Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
8/F Philippine Heart Center Bldg. East Ave., Quezon City
Tel. 927-1575, 923-1301 loc. 3805-3815, Fax No. 927-1272, 435-6180
(Claims Processing Department) 3/F JOCFER Bldg., Commonwealth Ave., Quezon City
Tel. 455-0826, 455-0963

PHILIPPINE CENTENNIAL 1898 - 1998 KALAYAAN KAYAMANAN NG BAYAN

PHILHEALTH CIRCULAR
NO. 002, series of 2000

TO : **ALL ACCREDITED INSTITUTIONAL HEALTH CARE PROVIDERS**

FROM : **ENRIQUE M. ZALAMEA**
President and CEO

SUBJECT: **Guidelines on Application for 2000 Renewal of Accreditation**

DATE : 10 February 2000

The current accreditation of institutional health care providers will expire on the following dates:

NCR including Rizal	-	September 30, 2000
Regions 1 - 3	-	October 31, 2000
Regions 4 - 6	-	November 30, 2000
Regions 7 - 13 and CAR	-	April 30, 2000

In this regard, please be guided by the following schedule of renewal of accreditation of institutional health care providers for 2000:

REGION	DEADLINE FOR FILING	60-DAY PROCESSING	PERIOD OF VALIDITY
NCR (including Rizal)	August 1, 2000	Aug. 1 - Sept. 30	Oct. 1, 2000 - Sept. 30, 2001
REGIONS 1-3	September 1, 2000	Sept. 1 - Oct. 31	Nov. 1, 2000 - Oct. 31, 2001
REGIONS 4-6	October 1, 2000	Oct. 1 - Nov. 30	Dec. 1, 2000 - Nov. 30, 2001
REGIONS 7-13 & CAR	February 29, 2000	Feb. 29 - April 30	May 1, 2000 - April 30, 2001

We highly encourage institutions to file their application for renewal before the deadline to avoid gaps in their accreditation. Hospitals are required to submit applications with complete data on the previous accreditation year as well as licenses issued in 2000. However, if the Department of Health has not issued such licenses, hospitals may submit proofs of renewal of licenses such as a photocopy of application for renewal, official receipt of payment, or certification from the licensing agency. The hospital must submit a copy of the ancillary licenses within one hundred twenty (120) days from date of deliberation by the Accreditation Committee,

otherwise, the hospital's category will be downgraded to primary. Likewise, the hospital's license to operate (LTO) from DOH must be submitted within sixty (60) days from deliberation, otherwise the application will be denied.

Since hospitals in Regions 7 - 13 and CAR have not been issued their licenses for 2000, licenses in 1999 will be acceptable for renewal of accreditation. However, they should be able to present their 2000 licenses when the corporation conducts post-accreditation inspections later in the year.

Furthermore, in the light of Memorandum Circular No. 09 s. 1999, the following requirements for accreditation are hereby added:

1. Secondary hospitals - (both government and private) Therapeutics Committee members and activities
2. Tertiary hospitals - (both government and private)
   2.1 Therapeutics Committee members and activities
   2.2 Antimicrobial resistance surveillance program, names of personnel involved or Infection Control Committee, with names of members and activities

Procedure for filing of applications

Hospitals are encouraged to follow these guidelines in filing applications for accreditation:

1. Secure copies of the application forms from the PhilHealth Central Office, from any of the Regional Health Insurance Offices (RHIOs) or any local chapter of the Philippine Hospital Association (PHA) nationwide. It is the responsibility of hospitals seeking accreditation to secure copies of the forms which may be reproduced without permission from PhilHealth.

2. Accomplish the form completely and legibly. The hospital administrator; director or chief must duly sign forms.

3. Have the form notarized by a notary public.

4. Submit the completed forms to the RHIO in your area, or to the PhilHealth Central Office for hospitals in NCR and Rizal together with all the required attachments and accreditation fee as indicated below.

   The RHIO shall officially receive the application and indicate the date of receipt therein. Upon verification and inspection of your hospital, the RHIO will forward the application and recommendation to the PhilHealth Central Office for deliberation of approval.

