Accreditation Unit and Benefit Administration Section of the PRO upon its receipt of the writ.

- b. In the event that the authorized officials or representatives of the respondent health care institution refuse to expressly receive the writ, the Legal Office shall take note of such refusal and tender the writ by leaving a copy thereof at the premises of the health care institution. Tender of the writ is tantamount to an effective service of the same.
- c. After personal service of the writ, the Legal Office shall submit within seven (7) days a report or certification of compliance to the directive, attaching thereto satisfactory evidence or proof of service, to the Arbiter and the Manager of the Accreditation Department. The Legal Office shall keep a record of the writs received and personally served for verification purposes.
- d. After receipt of the compliance report or certification, the Accreditation Department shall then commence appropriate revisions in the database of the accreditation status of the respondent health care institution. The Accreditation Department shall immediately inform the Legal Office, Accreditation Unit and Benefit Administration Section of the PRO wherein the respondent health care institution is situated once the revision has been effected.

SECTION 142. Notice of Suspension/Revocation

Within ten (10) days prior to the commencement of the suspension or revocation as stated in the writ, the Legal Office together with representatives from the Accreditation Unit of the PRO, shall post notices of suspension/revocation (“notice” for brevity) in three (3) conspicuous areas of the facility, namely (1) near the signage which says “PhilHealth Accredited”; (2) the main entrance; and (3) the billing or accounting office where settlement of hospital bills are transacted.

- a. The notice must be made of white tarpaulin and in the same size as that of the required signage and in bold black letters must state clearly and visibly as follows: “the PhilHealth Accreditation of (name of hospital) is suspended from (date of start) until (date of conclusion). No claims for confinements at this hospital during this period shall be received, processed and paid by PhilHealth” or “the PhilHealth Accreditation of (name of hospital) is revoked effective on (date). No claims for confinements on such date and onwards shall be paid by PhilHealth”, as the case may be. If possible, a translation in the vernacular may likewise be inserted in the notice. With due consent of the convicted health care provider, the signage of “PhilHealth Accredited” or any other sign or marker informing the public of its PhilHealth accreditation should be removed if possible.
- b. The Legal Office and Accreditation Unit representatives shall exhaust all efforts to monitor faithful compliance on the posting of the notice and to the writ by the respondent health care institution. In case there shall be a violation of the same, such acts shall constitute a ground for the filing of a new case for the administrative offense of breach of Warranties of Accreditation/Performance Commitment.
- c. The PRO through its public relations/information office shall exert efforts to inform PhilHealth members of the suspension or revocation of accreditation of the respondent health care institution in their region after the writ has been served.

SECTION 143. Report

After satisfaction of the writ and within fifteen (15) days from the expiration of the period of suspension, the Legal Office shall make a report stating therein that the provider faithfully complied with the same. The report shall be addressed to the Executive Arbiter and Manager of the Accreditation Department.

SECTION 144. Deduction of Fines from Benefit Claims

Where the respondent health care institution refuses or fails to timely satisfy or pay the penalty of fine despite having been duly served with a writ of execution, the said fine shall be deducted by the Corporation from the proceeds of the pending or future benefit claims with the Corporation of the respondent health care institution.

Rule XIII
WRIT OF EXECUTION ON HEALTH CARE PROFESSIONALS

SECTION 145. Writ of Execution on Health Care Professionals

After the lapse of the fifteen (15) day period to appeal decisions of the Arbiter wherein the penalty imposed is suspension or revocation of accreditation, or after the decision of the Board on appealed cases affirming the imposition of the penalty of suspension or revocation has become final and executory and upon motion of the prosecution, an order granting the issuance of a Writ of Execution (“writ” for brevity) shall be issued by the Arbiter. The writ shall state therein the exact date of implementation and effectivity of the suspension or revocation, as the case may be, which in no case shall be earlier than sixty (60) days from the date of issuance of the writ. No motion for reconsideration, opposition or any other similar pleading shall be allowed and entertained by the Arbitration Office except on the ground that the decision is not yet final and executory or that the penalties imposed therein have already been fully satisfied.

SECTION 146. Directive to Execute Writ

Attached to the order granting the issuance of the writ is the directive to the Legal Office under whose regional jurisdiction the respondent health care professional is situated, to execute and implement it. Copies of the said directive shall likewise be furnished to the Office of the Regional Vice-President or Head of the receiving PRO, the Accreditation and Prosecution Departments of the Central Office.

