Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Healthline 637-9999 *www.philhealth.gov.ph*

PHILHEALTH CIRCULAR
No. 21, s-2007

TO : ALL ACCREDITED INSTITUTIONAL HEALTH CARE PROVIDERS, LOCAL GOVERNMENT UNITS AND ALL OTHERS CONCERNED

SUBJECT : Three-in-One (3 in 1) Accreditation

I. RATIONALE

Consistent with the thrust of the corporation to facilitate the accreditation of Health Care Providers (HCPs) and reduce administrative costs for the corporation and its stakeholders, the "3 in 1 Accreditation" shall be adopted.

This new scheme aims to simplify the process of accreditation by allowing a single application form to be utilized by the facility that intends to provide all the following packages:

a. Outpatient Primary Care Benefit (OPB) Package;
b. Maternity Care (MC) Package; and,
c. Directly Observed Treatment Short Course (DOTS) Package.

II. ELIGIBILITY

All **government** HCPs nationwide that have the capability to deliver the OPB, MC and DOTS Packages may avail of the "3 in 1 Accreditation".

III. PROCESS OF ACCREDITATION

1. The applicant shall accomplish and submit the "3 in 1" notarized application form (*see Annex A*).
2. In addition to the duly accomplished and notarized "3 in 1" application form, the documentary requirements provided for in Part IV of this Circular, shall be submitted to the appropriate PhilHealth office.
3. PhilHealth shall review the completeness of the submitted documents.
4. If found complete, the applicant shall pay Php1,000.00 as accreditation fee.
5. The applicant facility shall be scheduled for pre-accreditation survey within 15 days from receipt of the application documents. The concerned LGU will be notified of the date of the said visit.
6. The Accreditation Department/Unit of the Central Office (CO)/PhilHealth Regional Office (PRO) shall conduct pre-accreditation survey to validate the capability of the facility to provide the services of the OPB, MC and DOTS Packages.

7. Post survey reports:
   7.1 By the Accreditation Units of the PRO:
      7.1.1 Accomplishes the post survey report.
      7.1.2 Recommends the status of accreditation (to approve or deny accreditation) of the applicant facility.
      7.1.3 Retains a copy of the accreditation documents and forwards the original application and documentary requirements to the Accreditation Department, CO.
   7.2 By the Accreditation Department, CO:
      7.2.1 Accomplishes the post survey report.
      7.2.2 Recommends the status of accreditation (to approve or deny accreditation) of the applicant facility.
8. All submitted documents for the "3 in 1" applications for initial or re-accreditation shall be included in the succeeding Accreditation Committee Meeting. Applications for renewal of accreditation will be included in the agenda of the Subcommittee Meeting for deliberation.
9. All concerned PhilHealth offices will be informed of the status of applications for accreditation upon the deliberation of the Accreditation Committee/Subcommittee.
10. All health facilities approved for the "3 in 1" accreditation are issued only 1 Certificate of Accreditation as providers of the 3 outpatient benefit packages.
11. The validity of accreditation shall be for one year or shall be based on PhilHealth Circular 11, s. 2006 re: Renewal of Accreditation of Out Patient Clinics.

IV. DOCUMENTARY REQUIREMENTS

A. INITIAL ACCREDITATION/RE-ACCREDITATION

1. PhilHealth application form - properly accomplished and notarized;
2. Complete list of staff with respective designations;
3. Photocopy of updated PRC licenses of the RHU/HC physician, nurses, midwives and medical technologists or certified true copy of the PRC claim stub or certification of good standing from PRC indicating the validity of the license;
4. Organizational chart of the facility;
5. Validated Remittance Form I (RF-1)/proofs of PhilHealth premium contributions of the RHU/HC/facility personnel;
6. Memoranda of Agreement (MOA):
   6.1 Between LGU and PhilHealth (if available);
   6.2 With referral x-ray facility (if needed);
   6.3 With referral laboratory facility (if needed);
   6.4 Inter-local Health Zone MOA (if needed, for RHUs/HCs without the capability of delivering laboratory examinations and/or share manpower resources);
   6.5 With hospital of higher level to admit referred cases for the Maternity Package;

6.6 With a partner physician/s for MCP for midwife run/owned facilities (if necessary); and
6.7 With ambulance/transport service for MCP (if necessary).

