Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre Building, 709 Shaw Boulevard, Pasig City
Healthline 441-7444 www.philhealth.gov.ph

PHILHEALTH CIRCULAR
No. 021 - 2014

TO : **HEALTH CARE INSTITUTIONS, HEALTH INFORMATION TECHNOLOGY PROVIDERS, PHILHEALTH REGIONAL OFFICES, LOCAL HEALTH INSURANCE OFFICES, AND ALL OTHERS CONCERNED**

SUBJECT : **Guidelines for Eclaims System Simulation**

I. RATIONALE:

The eClaims System is an interconnected modular information system for claim reimbursement transaction beginning from the time a patient signifies the intention of using a PhilHealth benefit and ends when the claim is paid. It is divided into five modules, to wit:

1. **Module 1. Claim Eligibility Web Service (CEWS)**- allows HCI to determine eligibility of patient to avail of PhilHealth benefit
2. **Module 2. Electronic Claim Submission (ECS)**- allows HCI to submit a claim online
3. **Module 3. Electronic Claim Status Verification (CSV)**- allows HCI to track and verify status of its claim
4. **Module 4. Electronic Claim Review and Processing**- allows PhilHealth to review and process submitted claim online
5. **Module 5. Auto Credit Payment Scheme**-ability for the HCI to be reimbursed for the claim through direct crediting a HCI deposit account.

Prior to implementing the full eclaims system across all health care institutions, health information technology providers (HITP) shall conduct an eClaims System simulation in test environment. The purpose is to test the applications developed by the HITP and assess the cycle of electronic claims submission and processing before actual implementation.

II. SCOPE:

1. The eClaims System shall apply to the All Case Rate (ACR) payment mechanism, including the Outpatient Malaria Package, Maternity Care Package, Newborn Care Package, TB DOTS Package and Animal Bite Treatment Package.
2. A total of seven (7) HCIs will participate in the eClaims System simulation as identified by their respective accredited HITPs (PhilHealth Circular No. 38, s. 2012):
    a. Dr. Jesus C. Delgado Memorial Hospital (Quezon City)- Eurolink Network International, Inc.
    b. JNRAL Family Corporation (Tanza, Cavite)- Topaz Philippines Software Development and Management Services
    c. Novaliches General Hospital (Quezon City)- Total Transcription Solutions, Inc.
    d. Quirino Memorial Medical Center (Quezon City)- Department of Health- IMS

e. Skywood Health Services, Inc./ My Health Clinic (Mandaluyong City)- Medilink Network, Inc.
f. Southern Philippines Medical Center (Davao City)- Segworks Technologies Corporation
g. Victor R. Potenciano Medical Center (Mandaluyong City)- BizBox, Inc.

3. This shall cover all claims with date of admission that falls on the effectivity of the eClaims System simulation.
4. The eClaims System simulation shall run for a maximum of two (2) weeks.
5. One hundred percent (100%) of total claims of participating HCI will go through eClaims System simulation.
6. eClaims System simulation will cover Modules 1 to 4 of the eClaims System from encoding of data in the claim forms (hospital side) until generation of voucher only .

III. GENERAL GUIDELINES:

1. The eClaims System simulation shall be conducted inside the test environment.
2. Real HCI data shall be used for claim transactions under modules 1 to 3.
3. Hard copy of the electronically submitted claims will also be submitted to respective PROs at least five days after date of discharge.
4. Submitted hard copy of claims shall be the basis for processing of payment.
5. eClaims System simulation will not cover Module 5. Auto Credit Payment of Claim.
6. All identified system bugs/ errors shall be addressed and fixed within the covered period for the simulation.
7. The extension of simulation period shall be subject to approval of the PhilHealth Management.
8. Each HITP shall engage one client health care institution (HCIs) in the eClaims System simulation.
9. Contractual obligations for the conduct of the eClaims System simulation between HCI and HITP should also contain relevant provisions stipulated under "Obligations and Undertakings of HITP"in the Business Agreement of PhilHealth Circular No. 038, series 2012.

IV. SPECIFIC GUIDELINES *AND PROCEDURES:*

A. HCI Registration into eClaims System

1. HITP shall provide a duly filled out Health Care Institution eClaims Account Form (HCIeCAF) and Non-Disclosure Agreement (NDA) of its identified HCI to PMT for Claims at eclaims@philhealth.gov.ph (see ANNEXES A and B).
2. PhilHealth Management will issue digital certificates to the HCI.
3. All participating HCIs in the eClaims System simulation must be registered on or before the start of the eClaims System simulation.