- a. After receipt of the directive to execute, the respective Legal Office shall personally serve the writ to the respondent health care professional within seven (7) days. The Legal Office shall also coordinate with and inform the Accreditation Unit and Benefits Administration Section of the PRO upon its receipt of the writ. Personal service of the writ shall be made on the last known residential address of the professional or in the institution wherein the professional regularly or is otherwise known to practice, as supplied by the professional to the Accreditation Department.
- b. In the event that the respondent health care professional refuses to expressly receive the writ, the Legal Office shall take note of such refusal and tender the writ by leaving a copy thereof. Tender of the writ is equivalent to an effective service of the same.
- c. In the event that personal service of the writ is no longer feasible due to valid and justified reasons, service by registered mail at the last known address of the professional shall be resorted to.
- d. After service of the writ under the modes above-mentioned, the Legal Office shall submit within fifteen (15) days a report or certification of compliance to the directive, attaching thereto satisfactory evidence or proof of service, to the Arbiter and the Manager of the Accreditation Department. In case the service shall be via registered mail, an explanation on the failure to personally serve the writ must be stated along with the verification of relevant dates to confirm completeness of service under this mode. The Legal Office shall keep a record of the writs received and personally served for verification purposes.
- e. After receipt of the compliance report or certification, the Accreditation Department shall then commence appropriate revisions in the database on the accreditation status of the respondent health care professional. The Accreditation Department shall immediately inform the Legal Office, Accreditation Unit and Benefit Administration Section of the PRO wherein the respondent health care professional is situated once the revision has been effected.

SECTION 147. Claims Filed with Suspended Professional

All claims for reimbursement filed with PhilHealth involving the suspended professional shall be denied payment with respect to the claim for the professional fees only but may still be subject to appeal following the regular procedures for appealed claims. Health care institutions are hereby enjoined to refrain from endorsing or referring PhilHealth members to suspended professionals who regularly render service or practice in their institution so as to avoid undue delay in the processing of their claims.

SECTION 148. Report

After satisfaction of the writ and within fifteen (15) days from the expiration of the period of suspension, the Legal Office shall make a report, stating therein that the respondent faithfully complied with the same. The report shall be addressed to the Executive Arbiter and Manager of the Accreditation Department of the Central Office.

SECTION 149. Deductions of Fines from Benefit Claims

Where the respondent health care professional refuses or fails to timely satisfy or pay the penalty of fine despite having been duly served with a writ of execution, the said fine shall be deducted by the Corporation from the proceeds of the pending or future benefit claims with the Corporation of the respondent health care professional.

Rule XIV WRIT OF EXECUTION ON MEMBERS

SECTION 150. Writ of Execution on Members

After the lapse of the fifteen (15) day period to appeal the decisions of the Arbiter wherein the penalty imposed is payment of fine and/or suspension of availment of PhilHealth benefits, or after the decision of the Board on appealed cases affirming the imposition of the penalty of suspension has become final and executor and upon motion of the prosecution, an order granting the issuance of a Writ of Execution (“writ” for brevity) shall be issued by the Arbiter. The writ shall state therein the exact date of implementation and effectivity of the suspension which in no case shall be earlier than sixty (60) days from the date of issuance of the writ. No motion for reconsideration, opposition or any other similar pleading shall be allowed and entertained by the Arbitration Office except on the ground that the decision is not yet final and executory or that the penalties imposed therein have already been fully satisfied.

- a. After receipt of the directive to execute, the respective Legal Office shall personally serve the writ to the respondent member within seven (7) days. The Legal Office shall also coordinate with and inform the concerned offices of the PRO upon its receipt of the writ. Personal Service of the writ shall be made on the last known residential address of the member.
- b. In the event that the respondent member refuses to expressly receive the writ, the Legal Office shall take note of such refusal and tender the writ by leaving a copy thereof. Tender of the writ is equivalent to an effective service of the same.
- c. In the event that personal service of the writ is no longer feasible due to valid and justified reasons, service by registered mail at the last known address of the member shall be resorted to.
- d. After service of the writ under the modes abovementioned, the Legal Office shall submit within fifteen (15) days submit a report or certification of compliance to the directive, attaching thereto satisfactory evidence or proof of service, to the Executive Arbiter and Heads of the concerned offices. In case the service shall be via registered mail, an explanation on the failure to personally serve the writ must be stated along with the verification of relevant dates to confirm completeness of service under this mode. The Legal Office shall keep a record of the writs received and personally served for verification purposes.
- e. After receipt of the compliance report or certification, the concerned offices shall then commence appropriate action in the database and shall inform the Arbiter of the action taken.

SECTION 151. Claims Filed by Suspended Member

All benefit claims for reimbursement filed with PhilHealth involving the suspended member shall be denied payment but may still be subject to appeal following the regular procedures for appealed claims.

SECTION 152. Report

After satisfaction of the writ, the Legal Office shall make a report, stating therein that the respondent member faithfully complied with the same, within fifteen (15) days from the expiration of the period of suspension. The report shall be addressed to the Executive Arbiter and Head of concerned office of the Central Office.