Payment of accreditation fees

1. Accreditation fees are as follows :

   PRIMARY - 200.00
   SECONDARY - 400.00
   TERTIARY AND AMBULATORY SURGICAL CLINICS - 600.00

2. For out-of-town applications, accreditation fees must be paid in cash or postal money order directly to the corresponding Regional Health Insurance Office. Postal money orders, should be properly filled out as follows :

   a) Pay to : Philippine Health Insurance Corporation
      From : Name of Hospital

   b) Signature of issuing officer should be present

   c) Month, date and year of issue should be clearly stamped

   d) Back of postal money order should be left blank

3. For Metro Manila and Rizal applications filed directly with the PhilHealth Central Office, payment of accreditation fees may be made directly to the PhilHealth Cashier, either in cash, DBP checks or postal money order payable only to PhilHealth or the Philippine Health Insurance Corporation. The Cashier's Office is open from 8:00-12:00 noon, 1:00-5:00 p.m., Mondays to Fridays.

Processing requirements

1. All requirements per hospital category as stipulated in the checklist must be complied with.

2. Applications with incomplete or insufficient documentary requirements shall automatically be denied, without prejudice to the option of the applicant to refile, upon submission of needed documents. Date of re-filing shall be deemed the date of submission for purposes of computing the 60-day approving period.

3. For further inquiries, please write to :

   The Director
   Accreditation and Quality Assurance Department
   Philippine Health Insurance Corporation
   Room- 711 7/F Jocfer Building, Commonwealth Avenue,
   Diliman, Quezon City

or call the Accreditation Hotline at 455-7388, 454-3391 and Telefax No. 951-7452.

For compliance.

Phcircular/jo

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
7/F Jocfer Building, Commonwealth Avenue, Diliman, Quezon City
Tel. Nos. ☎ 455-7388 • 454-3391
Fax No. 9517452

CHECKLIST OF REQUIREMENTS FOR HOSPITAL ACCREDITATION FOR Reg. 7-13 & CAR (TERTIARY)

Name of Hospital _____
Address _____

_____ 1. PhilHealth application form properly accomplished
_____ 2. Duly notarized warranties of accreditation
_____ 3. DOH License issued 1999
_____ 4. PHA/PHAP certificate of membership issued 1999
_____ 5. List of functional/serviceable equipment signed by Medical Director/Administrator (Annex A)
_____ 6. List of current hospital service charges (Annex B)
_____ 7. Ancillary Licenses issued/revalidated 1999
a) Laboratory License (optional for Primary)
b) Hospital Pharmacy License (optional for Primary)
c) Xray License (optional for Primary)
d) Certificate of affiliation of Laboratory and Xray services (for primary hospitals without Laboratory and Xray)
_____ 8. List of available drugs in the hospital pharmacy/drug room (for Primary hospitals)
_____ 9. Complete list of hospital staff with respective designation (for Primary & Secondary hosps.) Departmentalized list of medical and nursing personnel indicating position-full time or part time (for Tertiary hospitals) (Annex C)
_____ 10. Inspection verification by RHIO staff or AQA department staff
_____ 11. Accreditation fee by postal money order payable only to **Philppine Health Insurance Corporation** or cash paid directly to cashier
Primary-P 200.00 Secondary-P 400.00 Tertiary & Ambulatory Surgical Clinics-P 600.00
The accreditation fee is non-refundable.
_____12. Secondary hospitals - (both government and private) Therapeutics Committee members and activities
_____ 13. Tertiary hospitals - (both government and private)
13.1Therapeutics Committee members and activities
13.2Antimicrobial resistance surveillance program, names of personnel involved or Infection Control Committee, with names of members and activities

Additional Requirements for Initial Accreditation :

_____ 1. Current photographs of hospital facade, ER, Laboratory, Pharmacy, Xray, Nursery, DR, OR, recovery room, ICU, isolation room, CR, records, business office, nurses station, CSS, and other available hospital facilities – (Optional)
_____ 2. Current photograph of complete hospital staff – (Optional)
_____ 3. Current standard operating procedures
_____ 4. Quality Assurance Program
_____ 5. Training certificate in General Surgery of Resident Surgeon for Secondary-General hospital
_____ 6. SEC License/DTI certificate/CDA certificate
_____ 7. DOH Licenses of 3 previous successive years or Mayor's Permit

DOCUMENTS SUBMITTED TO RHIO:
Date Received _____
Received by _____
Date refiled _____
Region _____
RHIO staff are advised to strictly indicate the above data.

