Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
CityState Centre, 709 Shaw Blvd. corner Oranbo Drive, Pasig City
Healthline: 637-9999, www.philhealth.gov.ph

August 8, 2005

PHILHEALTH CIRCULAR
No. 18, s-2005

TO : ACCREDITED INSTITUTIONAL HEALTH CARE PROVIDERS AND ALL CONCERNED

SUBJECT : Renewal of Accreditation of Institutional Health Care Providers (IHCPs) with Complete Application

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All accredited IHCPs are advised to submit a complete application to facilitate processing of the renewal of their accreditation. Incomplete applications shall be returned for completion.

A complete application satisfies the following requirements:

1. Application form properly accomplished and duly notarized;
2. All documentary requirements in the checklist for accreditation are attached (see Annex A);
3. In lieu of hospital and ancillary service licenses, a DOH certification may be submitted pending the processing of the actual license(s). The certification should state that the hospital was inspected and found to have complied with the standards.
4. In lieu of the Fire Safety Inspection Certificate, a commitment letter may be submitted detailing the hospital's safety measures in case of fire and compliance to the inspection findings of the Bureau of Fire Protection.

All other issuances, which are not inconsistent herewith, shall remain in full force and effect.

This Circular takes effect 15 days after publication.

Lorna O. Fajardo
LORNA O. FAJARDO, CESO III
Office-in-Charge
Office of the President and CEO

Date Signed: AUG 19 2005

PHIC Form 1

Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

ACCREDITATION DEPARTMENT

12th Floor City State Centre Bldg., 709 Shaw Blvd. Oranbo, Pasig City
Tel No. 637-62-65 Trunk line 637-99-99 loc 1215, 1216, Telefax. 637-25-27

CHECKLIST OF REQUIREMENTS FOR HOSPITAL ACCREDITATION FOR REGIONS I – VI AND NCR

PHIC - SECONDARY DOH - PRIMARY CARE

NAME OF HOSPITAL: _____

ADDRESS: _____

_____ 1. PhilHealth application form properly accomplished.
_____ 2. Duly notarized Warranties of Accreditation.
_____ 3. DOH License issued 2005
_____ 4. PHA Certificate of Membership issued 2005
_____ 5. List of functional / serviceable equipment signed by Medical Director / Administrator (Annex A).
_____ 6. List of current hospital's room rates (Annex B).
_____ 7. List of current hospital service charges (Annex C).
_____ 8. Ancillary Licenses issued / revalidated 2005 - 2006.
  a.) Laboratory
  b.) X-ray
  c.) Pharmacy
_____ 9. Complete list of hospital staff with respective designation and signature (Annex D) Schedule of duties of medical, nursing staff and medical technologist/s.
_____ 10. Four Year Residency Training certificate in General Surgery of the Surgeon.
_____ 11. Residency Training certificate of the Anesthesiologist.
_____ 12. Accreditation fee by PMO payable to PHIC or cash paid directly to cashier and / or photocopy of OR from PRO. Accreditation fee is non-refundable.

Renewal - P4,000.00
Initial - P5,000.00
Re-accreditation - P5,000.00

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

_____ 13. Quality Assurance Program
_____ 14. Therapeutics Committee members and activities
_____ 15. Photocopy of Remittance Form I (RF1) for the last quarter. (for Private hospitals only)
_____ 16. Sanitary Permit of Dietary Section for the year 2005
_____ 17. Updated Health Certificate of Dietary personnel
_____ 18. Fire Safety Inspection Certificate for 2005.
_____ 19. International Classification of Diseases (ICD-10) Training Certificate
_____ 20. Financial Statement of the previous year

Additional Requirements for Initial Accreditation:

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

DOCUMENTS SUBMITTED:

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

Assessed / Evaluated By:

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

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

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

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

PhilHealth ACCREDITATION FORM
APPLICATION FOR ACCREDITATION (SECONDARY)

_____, 20__

THE PRESIDENT
Philippine Health Insurance Corporation
Pasig 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 Regulations 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.: _____ Fax No.: _____

Date established : _____ Date of Last Accreditation : _____

Chief / Medical Director : _____ Administrator : _____

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

Ownership / Management

( ) Single Proprietorship ( ) Cooperative
( ) Corporation ( ) Foundation
( ) National Government ( ) Local Government

Others, specify _____

A. PHYSICAL PLANT & ENVIRONMENT

1. Building
   - ( ) Concrete
   - ( ) Semi-concrete
   - ( ) Wood
   - ( ) Old structure
   - ( ) Renovated
   - ( ) New structure

2. Sanitation and 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 facilites ( ) Yes ( ) No

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

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

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

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

C. MANPOWER COMPLEMENT (Indicate the Number)

	Full Time	Part Time	Visiting
1. Medical Service			
a. Consultants:			
General 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 & X-ray			
a. Medical Technologist			
b. X-ray Technologist			
5. Dentist			
6. Dietitian			
7. Administrative Service			
8. Others			

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

D. CLINICAL FACILITIES

Emergency room
Doctor's / Consultation office
Clinical laboratory
Laboratory Lic. No. _____ valid from _____ to _____
X-ray facility
X-ray 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 functional or serviceable 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 logbook (Follow PhilHealth Cir. No. 56 s.1999 & No. 38 s.2000) [ ] Computerized

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

( ) Patient's chart
( ) Laboratory logbook

Case No.	Name of Patient	Age	Sex	Membership	Admitting Diagnosis	Type of Examination

( ) X-ray logbook

Case No.	Name of Patient	Age	Sex	Address	Membership	Admitting Diagnosis	Type of Examination	Date of Examination

( ) OPD logbook
( ) Outpatient surgical logbook
( ) Mandatory monthly hospital reports