Rule XV
APPEAL TO THE COURT OF APPEALS

SECTION 153. Appeal to Court of Appeals of Board Decisions

Final orders and decisions of the Board may be reviewed by the Court of Appeals through an appeal in accordance with the provisions of Revised Administrative Circular No. 1-95 issued by the Supreme Court on May 17, 1995, pursuant to Republic Act No. 7902, approved on February 23, 1995, expanding the jurisdiction of the Court of Appeals.

Title IX
DEFINITION OF ADMINISTRATIVE OFFENSES AND PENALTIES

Rule I
OFFENSES OF HEALTH CARE INSTITUTIONS

SECTION 154. Padding of Claims

Any health care institution who, for the purpose of claiming payment from the Program, files a claim for benefits which are in excess of the benefits actually provided by adding drugs, medicines, supplies, procedures and services.

SECTION 155. Claims for Non-Admitted or Non-Treated Patients

This is committed by any health care institution who, for the purpose of claiming payment from the Program, files a claim for a non-admitted or non-treated patient by:

- a. Making it appear that the patient was actually confined or treated in the health care institution; or,
- b. Using such other machinations that would result in claims for non-admitted or non-treated patient.

SECTION 156. Extending Period of Confinement

This is committed by any health care institution who, for the purpose of claiming payment from the Program, files a claim with extended period of confinement by:

- a. Increasing the period of actual confinement of any patient;
- b. Continuously charting entries in the Doctor's Order, Nurse's Notes and Observation despite actual discharge or absence of the patient; or,
- c. Using such other machinations that would result in the unnecessary extension of confinement.

SECTION 157. Post-Dating of Claims

Any health care institution who, for purposes of claiming payment from the Program, files a claim for payment of services rendered not within sixty (60) calendar days from the date of discharge of the patient or such other prescriptive periods as the Corporation may issue but makes it appear so by changing, erasing, adding to the period of confinement or in any manner altering dates so as to conform with the adopted prescriptive period.

SECTION 158. Misrepresentation by Furnishing False or Incorrect Information

Any health care institution shall be liable for fraudulent practice when, for the purpose of participation in the Program or claiming payment therefrom, it furnishes false or incorrect information concerning any matter required by R.A. 7875 as amended and this Rules. This offense covers or includes, but is not limited to, the following acts involving benefit claims for case-rate payment:

- a. Code substitution – claiming for unrelated illness or procedure with higher benefit payment in lieu of actual illness or procedure;
- b. Upcoding or upcasing or diagnosis creeping or procedure creeping – claiming for a related illness or procedure of higher severity or complexity to gain higher benefit payment; or,
- c. Adding a non-existing condition in the diagnosis in order to receive higher benefit payment.

SECTION 159. Filing of Multiple Claims - Any health care institution who files two or more claims for a patient for the same confinement or out-patient treatment or illness.

SECTION 160. Unjustified Admission Beyond Accredited Bed Capacity

Any private health care institution who, for the purpose of claiming payment from the Program, files claims for patients confined in excess of its accredited bed capacity at any given time without justification in the form and manner prescribed by the Corporation.

SECTION 161. Unauthorized Operations Beyond Service Capability

Any primary care facility which performs a surgical operation beyond its authorized capability except when the operation is done in an emergency to save life and referral to a higher category provider is physically impossible.

SECTION 162. Fabrication or Possession of Fabricated Forms and Supporting Documents

Any health care institution who is found preparing claims with misrepresentations or false entries, or to be in possession of claim forms and other documents with false entries.

SECTION 163. Other Fraudulent Acts

Any health care institution shall also be liable for the following fraudulent acts:

- a. Making it appear that the patient suffered from a compensable illness or underwent a compensable procedure;
- b. Failure or refusal to give benefits due to qualified members/dependents;
- c. Charging qualified patients for medicines and/or services which are legally chargeable to and covered by the Program;
- d. Failure or refusal to refund to the member the payment received from the Program within a period of thirty (30) days from the date of receipt of the refund check from the Corporation when the hospital charges and professional fees are fully paid in advance by the member;
- e. Failure or refusal to accomplish and submit the required forms in connection with letter d.;
- f. Failure or refusal to provide the members with the required forms for direct filing of claims, billing statements, official receipts and other documents required/necessary for filing of claims; or,
- g. Deliberate failure or refusal to comply with the requirements of RA 7875 as amended and this Rules.

SECTION 164. Breach of the Warranties of Accreditation/Performance Commitment

Any health care institution who commits any breach of the Warranties of Accreditation/Performance Commitment.