TO PhilHealth Central Office:
Date Received _____
Received by _____
Received & assessed by _____

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
7/F Jocfer Bldg., Commonwealth Avenue, Quezon City
Tel. Nos. ☎ 455-7388
Fax No. 🖷 456-0445

PhilHealth ACCREDITATION FORM 1 T
APPLICATION FOR ACCREDITATION (TERTIARY)

_____, 2000

THE PRESIDENT
Philippine Health Insurance Corporation
Quezon City, Philippines

SIR :

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

at _____ and the duly authorized representative to act for and in

behalf of _____, hereby applies for accreditation under
(Health Care Institution)

Sec.16 L of R.A.7875 and its Implementing Rules and Regulation thereto. For this purpose, I hereby submit

the following pertinent information and documentary requirements.

PART I - GENERAL INFORMATION

Name of Hospital : _____

Complete Address : _____ Postal Code : _____

PhilHealth Code No : _____ Tel.No. : _____

Date established : _____ Date of last accreditation : _____

Administrator : _____ Chief/Medical Director : _____

DOH License No. _____ valid from _____ to _____ issued on _____,19 ____

Ownership/Management

( ) Single proprietorship ( ) Partnership
( ) Corporation ( ) Cooperative
( ) Religious ( ) Foundation
( ) National Govt. ( ) Local Govt.

Others, specify _____

A. PHYSICAL PLANT & ENVIRONMENT

1. Building

( ) Concrete ( ) Old structure
( ) Semi-concrete ( ) Renovated
( ) Wood ( ) New structure

2. Sanitation & safety standard
   a. Water supply _____
   b. Electric power _____
      Stand by generator ( ) Yes ( ) No
   c. Sewage disposal
      Solid waste by _____
      Liquid waste by _____
      Pathological waste by _____
   d. Fire Escape ( ) Yes ( ) No
   e. Fire extinguisher ( ) Yes ( ) No
   f. Toilet facilities ( ) Yes ( ) No
3. Has there been any change in ownership or management ?
   ( ) Yes ( ) No If yes, when ? _____
4. Has the Health Care Institution transferred to another location?
   ( ) Yes ( ) No If yes, where? _____
   (complete address)
5. Has there been any change in category or authorized bed capacity since last accreditation? ( ) Yes ( ) No
   If Yes, when ? _____ What ? _____

B. HOSPITAL BEDS

	No. of Beds	Rate per Day
1. Accredited Bed Capacity per DOH license		
2. Implementing Beds :		
Private		
Semi Private		
Ward Beds		
Service/Charity Beds		
3. ICU Beds		

C. MANPOWER COMPLEMENT

(Indicate the Number)

	Full time	Part time	Visiting	Residents
1. Medical Services				
1.1 Consultants				
a) Surgery				
Gen. Surgery				
Cardio Vascular Surgery				
Neuro Surgery				
Orthopedic Surgery				
Opthalmology				
Otolaryngology				
Plastic Surgery				
Surgical Oncology				
Thoracic Surgery				
Urology				
b) OB-Gyn				
c) Anesthesia				
d) Internal Medicine :				
General Medicine & Infectious Disease				
Allergology				
Cardiology				
Endocrinology				
Dermatology				
Gastroentorology				
Haematology				
Nephrology				

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

F. CLINICAL SERVICES

( ) General Medicine
( ) Subspecialty of Internal Medicine. Enumerate available subspecialty services :

_____

_____

( ) General Surgery
( ) Subspecialty of Surgery. Enumerate available subspecialty services

_____

_____

( ) OB-Gyn
( ) Gen. Pediatrics
( ) Subspecialty of Pediatrics. Enumerate available subspecialty services

_____

_____

( ) Opthalmology
( ) Otolaryngology

G. RECORDS

( ) Admission/discharge records
( ) prescribed logbook ( ) computerized
( ) OPD records
( ) logbook ( ) index card ( ) computerized
( ) Laboratory logbook
( ) Xray logbook
( ) Major OR logbook
( ) DR logbook
( ) Minor surgical logbook
( ) Transmittal copy file
( ) Others, specify _____