H. QUALITY ASSURANCE PROGRAM OF THE INSTITUTION

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

ANNEX 4

NEW DRUGS AND DRUG PREPARATIONS INCLUDED IN THE PNDF VOL. ONE (1) SIXTH (6TH) EDITION

Section 12.0 ANTIDOTES

A. NEWLY LISTED DRUGS (compensable by March 1, 2005)

CATEGORY	ROUTE	PREPARATION
Bromocriptine (neuroleptic malignant syndrome)	Oral:	2.5 mg tablet (as mesilate)
Dimercaptopropane-sulphonate (DMPS) (for arsenic and methyl mercury poisoning)	Inj.:	100 mg/mL, 1 mL ampul, 10 mL vial (IM)
Lorazepam (for drug-induced seizures)	Inj.:	4 mg/mL, 1 mL ampul (IM,IV) (Also listed under Section 1.0 Drugs Acting on the Nervous System)
★ **Methylene blue (for severe methemoglobinemia)**	Oral:	1% solution 55 mg and 65 mg tablet
	Inj.:	10 mg/mL, 1 mL and 10 mL ampul/vial (IV)
Naltrexone (for narcotic addiction and alcoholism)	Oral:	50 mg tablet (as hydrochloride)

-Nothing follows-

B. NEWLY LISTED DRUG PREPARATIONS (compensable by March 1, 2005)

Note: The following drugs, in their generic/international non-proprietary names (INN), are already included in the 5th edition of the PNDF. Below are the newly listed preparations of these drugs as contained in the 6th (latest) edition of the PNDF.

GENERIC NAME	ROUTE	PREPARATION
Calcium folinate (leucoverin calcium for drug-induced megaloblastic anemia, formaldehyde and methyl alcohol poisoning and methotrexate toxicity)	Oral:	**15 mg capsule and 25 mg tablet (as anhydrous) (equiv. to 25 mg folinic acid)**
	Inj.:	**3 mg/mL, 1 mL ampul (IM, IV)** **10 mg/mL, 10 mL vial (IM, IV)** **15 mg/mL, 1 mL ampul (IM, IV)** **340 mg vial (IM, IV, IV infusion)**
Deferoxamine (1) (for iron poisoning)	Inj.:	**powder, 2 g vial (IM, IV, SC) (as mesilate)**
Flumazenil (for benzodiazepine poisoning)	Inj.:	**100 mcg/mL, 10 mL ampul (slow IV, IV infusion)**
Pyridoxine (Vitamin B6) (for isoniazid poisoning, hydrogen sulfide poisoning, gynomethrin mushroom poisoning and theophylline poisoning)	Inj.:	**100 mg/mL, 10 mL ampul (IM, IV) (as hydrochloride)**
★ Sodium nitrite (for cyanide poisoning)	Inj.:	**30 mg/mL, 10 mL ampul (IV)**

-Nothing follows-

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 the PhilHealth's duly authorized representative shall be accorded with courtesy and respect by the hospital management and staff during inspection / visitation / investigation of the institution,

6.3 That it shall cooperate in the inspection / visitation / investigation by making ready and available all hospital records (medical & financial) and other pertinent documents,

6.4 That it shall obey without delay summons, subpoena or subpoena duces tecum from the Corporation or Local Health Insurance Office.

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

_____

MEDICAL DIRECTOR / ADMINISTRATOR
(Signature over Printed Name)

SUBSCRIBED AND SWORN TO. this _____ day of _____ 20__

at _____.

_____

Notary Public

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

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

SECONDARY

ANNEX

LIST OF FUNCTIONAL / SERVICEABLE EQUIPMENT / APPARATUSES / INSTRUMENTS

NAME OF HOSPITAL: _____

ADDRESS: _____

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

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

Res. Cert. No.: _____

Issued at _____

Issued on _____

SECONDARY

Annex B

HOSPITAL'S BED RATES

NAME OF HOSPITAL : _____

ADDRESS : _____

CATEGORY : _____ ACCREDITATION NO.: _____

DOH BED CAPACITY : _____ EFFECTIVITY OF ACCREDITATION: _____

PHIC ACCREDITED BED : _____

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

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

_____
Date Accomplished

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

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

LIST OF CURRENT HOSPITAL SERVICE CHARGES

SERVICES	RATE
Laboratory procedure	
X-ray & other Radiologic procedures	
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 / Administrator's Signature over printed name

Res. Cert. No. _____

Issued at _____

Issued on _____

LIST OF HOSPITAL PERSONNEL

NAME	POSITION / SPECIALTY	EMPLOYMENT STATUS				PRC NO. for professionals	PHILHEALTH NO.	SIGNATURE
		FULLTIME	PARTTIME	VISITING	ON CALL			

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

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

_____
Date Accomplished

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

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

PHIC Form 1

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

CHECKLIST OF REQUIREMENTS FOR HOSPITAL ACCREDITATION FOR REGIONS I – VI AND NCR

PHIC - TERTIARY DOH – SECONDARY CARE

NAME OF HOSPITAL: _____

ADDRESS: _____

_____ 1. PhilHealth application form properly accomplished.
_____ 2. Duly notarized Warranties of Accreditation.
_____ 3. DOH License issued 2005.
_____ 4. PHA Certificate of Membership issued 2005.
_____ 5. List of functional / serviceable equipment signed by Medical Director/ Administrator (Annex A).
_____ 6. List of current hospital's room rates (Annex B).
_____ 7. List of current hospital service charges (Annex C).
_____ 8. Ancillary Licenses issued / revalidated 2005 - 2006.
a.) Laboratory
b.) X-ray
c.) Pharmacy
_____ 9. Departmentalized list of hospital staff with respective designation. (Annex D) Schedule of duties of medical, nursing staff and medical technologist/s.
_____ 10. Accreditation fee by PMO payable to PHIC or cash paid directly to cashier and / or photocopy of OR from PRO. Accreditation fee is non-refundable.