7. List of available drugs in the facility;
8. Flow chart of activities of patients of OPB, MC and DOTS;
9. Standard Operating Procedures;
10. Quality Assurance Programs/Activities;
11. Current photograph of the RHU/HC/facility;
12. Current photograph of the complete facility staff;
13. Location map of the facility;
14. Accreditation fee of Php1,000.00 by postal money order payable to Philippine Health Insurance Corporation or cash paid directly to the cashier (accreditation fee is non-refundable);
    Note: For discounts in accreditation fees, please refer to PhilHealth Circular 29 s. 2004
15. Additional Requirements (Certificates/Certifications, if available):
    15.1 Sentrong Sigla Certificate and
    15.2 Philippine Coalition Against TB (PhilCAT)/National Coordinating Committee – Private Public Mixed DOTS (NCC-PPMD) Certificate

B. RENEWAL OF ACCREDITATION

1. PhilHealth application form, properly accomplished and notarized;
2. Photocopy of updated PRC licenses of the RHU/HC physician, nurses, midwives and medical technologists or certified true copy of the PRC claim stub or certification of good standing from PRC indicating the validity of the license;
3. Validated Remittance Form I (RF-1)/proofs of PhilHealth premium contributions of the RHU/HC/facility personnel;
4. Quality Assurance Programs/Activities;
5. Location map of the facility (in case of transfer of location); and
6. Accreditation fee of Php1,000.00 by postal money order payable to Philippine Health Insurance Corporation or cash paid directly to the cashier (accreditation fee is non-refundable).

V. OTHER PROVISIONS

All LGUs applying for accreditation of their facilities which can only provide two (2) out-patient packages shall pay the following accreditation fees:

Benefit Packages	Accreditation Fee
OPB and MCP	Php 1,500.00
OPB and DOTS	Php 1,000.00
MCP and DOTS	Php 1,500.00

The accreditation fees also apply to **private** out-patient facilities capable of providing both Maternity Care and DOTS Packages.

VI. REPEALING CLAUSE

All previous policies and guidelines, and other administrative issuances with provisions inconsistent herewith are hereby amended, modified, superseded, repealed and/or revoked accordingly.

VII. EFFECTIVITY

This Circular shall take effect 15 days after its publication in the Official Gazette or in a newspaper of general circulation.

Lorna O. Fajardo

LORNA O. FAJARDO, CESO III
Acting President & CEO
Date signed: 12/26/07

Annex A

Republic of the Phillippines
PHILIPPINE HEALTH INSURANCE CORPORATION
City State 709 Shaw Blvd., Pasig City
Tel. No. 637-6265, www.philhealth.gov.ph

PHIC Form RHU-AF-3
0712/07

Application Form for Government-owned Facilities as Providers of OPB, MCP and/or DOTS Packages and Private Facilities as Providers of MCP and/or DOTS Packages

☐ **OPB Services** ☐ **TB DOTS** ☐ **Maternity Care**
(Please check the appropriate package)

_____
(Date)

THE PRESIDENT
Philippine Health Insurance Corporation
Pasig City, Philippines

SIR/MADAM:

I, _____, Filipino, of legal age, _____ with address at
(Position/ Designation)
_____ and the duly authorized representative to act for and in behalf of

_____, hereby applies for accreditation under Sec. 16 L of R.A. 7875 as amended by R.A. 9241
(Health Care Facility)
and its Implementing Rules and Regulations thereto. For this purpose, I hereby submit the following pertinent information and documentary requirements

GENERAL INFORMATION

Name of Out Patient Facility: _____
Complete Address: _____
_____ **Zip Code** _____
Telephone No. _____ **Fax No:** _____ **E-mail Address:** _____
Date Established: _____ **Director/MHO/CHO** _____
Hospital Affiliation/s: _____
Other Affiliations for Diagnostic Services: _____
Nature of Ownership: ☐ Government ☐ Private
Type of Application: ☐ Initial ☐ Renewal ☐ Re-accreditation

(Please check the box if the item is available in the facility, if not, write the alternative beside the item)

I. CLINIC FACILITY

A. General Infrastructure

1. Building
☐ Concrete ☐ Wood ☐ Renovated
☐ Semi-concrete ☐ Old Structure ☐ New Structure

2. Sanitation and Safety
Water supply
☐ Local Water District Syste ☐ Electricity ☐ Covered garbage containers with color-coded segregation
☐ Deep Well ☐ Fire Exit ☐ Separate receptacle for disposable pointed/sharp objects
☐ Artesian Well ☐ Fire extinguisher

3. Clinic Facility:
☐ Receiving area
☐ Generally clean environment
☐ Sufficient seats at waiting area
No of seats: ☐ ≤ 5 ☐ ≤ 10 ☐ ≤ 20
☐ Adequate lighting
☐ Adequate ventilation
☐ Examination room / cubicle with privacy
☐ Examination table with clean linen
☐ Toilet facility for clients
☐ Separate toilet facility for personnel
☐ Area for cleaning instruments
☐ Delivery room with delivery table
☐ Area for cleaning/resuscitation of newborn (for MCC only)
☐ Recovery area with bed/s
☐ Sputum collection area with hand washing facility (For TB DOTS only)
☐ Well ventilated sputum microscopy area
☐ Large & clear sign bearing the name of the Health Facility
☐ Additional sign indicating it is a "PhilHealth Provider for Out Patient Benefit Packages" (for renewal only)
☐ Additional sign indicating it's service components