H. SERVICE STATISTICS (Latest Annual Statistics)

For the months of January 1, 1999 to December 31, 1999

1. Patients served

1.1 Total admission (excluding newborn)

a. NHI GSIS _____
SSS _____
OWWA _____

b. Non-NHI/Charity _____

1.2 No. of Indigent patients under the NHI Program _____

1.3 Ave. days of confinement /NHI patient

Formula : Total Confinement Days (TCD) of NHI Beneficiaries

Total No. of NHI Beneficiaries Admitted

1.4 Ave. daily census (NHI & non-NHI) = _____

1.5 Monthly Bed Occupancy Rate = _____

Formula : TCD of NHI Beneficiaries + TCD of non-NHI

(No. of days/month) x (No. of accredited beds) x 100

2. NHI claims :

	GSIS	SSS	OWWA
No. of claims filed			
No. of claims paid			
No. of claims denied			
Unpaid claims as of Dec. 31, 1999			

	Full time	Part time	Visiting	Residents
Neurology	___	___	___	___
Oncology	___	___	___	___
Psychiatry	___	___	___	___
Pulmonary	___	___	___	___
Rheumatology	___	___	___	___
c) Pediatrics :	___	___	___	___
Gen Pediatrics				
Neonatology	___	___	___	___
Other Pediatric Subspecialty	___	___	___	___
f) Radiology	___	___	___	___
g) Pathology	___	___	___	___
h) Dental service	___	___	___	___
2. Nursing service :				
Registered Nurses	___	___		
Registered Midwives	___	___		
Nursing Aides	___	___		
3. Laboratory/Xray :				
Medical Technologist	___	___		
Xray Technician	___	___		
4. Pharmacy :				
Registered Pharmacist	___	___		
Pharmacy Aides	___	___		
5. Dietary Service :				
Dietitian	___	___		
Food servers	___	___		
6. Engineering & Maintenance service	___	___		
7. Others, specify _____				

Note : Submit complete list of hospital personnel. (See Annex C)

D. MEDICAL FACILITIES

( ) Emergency room
( ) Out-patient department
( ) Clinical laboratory
License No. _____ valid from _____ to _____
( ) Xray facility
License No. _____ valid from _____ to _____
( ) Labor room and Delivery room
( ) Nursery room _____ No. of Bassinet/s _____ No. of Incubator/s
( ) Operating room complex No. of OR _____
( ) I.C.U.
( ) Dental service
( ) Central stock supply
( ) Dietary service
( ) Pharmacy
License No. _____ valid from _____ to _____
( ) Blood bank
( ) Nuclear medicine
( ) Cancer clinic
( ) Rehabilitation department
( ) Medical records
( ) Ambulance service
( ) Training service
Accredited Internship Training Program ( ) Yes ( ) No
Residency Training Program ( ) Yes ( ) No
College of Nursing ( ) Yes ( ) No
School of Midwifery ( ) Yes ( ) No
( ) Others, specify _____

3. Cases

3.1 No. of patients in :

Gen. Medicine _____
Pediatrics _____
OB-Gyn _____
Major Surgery _____
Minor Surgery _____
Others, specify _____

3.2 Six (6) most common cases attended to

	Ave. cost per confinement/Case	
	Actual	NHI
1)	_____	_____
2)	_____	_____
3)	_____	_____
4)	_____	_____
5)	_____	_____
6)	_____	_____

I. QUALITY ASSURANCE PROGRAM OF THE INSTITUTION

PART II - WARRANTIES OF ACCREDITATION

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

_____
(Hospital / Ambulatory Surgical Clinic)

located at _____ warrants
(address)
the following :

1. ELIGIBILITY

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

2. COMPLIANCE TO PERTINENT LAWS

2.1 That the aforenamed health care institution shall in the course of its participation with the NHI program by virtue of its accreditation comply with the provisions of the National Health Insurance Law (RA 7875), its Implementing Rules and Regulations, all administrative orders of the corporation,
2.2 That it shall comply at all times with the provisions of the Hospital Licensure Act (RA 4226), its prevailing Implementing Rules and Regulations, Administrative Order # 24, s-1994 for ambulatory surgical clinics as well as other Administrative Orders,
2.3 That it shall accept the formal program of Quality Assurance, payment mechanism and utilization review of the NHI program,
2.4 That its personnel shall strictly adhere and comply at all times with the Codes of Ethics of the Medical and Nursing professions and other medical related professions of the Philippines.