Renewal	-	**P8,000.00**
Initial	-	**P8,000.00**
Re-accreditation	-	**P8,000.00**

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

_____ 11. Therapeutics Committee members and activities.
_____ 12. Infection Control Committee members and activities.
_____ 13. Quality Assurance Program.
_____ 14. Photocopy of Remittance Form I (RF1) for the last quarter (for Private hospitals only).
_____ 15. Sanitary Permit of Dietary Section for the year 2005.
_____ 16. Updated Health Certificate of Dietary personnel.
_____ 17. Fire Safety Insurance Certificate for 2005.
_____ 18. International Classification of Diseases (ICD-10) Training Certificate.
_____ 19. Financial Statement of the previous year.

Additional Requirements for Initial Accreditation:

_____ 1. Current photograph of hospital facade and other available facilities.
_____ 2. Organizational chart.
_____ 3. Current standard operating procedures.
_____ 4. SEC License / DTI certificate / CDA certificate.
_____ 5. DOH licenses of three (3) previous successive years or see attached PhilHealth Cicular No. 30 s.2004 in lieu of said licenses.

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

Assessed / Evaluated By:
Receiving Clerk _____ Date _____
AQAO / MO _____ Date _____

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

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

Republic of the Philippines
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Tel No. 637-62-65 Trunk line 637-99-99 loc 1215, 1216, Telefax. 637-25-27
E-mail: www.philhealth.gov.ph

PhilHealth ACCREDITATION FORM
APPLICATION FOR ACCREDITATION (TERTIARY)

1 T

_____, 20__

THE PRESIDENT
Philippine Health Insurance Corporation
Pasig 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 Regulations 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.: _____ Fax No.: _____

Date established : _____ Date of Last Accreditation : _____

Chief / Medical Director : _____ Administrator : _____

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

Ownership / Management

( )	Single Proprietorship	( )	Cooperative
( )	Corporation	( )	Foundation
( )	National Government	( )	Local Government

Others, specify _____

A. PHYSICAL PLANT & ENVIRONMENT

1. Building

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

2. Sanitation and 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 facilites ( ) Yes ( ) No

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

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

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

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

C. MANPOWER COMPLEMENT (Indicate the Number)

	Full Time	Part Time	Visiting	Residents
1. Medical Service				
1.1. Consultants:				
a. Surgery				
General 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				
Neurology				
Oncology				
Psychiatry				
Pulmonary				
Rheumatology				
e. Pediatrics				
General Pediatrics				
Neonatology				
Other Pediatric Subspecialty				
f. Pathology				
g. Radiology				
h. Dental Medicine				

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

	Full Time	Part Time
3. Pharmacist		
a. Registered Pharmacist	_____	_____
b. Pharmacy Aides	_____	_____
4. Laboratory & X-ray		
a. Medical Technologist	_____	_____
b. X-ray Technologist	_____	_____
5. Dietary Service		
a. Dietitian	_____	_____
b. Food Servers	_____	_____
6. Engineering & Maintenance Service	_____	_____
7. Others, specify _____	_____	_____

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

D. MEDICAL FACILITIES

( ) Emergency room
( ) Out-patient department
( ) Clinical laboratory
Laboratory Lic. No. _____ valid from _____ to _____
( ) X-ray facility
X-ray Lic. No. _____ valid from _____ to _____
( ) Pharmacy Lic. No. _____ valid from _____ to _____
( ) Labor room & Delivery room
( ) Nursery room : No. of Bassinet / s _____ No. of Incubator / s _____
( ) Operating room complex: No. of Minor OR _____ No. of Major OR _____
( ) ICU
( ) Recovery room
( ) Dental service
( ) Central stock supply
( ) Dietary service
( ) 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, please specify _____

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

F. CLINICAL SERVICE

( ) General Medicine
( ) Subspecialty of Internal Medicine. Enumerate available subspecialty services:
_____
_____
( ) General Surgery
( ) Subspecialty of Surgery. Enumerate available subspecialty services:
_____
_____
( ) OB-Gyn
( ) General Pediatrics
( ) Subspecialty of Pediatrics. Enumerate available subspecialty services:
_____
_____

H T

( ) Opthalmology
( ) Otolaryngology

G. RECORDS

( ) Admission & discharge records
| | Prescribed logbook (Follow PhilHealth Cir. No. 56 s.1999, No. 38 s.2000 & No. 7 s.2002) | | Computerized

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

( ) OPD records
| | Logbook | | Index card | | Computerized
( ) Laboratory logbook

Case No.	Name of Patient	Age	Sex	Type of Examination	Date of Examination

( ) X-ray logbook

Case No.	Name of Patient	Age	Sex	Type of Examination	Date of Examination

( ) Major OR logbook

Case No.	Name of Patient	Age	Sex	Membership	Admitting Diagnosis	Procedure Done	Surgeon	Date of Operation

( ) DR logbook
( ) Minor surgical logbook
( ) Patient's chart
( ) Mandatory monthly hospital reports

H. QUALITY ASSURANCE PROGRAM OF THE INSTITUTION

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

PART II – WARRANTIES OF ACCREDITATION

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

_____
(**Hospital**)

located at _____ 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,
1.3. That it is a member of good standing of _____ duly recognized by PhilHealth with its
(**association**)
established standards and criteria,
1.4 That it has the human resources, equipment, physical structure and other requirements in conformity with standards established by the Corporation,
1.5 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,
2.5 That it shall strictly enforce a smoke-free policy within the premises of the health care institutions. Premises shall be understood to include all areas of a health care institution's compound regardless whether the same is inside or outside an enclosed structure.