B. Equipment and Supplies

1. General Requirements
☐ Sphygmomanometer
☐ Stethoscope
☐ Thermometer (oral)
☐ Thermometer (rectal)
☐ Tape measure
☐ Lubrication jelly
☐ Disposable needles and syringes
☐ Disposable gloves
☐ Sterile cotton balls
☐ Sterile cotton swabs
☐ Applicator sticks
☐ Vaginal speculum (large)
☐ Vaginal speculum (small)
☐ Weighing scale (adult)
☐ Weighing scale (infant)
☐ Decontamination solutions
☐ 70% Isopropyl alcohol
☐ Used sharps container
☐ Covered pan and stove or sterilizer
☐ Cabinet for storage of sterile instruments and supplies

1.a Requirements for Laboratory Services (optional for those with referral laboratory facilities)

- ☐ Centrifuge
- ☐ Microscope*
- ☐ Counting chamber
- ☐ Glass slides and cover slips*
- ☐ Heparinized test tubes or capillettes
- ☐ Test tubes
- ☐ Blood lancets
- ☐ Sucking tube
- ☐ WBC diluting pipette
- ☐ WBC diluting fluid
- ☐ Reagents*
- ☐ 3% Acetic Acid
- ☐ Test strips for qualitative urine analysis

* Required for TB DOTS microscopy

1.b Requirements for Maternity Care Clinics

Equipment:

- ☐ Ambu bag (adult)
- ☐ Ambu bag (pedia)
- ☐ Bassinet/newborn carrier
- ☐ Stool
- ☐ Foot stool
- ☐ Kelly pad
- ☐ Pail
- ☐ Gooseneck lamp (2)
- ☐ IV stand
- ☐ Oxygen tank (5 lbs. minimum)
- ☐ Oxygen gauge/regulator, tubings and mask
- ☐ Rubber suction bulb
- ☐ Suction apparatus
- ☐ Portable emergency light or flashlight
- ☐ Wall clock with second hand
- ☐ Instrument cabinet
- ☐ Instrument table
- ☐ Iodine cup
- ☐ Stainless steel instrument tray with cover
- ☐ Stainless steel instrument tray without cover
- ☐ Stainless bowl (kidney shape)
- ☐ Stainless bowl (round shape)
- ☐ Haemostatic straight forceps (4)
- ☐ Needle holder (2)
- ☐ Sponge holding forceps
- ☐ Surgical scissors - straight (2)
- ☐ Tissue forceps 6" - regular (2)
- ☐ Ovum forceps 10'
- ☐ Uterine forceps 10" (optional)
- ☐ Uterine sound 12" (optional)

Supplies:

- ☐ Butterfly set (G19)
- ☐ D5LR solution
- ☐ IV tubing
- ☐ Plaster
- ☐ Nasal cannula
- ☐ Povidone iodine solution
- ☐ Soaking/Sterilizing solution
- ☐ Sterile cutting needle
- ☐ Sterile round needle
- ☐ Sterile absorbable suture with/without needle
- ☐ DR gown/scrub suit
- ☐ Bed sheets
- ☐ Linen for bassinet/newborn carrier
- ☐ Plastic apron
- ☐ Surgical masks
- ☐ Surgical cap
- ☐ Sterile gauze
- ☐ Sterile drapes
- ☐ Sterile cord clips/ties for baby
- ☐ Erythromycin ophthalmic ointment (0.5%)
- ☐ Vitamin K ampule
- ☐ Xylocaine/Lidocaine
- ☐ Methergin
- ☐ Tetanus Toxoid
- ☐ Oral contraceptive pills
- ☐ D-Medroxyprogesterone Acetate (DMPA)
- ☐ Intrauterine Device (copper T)

C. Means of Transport

- ☐ Transport vehicle for patient's use
- ☐ Contract with providers of ambulance services

II. CLINIC STAFF *(Please fill-up as applicable; Use separate sheet for additional staff, if necessary)*

	Name	PRC #	Validity	PHIC No.	Signature
For OPB Services and TB DOTS					
Clinical Service					
Physician					
Nurse					
Medical Technologist / Microscopist					
Midwife					
Additional for MCC					
Provider (Midwife/Physician)					
Provider (Midwife/Physician)					
Partner OB Physician					
Partner Pedia Physician					
Clinic Aide		N/A	N/A		
Additional for DOTS					
Administrative Service					
Administrative Officer		N/A	N/A		
Diagnostic Committee					
Radiologist					
Pulmonologist					
Infectious Disease					