3. CLINICAL SERVICES

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

4. CLINICAL RECORDS AND PREPARATION OF CLAIMS

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

5. MANAGEMENT INFORMATION SYSTEM

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

6. HOSPITAL INSPECTION / VISITATION / INVESTIGATION

6.1 That the aforenamed health care institution recognizes the authority of the PhilHealth and its duly authorized representative or agents deputized by Philhealth to conduct inspection, visitation or investigation of the institution at anytime,
6.2 That it shall cooperate in the inspection / visitation / investigation by making ready and available all hospital records (medical & financial) and other pertinent documents,
6.3 That it shall obey without delay summon, subpoena or subpoena duces tecum from the Corporation or Local Health Insurance Office.

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

_____
MEDICAL DIRECTOR / ADMINISTRATOR
(Signature Over Printed Name)

WITNESS MY HAND AND SEAL, this _____ day of _____ 2000 at _____.

_____

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

Doc. No. _____
Book No. _____
Page No. _____
Series of 19____

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PART III - VERIFICATION

In connection with the application for accreditation of the

_____

(Health Care Institution)

located at _____ **the following are the findings during**

my/our inspection conducted on _____**, 2000.**

1. **Deviation from the information data in the application as to :**

   a. **Ownership and/or management** _____
   b. **Location** _____
   c. **Safety measures in the building** _____
   d. **Number of beds** _____
   e. **Manpower complement :** _____
      _____
   f. **Clinical services** _____
   g. **Functional equipment** _____
   h. **Records** _____

2. **Other observations :**
   _____
   _____

3. **Recommendations :**
   _____
   _____

By :

_____	_____
Signature over Printed Name	**Signature over Printed Name**
_____	_____
Designation	**Designation**

Noted by Hospital Representative :

_____
Signature over Printed Name

_____
Designation

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Annex A

LIST OF FUNCTIONAL/SERVICEABLE EQUIPMENT/APPARATUSES/INSTRUMENTS

Facility	Equipment		Remarks
	Type	Number	(Functional, For repair, etc.)

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

_____
Date accomplished

_____
Med. Director's or Administrator's signature
over printed name

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

ANNEX B

LIST OF CURRENT HOSPITAL CHARGES

	RATE
a) Room Suite Private Semi-private Ward Nursery OR DR Others	
b) Laboratory procedure	
c) Xray & other Radiologic procedures	
d) Other Ancillary procedures	

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

_____
Date Accomplished

_____
Medical Director's or Administrator's signature over printed name

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

ANNEX C

LIST OF HOSPITAL PERSONNEL

NAME	POSITION/ SPECIALTY	EMPLOYMENT STATUS				(for professionals)		SIGNATURE
		FULL TIME	PART TIME	ON-CALL	VISITING	PRC NO.	PhilHealth No.	

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

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

_____
(Signature)

Res. Cert. _____
Issued at _____
Issued on _____

_____
Date Accomplished

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
8/F Philippine Heart Center Bldg., East Ave., Quezon City
Tel. 927-1575, 923-1301 loc. 3805-3815, Fax No. 927-1272
(*Accreditation and Quality Assurance Department*) 7/F JOCFER Bldg., Commonwealth Ave., Quezon City
Tel Nos. 455-7388, 456-0445 Fax: 454-3391

FOR : **MS. NADYA R. CASTILLO**
Dept. Manager - ASD

FROM: **MADELEINE R. VALERA, MScCHHM**
Director III
Accreditation and Quality Assurance Department

RE : **Printing of Application Forms for Hospital Accreditation**

DATE : 10 February 2000

==========

May we request for printing of application forms for hospital accreditation for the year 2000. For Primary and Secondary application form - 900 copies. For Tertiary application form - 150 copies.

Thank you.