SECTION 165. Criminal Liability

In addition, a criminal complaint shall be filed against the officials of the erring institutional health care providers before the appropriate Office of the Prosecutor for violations of this Rules and/or the Revised Penal Code.

Rule II
OFFENSES OF HEALTH CARE PROFESSIONALS

SECTION 166. Misrepresentation by False or Incorrect Information

Any health care professional shall be liable for fraudulent practice when, for purposes of participation in the Program or claiming payment from the Corporation, furnishes false or incorrect information concerning any matter required by R.A. 7875 as amended and this Rules. This offense covers or includes but is not limited to the following acts involving benefit claims for case-rate payment:

- a. Code substitution – claiming for unrelated illness or procedure with higher benefit payment in lieu of actual illness or procedure;
- b. Upcoding or upcasing or diagnosis creeping or procedure creeping – claiming for a related illness or procedure of higher severity or complexity to gain higher benefit payment;
- c. Adding a non-existing condition in the diagnosis in order to receive higher benefit payment.

SECTION 167. Breach of the Warranties of Accreditation/Performance Commitment

Any health care professional found to have committed any breach of the Warranties of Accreditation / Performance Commitment .

SECTION 168. Other Violations

Any other willful or negligent act or omission of the health care professional in violation of RA 7875 as amended and this Rules which tends to undermine or defeat the objectives of the Program shall be dealt with in accordance with Section 44 of RA 7875 as amended.

SECTION 169. Criminal Liability

In addition, a criminal complaint shall be filed against erring health care professionals before the appropriate Office of the Prosecutor for violations of this Rules and/or the Revised Penal Code.

Rule III
OFFENSES OF MEMBERS

SECTION 170. Fraudulent Acts

Any member who, for purposes of claiming PhilHealth benefits or entitlement thereto, shall commit any of the offenses provided for in Sections 154 to 163 and Sections 166 and 168 hereof, independently or in connivance with the health care provider.

SECTION 171. Criminal Liability

In addition, a criminal complaint shall be filed against the member before the Office of the Prosecutor for the above violations which carry a penalty of imprisonment of not less than six (6) months but not more than one (1) year.

Rule IV
CLASSIFICATION OF ADMINISTRATIVE OFFENSES

SECTION 172. Non-Fraudulent Offenses

The following are considered as non-fraudulent offenses:

- a. Breach of the Warranties of Accreditation/Performance Commitment
- b. Filing of multiple claims
- c. Unjustified admission beyond accredited bed capacity
- d. Unauthorized operations beyond service capability.

SECTION 173. Fraudulent Offenses

The following are considered as fraudulent offenses:

- a. Padding of claims
- b. Claims for non-admitted or non-treated patients
- c. Extending period of confinement
- d. Post-dating of claims
- e. Misrepresentation by false or incorrect information
- f. Misrepresentation by furnishing false or incorrect information
- g. Fabrication or possession of fabricated forms and supporting documents
- h. Other fraudulent acts

SECTION 174. Scale of Administrative Penalties

The following administrative penalties shall be respectively imposed on cases involving non-fraudulent and fraudulent offenses:

a. **Non-Fraudulent Offenses**

First Offense	Suspension of 3 months and/or Fine of not less than P50,000.00 but not more than P70,000.00
Second Offense	Suspension of 4 months and/or Fine of not less than P70,000.00 but not more than P90,000.00
Third Offense	Suspension of 6 months and/or Fine of not less than P90,000.00 but not more than P100,000.00
Fourth Offense	Revocation of accreditation and Fine of P100,000.00

b. **Fraudulent Offenses**

First Offense	Suspension of 3 months to 4 months and/or Fine of not less than P50,000.00 but not more than P70,000.00
Second Offense	Suspension of 4 months and 1 day to 6 months and/or Fine of not less than P70,000.00 but not more than P90,000.00
Third Offense	Revocation of accreditation and Fine of P100,000

Any member who, for purposes of claiming PhilHealth benefits or entitlement thereto, shall commit any of the above-mentioned offenses, independently or in connivance with the health care provider, shall suffer the penalties of a fine of not less than Five Thousand Pesos (5,000.00) but not more than Ten Thousand Pesos (10,000.00) and/or suspension from availment of PhilHealth benefits for not less than three (3) months but not more than six (6) months.

SECTION 175. Cumulative Application of Penalties/Recidivists

The determination of the degree of imposable administrative penalties shall be based cumulatively on the number of the offense or offense(s) of the same classification (non-fraudulent/fraudulent) that the appealing health care provider or member has been found guilty of in a prior case and/or decision. Guilt on two or more counts of the same offense in a decision shall be considered as one offense.

Recidivists are health care providers who have been found guilty of the maximum number of offenses and meted the penalty of revocation of accreditation in accordance with the herein Scale of Administrative Penalties. Recidivists may no longer be accredited by the Corporation.