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 at all times the required personnel, serviceable equipment and facilities for use of patients.

4. CLINICAL RECORDS AND PREPARATION OF CLAIMS

4.1 That the aforenamed health care institution shall maintain and accomplish at all times accurate chronological records of all patients, services rendered and health outcomes resulting from such services and health expenditures on patient care,
4.2 That it shall keep a neat and systematic records file in a safe but accessible place for easy retrieval,

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 ASC operation.

6. ASC 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 the PhilHealth's duly authorized representative shall be accorded with courtesy and respect by the ASC management and staff during inspection / visitation / investigation of the institution.
6.3 That it shall cooperate in the inspection / visitation / investigation by making ready and available all ASC records (medical & financial) and other pertinent documents,
6.4 That it shall obey without delay summons, subpoena or subpoena duces tecum from the Corporation or PhilHealth Regional 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 it Implementing Rules and Regulations and any of these Warranties of Accreditation.

_____
MEDICAL DIRECTOR / ADMINISTRATOR
(Signature over Printed Name)

SUBSCRIBED AND SWORN TO, this _____ day of _____, 20___

at _____.

_____
Notary Public

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

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

TERTIARY

ANNEX A

LIST OF FUNCTIONAL / SERVICEABLE EQUIPMENT / APPARATUSES / INSTRUMENTS

NAME OF HOSPITAL: _____

ADDRESS: _____

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

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

_____
Date Accomplished

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

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

TERTIARY

Annex B

HOSPITAL'S BED RATES

NAME OF HOSPITAL : _____

ADDRESS : _____

CATEGORY : _____ ACCREDITATION NO.: _____

DOH BED CAPACITY : _____ EFFECTIVITY OF ACCREDITATION: _____

PHIC ACCREDITED BED : _____

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

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

_____
Date Accomplished

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

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

TERTIARY

ANNEX C

LIST OF CURRENT HOSPITAL SERVICE CHARGES

SERVICES	RATE
Laboratory procedure	
X-ray & other Radiologic procedures	
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 / Administrator's Signature
over printed name

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

TERTIARY

ANNEX D

LIST OF HOSPITAL PERSONNEL

NAME	POSITION / SPECIALTY	EMPLOYMENT STATUS				PRC NO. for professionals	PHILHEALTH NO.	SIGNATURE
		FULLTIME	PARTTIME	VISITING	ON CALL			

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

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

Date Accomplished

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

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

2 T

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

CHECKLIST OF REQUIREMENTS FOR HOSPITAL ACCREDITATION FOR NCR & REGIONS I - XIII (TERTIARY)

NAME OF HOSPITAL: _____

ADDRESS: _____

_____ 1. PhilHealth application form properly accomplished.
_____ 2. Duly notarized Warranties of Accreditation.
_____ 3. DOH License issued 2003.
_____ 4. PHA / PHAP Certificate of Membership issued 2003.
_____ 5. List of functional / serviceable equipment signed by Medical Director / Administrator (Annex A).
_____ 6. List of current hospital's bed rates (Annex B).
_____ 7. List of current hospital service charges (Annex C).
_____ 8. Ancillary Licenses issued / revalidated 2002 - 2003.
  a.) Laboratory License
  b.) X-ray License
  c.) Hospital Pharmacy License
_____ 9. Complete / departmentalized list of hospital staff with respective designation indicating position as full time or part time and training if there are any (Annex D).
_____ 10. Accreditation fee of P3,000.00 for Tertiary Hospitals by postal money order payable to Philippine Health Insurance Corporation or cash paid directly to cashier and / or photocopy of OR from PRO.
_____ 11. Therapeutics Committee members and activities.
_____ 12. Antimicrobial resistance surveillance program, names of personnel involved or Infection Control Committee, with names of members and activities.
_____ 13. Ongoing Quality Assurance Program.
_____ 14. Photocopy of Remittance Form I (RF1) for the last quarter.
_____ 15. Sanitary permit of Dietary Section for the year 2003.
_____ 16. Updated Health Certificate of Dietary personnel.
_____ 17. Fire Safety Permit for 2003.

Additional Requirements for Initial Accreditation:

_____ 1. Current photographs of hospital façade, ER, Laboratory, Pharmacy, X-ray, Nursery, DR, OR, Recovery Room, ICU, Isolation Room, CR, Records, Business Office, Nurses Station, CSS and other available hospital facilities.
_____ 2. Current photograph of complete hospital staff.
_____ 3. Current standard operating procedures.
_____ 4. SEC License / DTI certificate / CDA certificate.
_____ 5. DOH licenses of three (3) previous successive years or Mayor's Permit.

DOCUMENTS SUBMITTED TO PRO:
Region: _____
Date Received: _____
Received By: _____
Date Refiled: _____

TO PHILHEALTH CENTRAL OFFICE:
Date Received: _____
Received By: _____
Received and Assessed By: _____

PRO staff are advised to strictly indicate the above data.

