

Automatic Renewal of Accreditation of PhilHealth Konsulta Package Providers for CY 2024

To ensure continuity of member's access to the Konsulta Package, the Corporation shall grant automatic renewal of accreditation for CY 2024 to all PhilHealth Konsulta Package Providers (KPPs) whose accreditation shall expire on December 31, 2023, provided that the following requirements are submitted on or before December 29, 2023:

1. Fully-accomplished Letter of Intent (Annex A); and,
2. Accreditation fee of P2,000.00 (for standalone KPPs or KPPs plus one or more combination of other outpatient packages) or P1,000.00 (for hospital-based KPPs)¹.

For further inquiries, kindly reach us through the following designated communication channels:

Email : actioncenter@philhealth.gov.ph
Social Media : <https://www.facebook.com/PhilHealthofficial>
Twitter : <https://twitter.com/teamphilhealth>

Thank you.

(Sgd.) EMMANUEL R. LEDESMA, JR.
President and Chief Executive Officer (PCEO)
Date signed: December 11, 2023

¹PhilHealth Circular No. 2023-0012 or "Omnibus Guidelines on the Accreditation of Health Facilities (HFs) to the National Health Insurance Program", Policy Statement U, Item 2.

Annex A: Letter of Intent re Automatic Renewal of Accreditation of KPPs for CY2024

Date: _____

To PhilHealth:

LETTER OF INTENT

Relative to the automatic renewal of accreditation as a PhilHealth Konsulta Package Provider (KPP) for **CY 2024**, I agree with the following statements:

1. That I am amenable that the accreditation of the KPP shall be automatically renewed for **CY 2024**, subject to the requirements and standards provided by PhilHealth;
2. That being an accredited KPP means we shall continue to commit to abide by the provisions in our Performance Commitment; and,
3. That we shall inform PhilHealth of any changes in our facility, including the number of beneficiaries that we can cater based on the number of full time and/or full-time equivalent physicians in our health facility.

Printed Name and Signature of the Head of the KPP

Name of Health Facility: _____

Address: _____