Rule V
GENERAL PROVISIONS

SECTION 176. Mitigating and Aggravating Circumstances

The following circumstances shall affect the gravity of the violation and the liability of the erring health care provider:

- a. Mitigating Circumstances – The following circumstances shall mitigate the liability: voluntary admission of guilt; good track record; or first offense.
- b. Aggravating Circumstances – The following circumstances shall aggravate the liability: Previous conviction of an offense, as provided for in this Rules; connivance and/or conspiracy to facilitate the commission of the violation; or gross negligence.
- c. Such other similar circumstances that may mitigate or aggravate the violation and liability of the health care provider as may be determined by the Arbitration Office or Board, as the case may be.

SECTION 177. Application of Circumstances in the Imposition of Penalties

- a. The presence of a mitigating circumstance without any aggravating circumstance shall limit the imposable penalty to its minimum.
- b. When there is neither a mitigating nor an aggravating circumstance, the imposable penalty shall be between the minimum and the maximum of the applicable penalty for the offense committed, at the discretion of the Corporation. The same shall apply when both mitigating and aggravating circumstances are present.
- c. The presence of any aggravating circumstance without any mitigating circumstance shall increase the penalty for the offense to its maximum.

SECTION 178. Application of Suspension and Revocation of Accreditation

If the penalty of suspension imposed upon the health care provider exceeds the validity of the current accreditation, the application for renewal or re-accreditation of the health care provider shall not be acted upon until the full term of the suspension imposed has lapsed. Suspension shall be carried out by the temporary cessation of the benefits or privileges of the health care provider under the Program. Revocation shall be carried out by the permanent cessation of the benefits or privileges of the health care provider under the Program.

Title X
PENAL OFFENSES AND PENALTIES

Rule I
OFFENSES OF OFFICERS AND EMPLOYEES OF THE CORPORATION

SECTION 179. Infidelity in the Custody of Property

This offense is committed by any officer or employee of the Corporation who:

- a. Receives or keeps funds or property belonging, payable or deliverable to the Corporation, or who shall appropriate the same; or
- b. Shall take or misappropriate such property or fund wholly or partially; or
- c. Shall consent, or through abandonment or negligence, shall permit any other persons to take such property or funds wholly or partially.

The officer or employee found liable for misappropriation of funds or property shall suffer imprisonment of not less than six (6) years but not more than twelve (12) years and a fine of not less than Ten Thousand Pesos (P10,000.00) but not more than Twenty Thousand Pesos (P20,000.00).

Any shortage of funds or loss of the property upon audit shall be deemed prima facie evidence of the offense.

SECTION 180. Other Violations Involving Funds

All other violations involving funds of the Corporation shall be governed by the applicable provisions of the Revised Penal Code or other laws, taking into consideration the provisions under this Rules on collection, remittances, and investment of funds.

SECTION 181. Connivance

Any officer or employee of the Corporation who shall connive, conspire, agree, plot, scheme, contrive or collude with any health care provider or any member, or through gross negligence or imprudence shall facilitate or consent to the commission of the same offenses enumerated in this Rules shall be prosecuted under applicable penal laws, rules and regulations, without prejudice to the filing of appropriate administrative action with the appropriate agency.

Rule II OFFENSES OF EMPLOYERS

SECTION 182. Failure or Refusal to Register/Deduct Contributions

Any employer or officer who fails or refuses to register/deduct contributions from the employee's compensation shall be penalized with a fine of not less than Five Thousand Pesos (P5,000.00) but not more than Ten Thousand Pesos (P10,000.00) multiplied by the total number of employees of the firm.

SECTION 183. Failure or Refusal to Remit Contributions

Any employer or officer authorized to collect contributions who, after collecting or deducting the monthly contributions due from the employees, fails or refuses to remit said contributions to the Corporation within thirty (30) days from the date they become due shall be punished with a fine of not less than Five Thousand Pesos (P5,000.00) but not more than Ten Thousand Pesos (P10,000.00) multiplied by the total number of employees of the firm.

SECTION 184. Unlawful Deductions

Any employer or officer who shall deduct directly or indirectly from the compensation of the covered employees or otherwise recover from them their own contribution on behalf of such employees shall be punished with a fine of Five Thousand Pesos (P5,000.00) multiplied by the total number of affected employees.

SECTION 185. Institution as Offender

If any of the acts or omissions provided in the preceding Sections of this Rules be committed by an association, partnership, corporation or any other institution, its managing directors or partners or president or general manager and/or any other persons responsible for the commission of the said acts or omissions shall be liable for the penalties provided for in this Rules and other laws for the offense.