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

PhilHealth ACCREDITATION FORM 1 T
APPLICATION FOR ACCREDITATION (TERTIARY)

_____, 20__

THE PRESIDENT
Philippine Health Insurance Corporation
Pasig 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 Regulations 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.: _____ Fax No.: _____

Date established : _____ Date of Last Accreditation : _____

Chief / Medical Director : _____ Administrator : _____

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

Ownership / Management

( ) Single Proprietorship ( ) Cooperative
( ) Corporation ( ) Foundation
( ) National Government ( ) Local Government

Others, specify : _____

A. PHYSICAL PLANT & ENVIRONMENT

1. Building
( ) Concrete ( ) Old structure
( ) Semi-concrete ( ) Renovated
( ) Wood ( ) New structure

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

C. MANPOWER COMPLEMENT (Indicate the Number)

	Full Time	Part Time	Visiting	Residents
1. Medical Service				
1.1. Consultants:				
a. Surgery				
General 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				
Neurology				
Oncology				
Psychiatry				
Pulmonary				
Rheumatology				
e. Pediatrics				
General Pediatrics				
Neonatology				
Other Pediatric Subspeciality				
f. Pathology				
g. Radiology				
h. Dental Medicine				

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

3 T

	Full Time	Part Time
3. Pharmacist		
a. Registered Pharmacist	_____	_____
b. Pharmacy Aides	_____	_____
4. Laboratory & X-ray		
a. Medical Technologist	_____	_____
b. X-ray Technologist	_____	_____
5. Dietary Service		
a. Dietitian	_____	_____
b. Food Servers	_____	_____
6. Engineering & Maintenance Service	_____	_____
7. Others, specify _____	_____	_____

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

D MEDICAL FACILITIES

( ) Emergency room
( ) Out-patient department
( ) Clinical laboratory
Laboratory Lic. No. _____ valid from _____ to _____
( ) X-ray facility
X-ray Lic. No. _____ valid from _____ to _____
( ) Pharmacy Lic. No. _____ valid from _____ to _____
( ) Labor room & Delivery room
( ) Nursery room : No. of Bassinet / s _____ No. of Incubator / s _____
( ) Operating room complex: No. of Minor OR _____ No. of Major OR _____
( ) ICU
( ) Recovery room
( ) Dental service
( ) Central stock supply
( ) Dietary service
( ) 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, please specify _____

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

F CLINICAL SERVICE

( ) General Medicine
Subspecialty of Internal Medicine. Enumerate available subspecialty services:
_____
_____
General Surgery
Subspecialty of Surgery. Enumerate available subspecialty services:
_____
_____
OB-Gyn
General Pediatrics
Subspecialty of Pediatrics. Enumerate available subspecialty services:
_____
_____

( ) Opthalmology
( ) Otolaryngology

G. RECORDS

( ) Admission & discharge records
[ ] Prescribed logbook (Follow PhilHealth Cir. No. 56 s.1999, No. 38 s.2000 & No. 7 s.2002) [ ] Computerized

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

( ) OPD records
[ ] Logbook [ ] Index card [ ] Computerized
( ) Laboratory logbook

Case No.	Name of Patient	Age	Sex	Type of Examination	Date of Examination

( ) X-ray logbook

Case No.	Name of Patient	Age	Sex	Type of Examination	Date of Examination

( ) Major OR logbook

Case No.	Name of Patient	Age	Sex	Membership	Admitting Diagnosis	Procedure Done	Surgeon	Date of Operation

( ) DR logbook
( ) Minor surgical logbook
( ) Patient's chart
( ) Mandatory monthly hospital reports

H. QUALITY ASSURANCE PROGRAM OF THE INSTITUTION

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

PART II – WARRANTIES OF ACCREDITATION

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

_____
(Hospital)

located at _____ 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,
1.3. That it is a member of good standing of _____ duly recognized by PhilHealth with its
(association)
established standards and criteria,
1.4 That it has the human resources, equipment, physical structure and other requirements in conformity with standards established by the Corporation,
1.5 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,
2.5 That it shall strictly enforce a smoke-free policy within the premises of the health care institutions. Premises shall be understood to include all areas of a health care institution's compound regardless whether the same is inside or outside an enclosed structure.

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 at all times the required personnel, serviceable equipment and facilities for use of patients.

4. CLINICAL RECORDS AND PREPARATION OF CLAIMS

4.1 That the aforenamed health care institution shall maintain and accomplish at all times accurate chronological records of all patients, services rendered and health outcomes resulting from such services and health expenditures on patient care.
4.2 That it shall keep a neat and systematic records file in a safe but accessible place for easy retrieval.

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 ASC operation.

6. ASC 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 the PhilHealth's duly authorized representative shall be accorded with courtesy and respect by the ASC management and staff during inspection / visitation / investigation of the institution.

6.3 That it shall cooperate in the inspection / visitation / investigation by making ready and available all ASC records (medical & financial) and other pertinent documents.

6.4 That it shall obey without delay summons, subpoena or subpoena duces tecum from the Corporation or PhilHealth Regional 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 it Implementing Rules and Regulations and any of these Warranties of Accreditation.

_____

MEDICAL DIRECTOR / ADMINISTRATOR
(Signature over Printed Name)

SUBSCRIBED AND SWORN TO, this _____ day of _____, 20__

at _____.

_____

Notary Public

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

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

TERTIARY

ANNEX A

LIST OF FUNCTIONAL / SERVICEABLE EQUIPMENT / APPARATUSES / INSTRUMENTS

NAME OF HOSPITAL: _____

ADDRESS: _____

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

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

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

TERTIARY

Annex B

HOSPITAL'S BED RATES

NAME OF HOSPITAL :
ADDRESS :
CATEGORY :
DOH BED CAPACITY :
PHIC ACCREDITED BED :

ACCREDITATION NO.:
EFFECTIVITY OF ACCREDITATION:

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

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

Date Accomplished

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

Res. Cert. No.
Issued at
Issued on

TERTIARY

ANNEX C

LIST OF CURRENT HOSPITAL SERVICE CHARGES

SERVICES	RATE
Laboratory procedure	
X-ray & other Radiologic procedures	
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 / Administrator's Signature over printed name

