

Health Facility Logo
Health Facility Name
Health Facility Address

Letter of Undertaking as Provider of Selected Outpatient Screening Tests for Cancer

Date: _____

NAME OF RVP

Address

Dear RVP _____:

We, the _____ Name of Health Facility, with address at _____ would like to signify our intent to be a PhilHealth accredited Provider of Selected Outpatient Screening Tests for Cancer, specifically for the following services:

*Please check item/s as applicable

- | | |
|--|--------------|
| <input type="checkbox"/> Mammogram | (P2,610.00) |
| <input type="checkbox"/> Breast Ultrasound | (P1,350.00) |
| <input type="checkbox"/> Liver Ultrasound | (P960.00) |
| <input type="checkbox"/> Alpha-fetoprotein (AFP) | (P1,230.00) |
| <input type="checkbox"/> Low-dose Chest CT Scan | (P7,220.00) |
| <input type="checkbox"/> Colonoscopy | (P23,640.00) |

Further, we hereby commit that:

1. Our facility has the capability and necessary licenses/permits to provide the above services;
2. We acknowledge that PhilHealth shall pay for the services through case-based payment as stipulated above;
3. We agree with the set rates and shall apply the “**no co-payment**” scheme to all patients availing the said services;
4. We will comply with the PhilHealth implementing guidelines for Selected Outpatient Screening Tests for Cancer; and,
5. We will immediately implement the new benefit coverage once in effect.

Very truly yours,

Name of Medical Director/Chief of Hospital

Name of Facility

“**SUBSCRIBED AND SWORN TO** before me this ____ day of _____, 20, in _____, affiant exhibiting to me his/her _____, issued on _____ at _____.

NOTARY PUBLIC

Doc. No. _____

Page No. _____

Book No. _____

Series of 20 _____