SECTION 186. Reports on Penal Violations by Employers

The PRO shall submit to the Chief Operating Officer a quarterly report on all violations by employers within the area of jurisdiction of the PRO for deduction of their counterpart contributions from their employees' compensation, under remittance and/or non-remittance of their employees' contributions to the Corporation. Such report shall simultaneously be copy furnished by the PRO to the SVP-LS and to its Legal Office and Collection Unit of the PRO for their appropriate action.

SECTION 187. Affidavit-Complaint and Complainant in Penal Actions

The Head or Officer-In-Charge (OIC) of the Collections Unit of the PRO shall, within five (5) days upon receipt from its Legal Office of the final draft affidavit-complaint, execute or sign the same as the complainant and nominal witness in behalf of the Corporation against employers within their area of jurisdiction for any of the

aforementioned offenses. In the absence, failure or inability of the Head or OIC of the Collection Unit of the PRO to do so, the Regional Vice-President or OIC of the PRO shall timely perform the same duty.

SECTION 188. Preparation and Filing of Affidavit-Complaint

The affidavit-complaint shall be prepared and filed with the appropriate Office of the Prosecutor by the Legal Office of the PRO within thirty (30) days from its receipt of the quarterly report; provided that, the SVP-LS may likewise direct the Legal Office to prepare and file an affidavit-complaint based on considerations other than such report.

**Rule III
FINAL PROVISIONS**

SECTION 189. Prosecution of Offenses

Offenses defined under Rules I and II, Title X hereof, shall be prosecuted in the regular courts of justice of competent jurisdiction without prejudice to administrative action that may be instituted by the Corporation under existing laws.

SECTION 190. Filing of Complaint - The filing of a complaint before the Corporation shall not bar a separate independent criminal action before any board, office, tribunal or court against the erring health care provider or member, and vice versa.

SECTION 191. Execution of Penalty - When a health care institution ceases operation or an independent health care professional stops practicing before serving the suspension, execution of penalty shall be deferred, to be implemented when the same owner or medical director opens or operates a new institution irrespective of the name or location, or when the health care provider practices again; *Provided*, that the dispositive part of the resolution or decision requiring payment of fines, reimbursement of paid claim or denial of payment shall be immediately executory.

A spouse or relative within the fourth (4th) degree of consanguinity or affinity of the owner or medical director shall be presumed to be the alter ego of such owner or medical director for the above purposes.

Despite the cessation of operation or practice of a health care provider while the complaint is being heard, the proceedings may continue until rendition of judgment for the purpose of determining future relationships between the Corporation and the erring provider.

SECTION 192. Applicability of this Rules

Complaints already filed with and under deliberation by appropriate bodies of the Corporation prior to the effectivity of this Rules shall be governed in accordance with the previous rules.

Title XI
ADMINISTRATIVE REMEDIES OF
HEALTH CARE PROVIDERS AND MEMBERS

Rule I
COMMON PROVISIONS

SECTION 193. Jurisdiction

The Corporation, through the Grievance and Appeals Review Committee (GARC) and the Board, shall hear and decide all grievances filed by any accredited health care provider or by any member against any program implementor. The Corporation shall likewise act on all protests against administrative decisions involving payments of charges, fees or claims, subject to the procedures hereafter provided.

SECTION 194. Grievance and Protests Not Covered

Any action of a program implementor which can be the basis of an administrative or criminal complaint or charge under the jurisdiction of the Office of the Ombudsman, Sandiganbayan, Civil Service Commission, or the regular courts of justice is neither a grievance nor a protest covered by this Rules and shall be dealt with in accordance with applicable laws.

Rule II
GRIEVANCE AGAINST PROGRAM IMPLEMENTORS

SECTION 195. Grounds for Grievances - The following acts shall constitute valid grounds for grievance:

- a. Any violation of the rights of patients;
- b. Willful neglect of duty resulting in the loss or non-availment of benefits by members or their dependents;
- c. Unjustifiable delay in actions on claims;
- d. Delay in the processing of claims that extends beyond the prescribed period; and,
- e. Any other act or omission that tends to undermine or defeat the purposes of the Act and this Rules.

SECTION 196. Who May File

Any aggrieved health care provider or member may file a verified complaint for a grievance.

SECTION 197. Venue

A grievance covered by this Rules may be filed with the PhilHealth Office where the aggrieved health care provider is located or where the member resides.

SECTION 198. Contents of Grievance

All complaints for grievance shall contain, among others, the following:

- a. Name/s and address/es of the aggrieved party/ies;
- b. Name/s and address/es of respondent program implementor/s;
- c. A clear and concise statement of the aggrieved party's cause/s of action, citing the specific ground relied upon and the acts or omissions complained of which constitute the same; and,
- d. The relief/s sought.