Res. Cert. No. _____

Issued at _____

Issued on _____

TERTIARY

ANNEX D

LIST OF HOSPITAL PERSONNEL

NAME	POSITION / SPECIALTY	EMPLOYMENT STATUS				PRC NO. for professionals	PHILHEALTH NO.	SIGNATURE
		FULLTIME	PARTTIME	VISITING	ON CALL			

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

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

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

Date Accomplished

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

PHIC Form 1

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

CHECKLIST OF REQUIREMENTS FOR AMBULATORY SURGICAL CLINIC ACCREDITATION FOR REGIONS I – VI AND NCR

NAME OF ASC: _____
ADDRESS: _____

_____ 1. PhilHealth application form properly accomplished.
_____ 2. Duly notarized Warranties of Accreditation.
_____ 3. DOH Accreditation Certificate issued 2005.
_____ 4 . Complete list of ASC staff with respective designation (Annex B).
_____ 5. List of functional / serviceable equipment signed by Medical Director/ Administrator (Annex A).
_____ 6. List of surgical procedures being performed.
_____ 7. List of current service charges (Annex C).
_____ 8. Ancillary Licenses issued/revalidated 2005-2006, ***(if provided in-house it should comply with the requirements)***
a.) Laboratory
b.) X-ray
c.) Pharmacy
_____ 9. Certificate of affiliation of Surgeon in a Tertiary hospital
_____ 10. Memorandum of Agreement (MOA) between Tertiary hospital nearest to the clinic.
_____ 11 TIN of the proprietor for single proprietorship or that of the managing partner of the corporation as the case maybe.
_____ 12. Accreditation fee by PMO payable to PHIC or cash paid directly to cashier and / or photocopy of OR from PRO. Accreditation fee is non-refundable.

Renewal	-	**P4,000.00**
Initial	-	**P5,000.00**
Re-accreditation	-	**P5,000.00**

(see attached PhilHealth Circular No. 29, s.2004 and Payment Scheme)
_____ 13. Quality Assurance Program.
_____ 14. Photocopy of Remittance Form I (RF1) for the last quarter.
_____ 15. Fire Safety Insurance Certificate for 2005.
_____ 16. Sanitary Permit for 2005.
_____ 17. International Classification of Diseases Training Certificate.
_____ 18. Financial Statement of the previous year.

Additional Requirements for Initial Accreditation:

_____ 1. Current photograph of ASC facade and other available facilities.
_____ 2. Organizational Chart of ASC.
_____ 3. Current standard operating procedures.
_____ 4. SEC License / DTI certificate / CDA certificate.
_____ 5. Professional Tax Receipt (PTR) of practitioner staff of the clinic.
_____ 6. DOH accreditation of three (3) previous successive years.
_____ 7. Mayor's Permit of three (3) previous successive years in lieu of the DOH accreditation.

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

Assessed / Evaluated By:
Receiving Clerk _____ Date _____
AQAO / MO _____ Date _____
Returned By _____ Date _____

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

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

Revised Checklist
MMC 011005

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

PhilHealth ACCREDITATION FORM 1 ASC
APPLICATION FOR ACCREDITATION (ASC)

_____, 20___

THE PRESIDENT
Philippine Health Insurance Corporation
Pasig 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 Regulations thereto. For this purpose, I hereby submit the following pertinent information and documentary requirements.

PART I - GENERAL INFORMATION

Name of ASC : _____

Complete Address : _____ Postal Code : _____

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

Date established : _____ Date of Last Accreditation : _____

Chief / Medical Director : _____ Administrator : _____

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

Ownership / Management

( ) Single Proprietorship ( ) Cooperative
( ) Corporation ( ) Foundation
( ) Others, specify _____

A. PHYSICAL PLANT & ENVIRONMENT

1. Building
   ( ) Concrete ( ) Old structure
   ( ) Semi-concrete ( ) Renovated
   ( ) Wood ( ) New structure

2. Sanitation and 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 facilites ( ) 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 since last accreditation ?
( ) Yes ( ) No If yes, when ? _____ What ?

_____

B. RECOVERY ROOM BEDS _____ (Indicate the number)

C. MANPOWER COMPLEMENT (Indicate the Number)

1. Medical Service. Member of a medical staff of a Tertiary hospital located within a reasonable distance from the clinic.

a. Consultants:	Full Time	Part Time	Visiting
General Surgery			
Sub-surgical Specialty			
OR-Gyn			
Pediatrics			
Internal Medicine			
Pathology			
Radiology			
Dental			
Certified Anesthesiologist			
b. Residents			
2. Nursing Service			
a. Registered Nurse			
b. Registered Midwives			
c. Nursing Aides			
3. Pharmacist			
4. Laboratory & X-ray			
a. Medical Technologist			
b. X-ray Technologist			
5. Dentist			
6. Administrative Service			
7. UW/IW			
8. Others			

NOTE : Submit complete list of hospital personnel (See Annex B) with conforme appointment.

D. CLINICAL FACILITIES

1. Administrative Services:
   a. Lobby
      ( ) Information Counter / admitting area
      ( ) Communication area
      ( ) Waiting area
      ( ) Toilet facilities

b. Business office
( ) Cashier / billing
( ) Finance / budget / auditor
( ) Toilet facilities

2. Surgical Service Complex
( ) Major operating room w / airconditioning unit
( ) Minor operating room w / airconditioning unit
( ) Scrub-up area
( ) Sterile instrument, supply and anesthesia storage area
( ) Sub-sterilization room
( ) Clean-up area
( ) Doctors locker room and lounge w / comfort room
( ) Nurses locker room and lounge w / comfort room
( ) IW / UW 's closet
( ) Central sterilization and supply area
( ) Receiving and releasing area