Enclosed : hosp. application forms

Accreditation & Monitoring Section
FZS/jla02102000

Rated : 7/5

Note: 20 reams received on 16 Feb. at 4pm

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
7/F Jocfer Building, Commonwealth Avenue, Diliman, Quezon City
Tel. Nos. ☎ 455-7388 • 454-3391
Fax No. 🖷 9517452

CHECKLIST OF REQUIREMENTS FOR HOSPITAL ACCREDITATION FOR Reg. 7-13 & CAR (PRIMARY & SECONDARY)

Name of Hospital _____
Address _____

_____ 1. PhilHealth application form properly accomplished
_____ 2. Duly notarized warranties of accreditation
_____ 3. DOH License issued 1999
_____ 4. PHA/PHAP certificate of membership issued 1999
_____ 5. List of functional/serviceable equipment signed by Medical Director/Administrator (Annex A)
_____ 6. List of current hospital service charges (Annex B)
_____ 7. Ancillary Licenses issued/revalidated 1999
a) Laboratory License (optional for Primary)
b) Hospital Pharmacy License (optional for Primary)
c) Xray License (optional for Primary)
d) Certificate of affiliation of Laboratory and Xray services (for primary hospitals without Laboratory and Xray)
_____ 8. List of available drugs in the hospital pharmacy/drug room (for Primary hospitals)
_____ 9. Complete list of hospital staff with respective designation (for Primary & Secondary hosps.) Departmentalized list of medical and nursing personnel indicating position-full time or part time (for Tertiary hospitals) (Annex C)
_____ 10. Inspection verification by RHIO staff or AQA department staff
_____ 11. Accreditation fee by postal money order payable only to **Philppine Health Insurance Corporation** or cash paid directly to cashier
Primary-P 200.00 Secondary-P 400.00 Tertiary & Ambulatory Surgical Clinics-P 600.00
The accreditation fee is non-refundable.
_____12. Secondary hospitals - (both government and private) Therapeutics Committee members and activities
_____ 13. Tertiary hospitals - (both government and private)
13.1Therapeutics Committee members and activities
13.2Antimicrobial resistance surveillance program, names of personnel involved or Infection Control Committee, with names of members and activities

Additional Requirements for Initial Accreditation :

_____ 1. Current photographs of hospital facade, ER, Laboratory, Pharmacy, Xray, Nursery, DR, OR, recovery room, ICU, isolation room, CR, records, business office, nurses station, CSS, and other available hospital facilities – (Optional)
_____ 2. Current photograph of complete hospital staff – (Optional)
_____ 3. Current standard operating procedures
_____ 4. Quality Assurance Program
_____ 5. Training certificate in General Surgery of Resident Surgeon for Secondary-General hospital
_____ 6. SEC License/DTI certificate/CDA certificate
_____ 7. DOH Licenses of 3 previous successive years or Mayor's Permit

DOCUMENTS SUBMITTED TO RHIO:
Date Received _____
Received by _____
Date refiled _____
Region _____
RHIO staff are advised to strictly indicate the above data.

TO PhilHealth Central Office:
Date Received _____
Received by _____
Received & assessed by _____

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
7/F Jocfer Bldg., Commonwealth Avenue, Diliman, Quezon City
Tel. Nos. ☎ 455-7388 • 454-3391
Fax No. 🖷 951-7452

1P & S

PhilHealth ACCREDITATION FORM
APPLICATION FOR ACCREDITATION (PRIMARY & SECONDARY)

_____, 2000

THE PRESIDENT
Philippine Health Insurance Corporation
Quezon City, Philippines

SIR :

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

at _____ and the duly authorized representative to act for and in

behalf of _____, hereby applies for accreditation under
(Health Care Institution)

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

PART I - GENERAL INFORMATION

Name of Hospital : _____

Complete Address : _____ Postal Code : _____

PhilHealth Code No : _____ Tel.No. : _____

Date established : _____ Date of last accreditation : _____

Administrator : _____ Chief/Medical Director : _____

DOH License No. _____ valid from _____ to _____ issued on _____,19 ____

Ownership/Management

( )	Single proprietorship	( )	Partnership
( )	Corporation	( )	Cooperative
( )	Religious	( )	Foundation
( )	National Govt.	( )	Local Govt.