III. SERVICE CAPABILITY

A. OPB Consultative Services

- ☐ Pediatrics
- ☐ Internal Medicine
- ☐ OB-Gyne
- ☐ Minor Surgery

B. Diagnostic Services

1. Laboratory Examination (CBC, Urinalysis, Fecalysis) ☐ In house ☐ Referred to _____
2. Sputum Microscopy ☐ In-house ☐ Referred to _____
3. Chest X-Ray Examination ☐ In-house ☐ Referred to _____

Note: Please indicate complete name and address of referral facilities

C. Additional for MCC

- ☐ Pre-natal Care
- ☐ Normal Spontaneous Delivery
- ☐ Post Natal Care
- ☐ Newborn Care
- ☐ Family Planning Services

IV. QUALITY ASSURANCE ACTIVITIES *(Please check any of the following items if applicable)*

A. Quality Assurance Documents

1. For OPB

- ☐ QA Handbook
- ☐ Mission /Vision
- ☐ Annual Report
- ☐ Action Plans
- ☐ Current Standard Operating Procedures (SOPs)

2. For DOTS

- ☐ NTP Treatment Card
- ☐ NTP Registry

3. For MCC

- ☐ Consultation/admission logbooks
- ☐ Patient's clinical record
- ☐ Printed materials/posters for patient education

B. Leadership Capability

- ☐ Medical Management
- ☐ Financial Management
  - ☐ Involvement in budget preparation
  - ☐ Financial Reports
- ☐ Supervision/Managerial
  - ☐ Regular staff meetings on clinic management

Additional for MCC

- ☐ Maternal Care Management

C. Process Control Based on Standards

- ☐ Standards for Specific Management
  - ☐ Posters on treatment protocols or maternal & newborn health care
- ☐ Records Management
- ☐ Standards for referral
  - ☐ Referral forms
- ☐ Standards for patient education
  - ☐ Brochures ☐ Mother's Class

D. Human Resource Management

- ☐ Training/education of management
- ☐ Continuous education based on priorities
- ☐ Participation in QA activities within regular working hours
- ☐ Systematic feedback on facility staff

E. Quality Improvement Procedures

- ☐ Satisfaction survey among patients
- ☐ Satisfaction survey among employees
- ☐ Utilization of individual care plans
- ☐ Management Information System

F. Internet Access (optional)

- ☐ Computer Unit
- ☐ Telephone Line
- ☐ Other means of access to internet (pls. specify) _____

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

_____
Owner/Municipal or City Mayor

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

Status of Application:

☐ Approved
Date: _____

☐ Deferred
Date: _____

☐ Denied
Date: _____

Date Received at CO: _____

Date Received at PRO: _____

WARRANTIES OF ACCREDITATION FOR OUT PATIENT HEALTH FACILITIES

The undersigned, as representative to act for and on behalf of _____
(Name of Out Patient Facility)
located at _____ warrants the following :

1. ELIGIBILITY

1.1 That it is qualified to apply for accreditation under the Out-patient Primary Care Benefit Package, Maternity Care Package and/or the Out Patient TB-DOTS Package;
1.2 That it is affiliated with a PHIC accredited secondary or tertiary hospital (for OPB and MCC), or a licensed x-ray facility (for OPB);
1.3 That it has the human resources, equipment, physical structure and other requirements in conformity with standards established by the Corporation;
1.4 That it has an ongoing quality assurance program.

2. COMPLIANCE TO PERTINENT LAWS

2.1 That the aforenamed health care institution shall comply with the provisions of the National Health Insurance Law (RA 7875 as amended by RA 9241), its Implementing Rules and Regulations, and all administrative orders of the corporation in the course of its participation with the NHI Program by virtue of its accreditation;
2.2 That it shall accept the formal program of quality assurance, payment mechanism and utilization review of the NHI Program;
2.3 That its personnel shall strictly adhere and comply at all times with the Code of Ethics of their respective professions and other related professions of the Philippines.

3. CLINICAL SERVICES

3.1 That the aforenamed health care institution shall guarantee safe, adequate and standard medical/maternal 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 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 patient's discharge (for TB-DOTS and Maternity Care); duly accomplished forms required by this Corporation needed prior to the release of the next quarter's capitation fund (for OPB Services only);
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 for remittance (for TB-DOTS and Maternity Care) and for capitation fund (for OPB Services only) 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 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 diagnosed 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 the outpatient clinic operation.

6. OUTPATIENT CLINIC 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 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 Regional Health Insurance Office.

Finally, the undersigned hereby affirms that the PhilHealth, by virtue of its power under RA 7875 as amended by RA 9241 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.

WITNESS MY HAND AND SEAL, this _____ day of _____ 200_ at _____.

_____
Owner/Head of the Facility
Signature Over Printed Name

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

Doc. No. _____
Book No. _____
Page No. _____
Series of 200__