3. ( ) Recovery Room Area with toilet facilities
4. ( ) Clinical laboratory (optional)
Laboratory Lic. No. _____ valid from _____ to _____
Affiliation ( ) Yes ( ) No If yes, specify _____
- Laboratory Lic. No. _____ valid from _____ to _____
5. ( ) X-ray facility (optional)
X-ray Lic. No. _____ valid from _____ to _____
Affiliation ( ) Yes ( ) No If yes, specify _____
- X-ray Lic. No. _____ valid from _____ to _____
6. ( ) Pharmacy (optional)
Pharmacy Lic. No. _____ valid from _____ to _____
7. ( ) Dental room
8. ( ) Others, please specify _____

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

F. CLINICAL SERVICE

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

G. RECORDS

( ) Out patient Surgical Logbook
[ ] Prescribed logbook (Follow PhilHealth Cir. No. 56 s.1999, No. 38 s.2000 & No. 7 s.2002) [ ] Computerized
Others, specify _____
( ) Laboratory logbook (optional)

Case No.	Name of Patient	Age	Sex	Type of Examination	Date of Examination

( ) X-ray logbook (optional)

Case No.	Name of Patient	Age	Sex	Type of Examination	Date of Examination

H. QUALITY ASSURANCE PROGRAM OF THE INSTITUTION

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

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PART II – WARRANTIES OF ACCREDITATION

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

_____
(**Hospital**)

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,
1.3. That it is a member of good standing of _____ duly recognized by PhilHealth with its
(**association**)
established standards and criteria,
1.4 That it has the human resources, equipment, physical structure and other requirements in conformity with standards established by the Corporation,
1.5 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,
2.5 That it shall strictly enforce a smoke-free policy within the premises of the health care institutions. Premises shall be understood to include all areas of a health care institution's compound regardless whether the same is inside or outside an enclosed structure.

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 at all times the required personnel, serviceable equipment and facilities for use of patients.

4. **CLINICAL RECORDS AND PREPARATION OF CLAIMS**

4.1 That the aforenamed health care institution shall maintain and accomplish at all times accurate chronological records of all patients, services rendered and health outcomes resulting from such services and health expenditures on patient care,
4.2 That it shall keep a neat and systematic records file in a safe but accessible place for easy retrieval,

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 ASC operation.

6. ASC 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 the PhilHealth's duly authorized representative shall be accorded with courtesy and respect by the ASC management and staff during inspection / visitation / investigation of the institution.
6.3 That it shall cooperate in the inspection / visitation / investigation by making ready and available all ASC records (medical & financial) and other pertinent documents,
6.4 That it shall obey without delay summons, subpoena or subpoena duces tecum from the Corporation or PhilHealth Regional 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 it Implementing Rules and Regulations and any of these Warranties of Accreditation.

_____
MEDICAL DIRECTOR / ADMINISTRATOR
(Signature over Printed Name)

SUBSCRIBED AND SWORN TO, this _____ day of _____. 20__

at _____.

_____
Notary Public

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

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

ASC

ANNEX A

LIST OF FUNCTIONAL / SERVICEABLE EQUIPMENT / APPARATUSES / INSTRUMENTS

NAME OF ASC : _____

ADDRESS: _____

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

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

_____

Date Accomplished

_____

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

Res. Cert. No.: _____

Issued at : _____

Issued on : _____

LIST OF ASC PERSONNEL

NAME	POSITION / SPECIALTY	EMPLOYMENT STATUS				PRC NO. for professionals	PHILHEALTH NO.	SIGNATURE
		FULLTIME	PARTTIME	VISITING	ON CALL			

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

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

_____
Date Accomplished

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

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

LIST OF CURRENT ASC SERVICE CHARGES

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

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

Date Accomplished

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

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

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

CHECKLIST OF REQUIREMENTS FOR HOSPITAL ACCREDITATION FOR REGIONS I – VI AND NCR

PHIC - PRIMARY DOH - INFIRMARY

NAME OF HOSPITAL: _____

ADDRESS: _____

_____ 1. PhilHealth application form properly accomplished.
_____ 2. Duly notarized Warranties of Accreditation.
_____ 3. DOH License issued 2005
_____ 4. PHA Certificate of Membership issued 2005.
_____ 5. List of functional / serviceable equipment signed by Medical Director/ Administrator (Annex A).
_____ 6. List of current hospital's room rates (Annex B).
_____ 7. List of current hospital service charges (Annex C).
_____ 8. Ancillary Licenses issued / revalidated 2005 - 2006.
a.) Laboratory (optional)
b.) X-ray (optional)
c.) Pharmacy (optional)

NOTE: ***If a certain ancillary service is present, it should comply with the requirements.***

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

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

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

_____ 12. Quality Assurance Program.
_____ 13. Photocopy of Remittance Form 1 (RF1) for the last quarter (for Private hospitals only).
_____ 14. Updated Health Certificate of Kitchen personnel.
_____ 15. Sanitary Permit for 2005.
_____ 16. Fire Safety Insurance Certificate for 2005.
_____ 17. International Classification of Diseases (ICD-10) Training Certificate.
_____ 18. Financial Statement of the previous year.

Additional Requirements for Initial Accreditation:

_____ 1. Current photograph of hospital facade and other available facilities.
_____ 2. Organizational Chart.
_____ 3. Current standard operating procedures.
_____ 4. SEC License / DTI certificate / CDA certificate.
_____ 5. DOH licenses of three (3) previous successive years
_____ 6. Mayor's Permit of three (3) previous successive years in lieu of the DOH license.