The complaint shall be verified and accompanied by affidavits of the complainant and the witnesses as well as other supporting documents, in such number of copies as there are respondents, plus two (2) copies for the official file.

SECTION 199. Investigation

Upon the filing of a complaint for grievance and subject to Section 203 hereof, the GARC shall conduct an inquiry to determine whether there is sufficient ground to engender a well-founded belief that a grievance cognizable by the GARC has been committed by a program implementor and that prosecution and adjudication of the case by the GARC is necessary to give the aggrieved party redress.

Rule III THE GRIEVANCE AND APPEALS REVIEW COMMITTEE

SECTION 200. Grievance and Appeals Review Committee (GARC)

The GARC shall be composed of a Chairperson, Vice-Chairperson and three (3) members, to be designated by the Board, through which it shall hear and decide all actions for grievance; provided, that one of its members shall be a representative of any health care providers as endorsed by the DOH. The Board, through the GARC, shall likewise exercise jurisdiction to review the action of the Corporation dismissing the grievance against the program implementor upon a verified petition of the aggrieved party. The GARC shall be convened upon the filing of the petition and shall continue to meet as a body until a decision thereon is rendered.

SECTION 201. Quorum and Votes Required

Three (3) members of the GARC shall constitute a quorum to deliberate on and decide any grievance brought before it. In all cases, the concurrence of at least three (3) members of the GARC which shall include the President as the Presiding Officer shall be necessary to reach a decision, resolution, order or ruling.

SECTION 202. Preliminary Determination

Upon the endorsement of the grievance, the GARC, after consideration of the allegations thereof, may dismiss a case outright due to lack of verification, failure to state a cause of action, or any other valid ground for the dismissal of the grievance after consultation with the Board, or proceed to hear and determine the case.

If the respondent implementor failed to submit the verified answer, counter-affidavits and other supporting documents in the proceeding before the Corporation, the respondent implementor shall be required to file the same with the GARC within five (5) calendar days from the service of summons. Summons may be served in accordance with the provisions of this Rules.

SECTION 203. Judgment by Default

Should the respondent implementor fail to answer within the reglementary five (5) calendar-day period provided in the immediately preceding section, the GARC, *motu proprio*, or upon motion of the aggrieved party, shall render judgment as may be warranted by the facts on record and limited to what is prayed for in the complaint for grievance.

SECTION 204. Position Papers

After an answer is filed and the issues are joined, the GARC shall require the parties to submit, within ten (10) calendar days from receipt of the order, a brief statement of their respective positions setting forth the law and the facts relied upon by them. In the event the GARC finds, upon consideration of the pleadings, records of the proceeding before the Corporation and position papers submitted by the parties, that a judgment may be rendered thereon without need of a formal hearing, it may proceed to render judgment not later than ten (10) calendar days from submission of the position papers by the parties.

SECTION 205. Clarificatory Hearing

In cases where the GARC deems it necessary to hold a hearing to clarify specific factual matters before rendering judgment, it shall set the case for hearing for the said purpose. At such hearing, witnesses whose affidavits were previously submitted may be asked clarificatory questions by the proponent and by the GARC and may be cross-examined by the adverse party. The order setting the case for hearing shall specify the witnesses who will be called to testify, and the matters on which their examination will deal. The hearing shall be terminated within fifteen (15) calendar days, and the case shall be decided by the GARC within fifteen (15) calendar days from such termination.

SECTION 206. Contents of the Decision

Decisions of the GARC shall be clear and concise and shall include brief statements of the facts of the case, the issue/s involved, the applicable law/s or rule/s, conclusions and reasons therefor, and specific reliefs granted.

SECTION 207. Finality of Judgment

The decision of the GARC shall become final and executory fifteen (15) calendar days after notice thereof to the parties, unless an appeal is filed with the Board within the same period, in accordance with the procedure set forth in this Rules.

SECTION 208. Administrative Sanctions

Upon finding of guilt, the GARC may censure, reprimand, or suspend the respondent implementor from office, depending on the gravity of the offense; provided, that the suspension shall not exceed thirty (30) days.

SECTION 209. Construction and Suppletory Application of the Rules of Court

In all proceedings, the GARC and the Board shall not be bound by the technical rules of evidence; provided however, that the Rules of Court shall apply with suppletory effect.

SECTION 210. Powers of the GARC

The GARC can administer oaths, certify to official acts and issue subpoena ad testificandum to compel the attendance and testimony of witness, and subpoena duces tecum to enjoin the production of books, papers and other records pertinent to the case. Any act of contumacy shall be dealt with in accordance with Section 14, Chapter 3, Book VII of the Revised Administrative Code.