Others, specify _____

A. PHYSICAL PLANT & ENVIRONMENT

1. Building

( ) Concrete	( ) Old structure
( ) Semi-concrete	( ) Renovated
( ) Wood	( ) New structure

2. Sanitation & safety standard
   a. Water supply _____
   b. Electric power _____

Stand by generator ( ) Yes ( ) No

c. Sewage disposal
Solid waste by _____
Liquid waste by _____
Pathological waste by _____

d. Fire Escape ( ) Yes ( ) No
e. Fire extinguisher ( ) Yes ( ) No
f. Toilet facilities ( ) Yes ( ) No

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

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

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

B. HOSPITAL BEDS

	No. of Beds	Rate per Day
1. Accredited Bed Capacity per DOH license	_____	_____
2. Implementing Beds :		
Private	_____	_____
Semi Private	_____	_____
Ward Beds	_____	_____
Service/Charity Beds	_____	_____
	_____	_____
3. ICU Beds	_____	_____

C. MANPOWER COMPLEMENT

(Indicate the number)

	Full time	Part time	Visiting
1. Medical Service			
a. Consultants :			
Gen. Surgery	_____	_____	_____
Sub-surgical specialty	_____	_____	_____
OB-Gyn	_____	_____	_____
Pediatrics	_____	_____	_____
Internal Medicine	_____	_____	_____
Pathology	_____	_____	_____
Radiology	_____	_____	_____
Dental	_____	_____	_____
Others	_____	_____	_____
b. Residents	_____	_____	_____
2. Nursing service			
a. Registered nurse	_____	_____	_____
b. Registered midwives	_____	_____	_____
c. Nursing aides	_____	_____	_____
3. Pharmacist	_____	_____	_____
4. Laboratory & Xray			
a. Medical technologist	_____	_____	_____
b. Xray technologist	_____	_____	_____
5. Dentist	_____	_____	_____
6. Dietitian	_____	_____	_____

7. Administrative services _____ _____ _____

8. Others _____ _____ _____

Note : Submit complete list of hospital personnel. (See Annex C)

D. CLINICAL FACILITIES

( ) Emergency room
( ) Doctor's/Consultation office
( ) Clinical laboratory
Laboratory Lic. No._____ valid from _____ to _____
Affiliation ( ) Yes ( ) No
- Laboratory Lic. No._____ valid from _____ to _____
If yes, please attach certificate of affiliation properly subscribed to.
( ) Xray facility
Xray Lic.No. _____ valid from _____ to _____
( ) Pharmacy Lic. No. _____ valid from _____ to _____
( ) Dental room
( ) Drug room
( ) Labor room
( ) Delivery room
( ) Nursery room _____ No. of Bassinet/s _____ No. of Incubator/s
( ) Operating room _____ Minor OR _____ Major OR
( ) Recovery room
( ) Medical records room
( ) Dietary room
( ) Others, please specify _____

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

F. CLINICAL SERVICE

( )	General Medicine	( )	Anesthesia
( )	General Surgery	( )	OB-Gyn
( )	Orthopedic Surgery	( )	Pediatrics
( )	Opthalmology	( )	Dermatology
( )	Otolaryngology	( )	Others, specify _____

G. RECORDS

( ) Admission & discharge records
[ ] Prescribed logbbok [ ] Computerized
Others, please specify _____
( ) Laboratory logbook
( ) Xray logbook
( ) OR logbook
( ) OPD logbook
( ) Outpatient surgical logbook
( ) Clinical monthly reports
( ) Transmittal records

H. SERVICE STATISTICS (Latest annual statistics)
For the months of January 1 to December 31, 1999

1. Patients served
1.1 Total admission (exclude newborn)
a. NHI GSIS _____ SSS _____ OWWA _____
b. Non-NHI/charity _____
1.2 No. of indigent patients under the NHI program _____
1.3 Ave. days of confinement/NHI patients _____

Formula : Total Confinement Days (TCD) of NHI Beneficiaries

Total No. of NHI Beneficiaries Admitted

1.4 Ave. daily census (NHI and non-NHI) = _____

1.5 Monthly bed occupancy rate = _____

Formula : TCD of NHI Beneficiaries + TCD of non-NHI

(No. of days/month) x (No. of accredited beds) x 100

2. NHI claims :

	GSIS	SSS	OWWA
No. of claims filed			
No. of claims paid			
No. of claims denied			
Unpaid claims as of Dec. 31, 1999			