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

Assessed / Evaluated By:
Receiving Clerk _____ Date _____
AQAO / MO _____ Date _____
Returned By _____ Date _____

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

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

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

PhilHealth ACCREDITATION FORM
APPLICATION FOR ACCREDITATION (PRIMARY)

1 P

_____, 20__

THE PRESIDENT
Philippine Health Insurance Corporation
Pasig 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 Regulations 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.: _____ Fax No.: _____

Date established : _____ Date of Last Accreditation : _____

Chief / Medical Director : _____ Administrator : _____

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

Ownership / Management

( )	Single Proprietorship	( )	Cooperative
( )	Corporation	( )	Foundation
( )	National Government	( )	Local Government

Others, specify _____

A. PHYSICAL PLANT & ENVIRONMENT

1. Building

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

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

C. MANPOWER COMPLEMENT (Indicate the Number)

	Full Time	Part Time	Visiting
1. Medical Service			
a. Consultants:			
General 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 (optional)			
4. Laboratory & X-ray (optional)			
a. Medical Technologist			
b. X-ray Technologist			
5. Dentist			
6. Cook / Food Handlers			
7. Administrative Service			
8. Others			

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

D. CLINICAL FACILITIES

( ) Emergency room
( ) Doctor's / Consultation office
( ) Clinical laboratory (optional)
Laboratory Lic. No. _____ valid from _____ to _____
Affiliation ( ) Yes ( ) No If yes, specify _____
- Laboratory Lic. No. _____ valid from _____ to _____

( ) X-ray facility (optional)
X-ray Lic. No. _____ valid from _____ to _____
Affiliation ( ) Yes ( ) No If yes, specify _____
- X-ray Lic. No. _____ valid from _____ to _____
( ) Pharmacy (optional)
Pharmacy Lic. No. _____ valid from _____ to _____
( ) Dental room
( ) Drug room
( ) Labor room
( ) Delivery room
( ) Recovery room
( ) Medical Records room
( ) Kitchen
( ) Others, please specify _____

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

F. CLINICAL SERVICE

( ) General Medicine
( ) OB - Gyn (If with DR)
( ) Others, specify _____

G. RECORDS

( ) Admission & discharge records
[ ] Prescribed logbook (Follow PhilHealth Clr. No. 56 s.1999 & No. 38 s.2000) [ ] Computerized

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

( ) Patient's chart
( ) Laboratory logbook (optional)

Case No.	Name of Patient	Age	Sex	Membership	Admitting Diagnosis	Type of Examination

( ) X-ray logbook (optional)

Case No.	Name of Patient	Age	Sex	Address	Membership	Admitting Diagnosis	Type of Examination	Date of Examination

( ) OPD logbook
( ) Outpatient surgical logbook (Minor surgery)
( ) Mandatory monthly hospital reports

H. QUALITY ASSURANCE PROGRAM OF THE INSTITUTION

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

PART II – WARRANTIES OF ACCREDITATION

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

_____
(**Hospital**)

located at _____ 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,
1.3. That it is a member of good standing of _____ duly recognized by PhilHealth with its
(**association**)
established standards and criteria,
1.4 That it has the human resources, equipment, physical structure and other requirements in conformity with standards established by the Corporation,
1.5 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,
2.5 That it shall strictly enforce a smoke-free policy within the premises of the health care institutions. Premises shall be understood to include all areas of a health care institution's compound regardless whether the same is inside or outside an enclosed structure.

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 at all times the required personnel, serviceable equipment and facilities for use of patients.

4. CLINICAL RECORDS AND PREPARATION OF CLAIMS

4.1 That the aforenamed health care institution shall maintain and accomplish at all times accurate chronological records of all patients, services rendered and health outcomes resulting from such services and health expenditures on patient care,
4.2 That it shall keep a neat and systematic records file in a safe but accessible place for easy retrieval,

4.3 That it shall undertake measures to enter only true and correct data in all patients records and in the preparation of claims and ensure the filing of legitimate claims within the sixty (60) calendar days after the patients discharge,

4.4 That I, acting on behalf of this institution, together with the concerned personnel, shall take full responsibility for any omission or commission in the preparation of claims and in the entry of clinical records.

5. MANAGEMENT INFORMATION SYSTEM

5.1 That the 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 the PhilHealth's duly authorized representative shall be accorded with courtesy and respect by the hospital management and staff during inspection / visitation / investigation of the institution,

6.3 That it shall cooperate in the inspection / visitation / investigation by making ready and available all hospital records (medical & financial) and other pertinent documents,

6.4 That it shall obey without delay summons, subpoena or subpoena duces tecum from the Corporation or Local Health Insurance Office.

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

_____

MEDICAL DIRECTOR / ADMINISTRATOR
(Signature over Printed Name)

SUBSCRIBED AND SWORN TO, this _____ day of _____, 20__

at _____.

_____

Notary Public

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

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

PRIMARY

ANNEX

LIST OF FUNCTIONAL / SERVICEABLE EQUIPMENT / APPARATUSES / INSTRUMENTS

NAME OF HOSPITAL: _____

ADDRESS: _____

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

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

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

PRIMARY

Annex B

HOSPITAL'S BED RATES

NAME OF HOSPITAL : _____

ADDRESS : _____

CATEGORY : _____ ACCREDITATION NO.: _____

DOH BED CAPACITY : _____ EFFECTIVITY OF ACCREDITATION: _____

PHIC ACCREDITED BED : _____

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

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

_____
Date Accomplished

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

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

LIST OF CURRENT HOSPITAL SERVICE CHARGES

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

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

Date Accomplished

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

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

PRIMARY

ANNEX D

LIST OF HOSPITAL PERSONNEL

NAME	POSITION / SPECIALTY	EMPLOYMENT STATUS				PRC NO. for professionals	PHILHEALTH NO.	SIGNATURE
		FULLTIME	PARTTIME	VISITING	ON CALL			

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

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

_____
Date Accomplished

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

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

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