**Rule IV
REVIEW OF GARC DECISION**

SECTION 211. Appellate Jurisdiction of the Board Over Grievance Cases

The Board en banc shall have exclusive appellate jurisdiction to review the decisions of the GARC in grievances filed under RA 7875 as amended and this Rules.

SECTION 212. Period to File Petition for Review

A Petition for Review may be filed with the Board within a non-extendible period of thirty (30) calendar days from receipt of the decision of the GARC.

SECTION 213. Who May File Petition for Review

Any of the parties in a complaint for grievance decided by the GARC may file a Petition for Review.

SECTION 214. Decision of the Board

The Board shall resolve the petition within thirty (30) calendar days from receipt thereof with the records of the case.

**Rule V
ADMINISTRATIVE PROTESTS**

SECTION 215. Original Jurisdiction of the PRO

The respective PRO has original jurisdiction to act on all administrative protests filed by health care providers and members against the written notices of the respective claims processing unit or office which pertain to the denial or reduction of payment of benefit claims.

SECTION 216. Claims Subject to Protest

Benefit claims that were either denied or reduced payment may be the subject of a protest before the PRO.

SECTION 217. Form and Period to File

The protest shall be in writing, duly signed by the protestant and addressed to the concerned PRO. It must be accompanied by supporting documents and filed within sixty (60) calendar days from receipt of the written notice of the denial/reduction of payment of the benefit claim.

SECTION 218. Procedure Before the PRO

Upon receipt of the protest, the PRO may require submission of additional documents or affidavits pertinent to a just resolution of the protest.

SECTION 219. Action on Protests

After thorough deliberation, the PRO shall take the following actions on the protest through a decision or notice, as appropriate:

- a. Deny the protest if the same is without merit in the light of existing laws, pertinent circulars and orders of the Corporation;
- b. Grant the protest if the same is meritorious and to direct the payment of the benefit claim thereof, in whole or in part; or,
- c. Take such other actions as are just or equitable under the circumstances.

SECTION 220. Appeal Before the Protests and Appeals Review Department (PARD)

The decisions or notices of the PROs may be appealed by the aggrieved health care provider or member in writing to the PARD within fifteen (15) days from receipt of such decisions or notices.

The PARD may adopt, modify or reject the decisions or notices of the PRO on protests in whole or in part. Forthwith, the PARD shall issue an order resolving the appeals, as far as practicable, within a period of thirty (30) days from receipt of the appeal, citing the facts and the law or rules on which the same is based. The order of the PARD shall be final and executory.

**Rule VI
CONSTRUCTION AND APPLICATION**

SECTION 221. Title of this Rules

This Rules shall be known as the Rules of Procedure of the Corporation.

SECTION 222. Application of this Rules

This Rules shall apply to all administrative cases brought before the Corporation.

SECTION 223. Construction

This Rules shall be liberally construed to carry out the objectives of RA 7875 as amended and to assist the parties in obtaining an expeditious and inexpensive resolution of any case arising under the Act.

SECTION 224. Suppletory Application of the Rules of Court and Jurisprudence

In the absence of any applicable provisions in this Rules, the pertinent provisions of the Rules of Court of the Philippines and prevailing jurisprudence may be applied in a suppletory manner to all cases brought before the Corporation in the interest of expeditious resolution of these cases; provided that, the Corporation shall not be bound by the technical rules of evidence.

**TITLE XII
VISITORIAL POWERS OF THE CORPORATION**

SECTION 225. Visitorial Powers

Any duly authorized representative of the Corporation shall have the power to visit, enter and inspect facilities of health care providers and employers during office hours, unless there is reason to believe that inspection has to be done beyond office hours, and where applicable, secure copies of their medical, financial, and other records and data pertinent to the claims, accreditation, premium contribution and that of their patients or employees, who are members of the Program.

**Title XIII
TRANSITORY PROVISION**

SECTION 226. PhilHealth Identification Card

Members can temporarily use their PhilHealth Number Card which shall serve as the basis for availment of services until such time that they are issued a PhilHealth Identification Card.

**Title XIV
MISCELLANEOUS PROVISIONS**

SECTION 227. Nine (9) Months Contribution within Twelve (12) Months

The previous requirement of payment of (9) months contributions within the last twelve (12) months shall no longer be required in the member's entitlement to benefits.

SECTION 228. Repealing Clause

All PhilHealth circulars, orders and other issuances which are inconsistent with the provisions of this Rules are hereby considered repealed or amended.

SECTION 229. Separability Clause

In the event any provision of this Rules or the Act or the application of such provision to any person or circumstance is declared invalid, the remainder of this Rules or the application of said provisions to other persons or circumstance shall not be affected by such declaration.

SECTION 230. Effectivity

This Rules shall take effect fifteen (15) days after its publication in two (2) newspapers of general circulation.