3. Cases

3.1 No. of patients in :

NHI

General Medicine _____
Pediatrics _____
OB-Gyn _____
Major surgery _____
Minor surgery _____
Others, specify _____

3.2 Six (6) most common cases attended to

	Ave. cost per confinement/Case	
	Actual	NHI
1)		
2)	_____	_____
3)	_____	_____
4)	_____	_____
5)	_____	_____
6)	_____	_____
	_____	_____

I. QUALITY ASSURANCE PROGRAM OF THE INSTITUTION

PART II - WARRANTIES OF ACCREDITATION

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

_____
(Hospital / Ambulatory Surgical Clinic)

located at _____ warrants
(address)
the following :

1. ELIGIBILITY

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

2. COMPLIANCE TO PERTINENT LAWS

2.1 That the aforenamed health care institution shall in the course of its participation with the NHI program by virtue of its accreditation comply with the provisions of the National Health Insurance Law (RA 7875), its Implementing Rules and Regulations, all administrative orders of the corporation.
2.2 That it shall comply at all times with the provisions of the Hospital Licensure Act (RA 4226), its prevailing Implementing Rules and Regulations, Administrative Order # 24, s-1994 for ambulatory surgical clinics as well as other Administrative Orders,
2.3 That it shall accept the formal program of Quality Assurance, payment mechanism and utilization review of the NHI program,
2.4 That its personnel shall strictly adhere and comply at all times with the Codes of Ethics of the Medical and Nursing professions and other medical related professions of the Philippines.

3. CLINICAL SERVICES

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

4. CLINICAL RECORDS AND PREPARATION OF CLAIMS

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

5. MANAGEMENT INFORMATION SYSTEM

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

6. HOSPITAL INSPECTION / VISITATION / INVESTIGATION

6.1 That the aforenamed health care institution recognizes the authority of the PhilHealth and its duly authorized representative or agents deputized by Philhealth to conduct inspection, visitation or investigation of the institution at anytime,
6.2 That it shall cooperate in the inspection / visitation / investigation by making ready and available all hospital records (medical & financial) and other pertinent documents,
6.3 That it shall obey without delay summon, subpoena or subpoena duces tecum from the Corporation or Local Health Insurance Office.

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

_____
MEDICAL DIRECTOR / ADMINISTRATOR
(Signature Over Printed Name)

WITNESS MY HAND AND SEAL, this _____ day of _____ 2000 at _____.

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

Doc. No. _____
Book No. _____
Page No. _____
Series of 19____

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PART III - VERIFICATION

In connection with the application for accreditation of the

_____

(Health Care Institution)

located at _____ the following are the findings during

my/our inspection conducted on _____, 2000.

1. Deviation from the information data in the application as to :

   a. Ownership and/or management _____
   b. Location _____
   c. Safety measures in the building _____
   d. Number of beds _____
   e. Manpower complement : _____
   f. Clinical services _____
   g. Functional equipment _____
   h. Records _____

2. Other observations : _____

3. Recommendations : _____

By :

_____ _____

Signature over Printed Name Signature over Printed Name

_____ _____

Designation Designation

Noted by Hospital Representative :

_____

Signature over Printed Name

_____

Designation

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Annex A

LIST OF FUNCTIONAL/SERVICEABLE EQUIPMENT/APPARATUSES/INSTRUMENTS

Facility	Equipment		Remarks
	Type	Number	(Functional, For repair, etc.)

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

_____
Date accomplished

_____
Med. Director's or Administrator's signature over printed name

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

ANNEX B

LIST OF CURRENT HOSPITAL CHARGES

	RATE
a) Room Suite Private Semi-private Ward Nursery OR DR Others	
b) Laboratory procedure	
c) Xray & other Radiologic procedures	
d) Other Ancillary procedures	

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

_____
Date Accomplished

_____
Medical Director's or Administrator's signature over printed name

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

ANNEX C

LIST OF HOSPITAL PERSONNEL

NAME	POSITION/	EMPLOYMENT STATUS				(for professionals)		SIGNATURE
	SPECIALTY	FULL TIME	PART TIME	ON-CALL	VISITING	PRC NO.	PhilHealth No.	

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

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

_____
(Signature)

Res. Cert. _____
Issued at _____
Issued on _____

_____
Date Accomplished