B. Electronic Claim Submission

1. HITP shall provide a module for HCI users to load from the HCI's information system or encode claim information.
2. All information found in Claim Forms 1 and 2 shall be translated into its electronic format.
3. There shall be a minimum set of mandatory supporting documents *(see ANNEX C)* to an electronic claim, as required under existing policies. This is to enable adequate adjudication and post-payment audit of the claim.
4. Supporting documents (i.e. diagnostic results, operative records, etc.) shall be scanned and saved in HITP or HCI provider server.
5. Scanned files shall be saved as portable document format/archive (PDF/A) version.
6. The Claim Signature Form (CSF) contains portions from Claim Forms 1 and 2 that require signature from the hospital, member, patient, and employer *(see Annex D)* where applicable, it should be duly filled-out and signed before attaching the document as PDF file link with the electronic claim.

C. Electronic Claim Review and Processing

1. PMT for Claims shall review and process the electronic claim in test environment.
2. Parallel processing of the hard copy of the claims of the participating HCIs for the eClaims System Simulation shall be done by respective PROs (An illustration of the flow of Electronic Claim Review and Processing is provided in *ANNEX E).*

V. DEMO OF SIMULATION

The culminating activity shall be a demo of the simulation in the presence of the concerned PhilHealth third level officers or their designated representatives at a date and venue to be announced later.

VI. RESPONSIBILITIES OF THE HCIs, HITPs and PHILHEALTH

HCI Head (i.e. hospital director, chief of hospital) shall be responsible for ensuring the quality (i.e. validity, accuracy, completeness, etc.) of data submitted electronically including its counterpart in hard copy.

HITPs, apart from the proper execution of the requisite Non-Disclosure Agreements (NDAs), are required to develop, maintain policies and procedures for protecting personal health information (PHI) stored electronically which includes backups, archives and live electronic records which in turn will also be implemented by their client HCI Provider. They shall also provide technical support to its client HCIs during the eClaims simulation and address technical issues which can be resolved at their level.

All other unresolved technical queries/ concerns shall be elevated to the PhilHealth Management and resolved through its IT- helpdesk or at the HITP online forum. PhilHealth

Management shall also ensure that all claims regardless of its format shall be processed accordingly.

VII. MONITORING AND EVALUATION

1. Evaluation of the eClaims System simulation shall be according to the criteria and indicators provided in ANNEX F. PMT for Claims shall provide an evaluation report of each participating HCI.
2. PhilHealth Offices such as OCIO, ITMD, Information Security Department, Risk Management Department, PMO- PIMS, BDRD and PROs shall actively take part in monitoring and evaluation activities for HITPs and eClaims system simulation by HCIs specifically in validation of electronic claim against its hard copy.
3. HCI and HITP shall extend assistance to all PhilHealth personnel during monitoring activities such as random spot checks and evaluation activities.

VII. REPEALING CLAUSE:

All provisions in previous issuances that are inconsistent with any provisions of this Circular are hereby amended/ modified/ or repealed accordingly.

VIII. EFFECTIVITY:

This circular shall take effect fifteen days after its publication in the Official Gazette or in a newspaper of general circulation. The Circular shall be deposited with the National Administrative Register at the University of the Philippines Law Center.

IX. ANNEXES:

1. Annex A: Health Care Institution eClaims Account Form (HCIeCAF)
2. Annex B: Non-Disclosure Agreement (NDA)
3. Annex C: Mandatory supporting documents
4. Annex D: Claim Signature Form
5. Annex E: Process Flow Electronic Claim Review and Processing
6. Annex F: Evaluation Tool for eClaims System simulation

ALEXANDER A. PADILLA
President and CEO

9/8/14

MASTER DOCUMENT
DC: ____ Date: 9/9/14

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Healthline 441-7444 www.philhealth.gov.ph

ANNEX A: Health Care Institution eClaims Account Form (HCIeCAF)

Health Care Institution (HCI) eClaims Account

For digital certificate generation to connect to eClaims Web Services using Proxy server

Item	Details	Data
1.	HCI Name	
2.	Facility Accreditation Number/PMCC code	
3.	Address	
4.	Provider Public IP Address	
5.	Authorized Contact Person	
6.	Official Email Address	
7.	Official Contact Number	
8.	Name of Health Information Technology Provider (HITP), if applicable	
9.	HITP official email address	
10.	Type of Application	☐ Initial ☐ Renewal
11.	Date of Application	

I have read and agreed to the Terms of the Digital Certificate-Non Disclosure Agreement attached herewith as "Annex B" and with full knowledge of its meaning and legal implications.

Requested by:

_____
Signature over Printed Name of Authorized Personnel

Date signed_____

Approved by:

_____
(Owner/President/Administrator)

Date signed_____

ANNEX B: Non-Disclosure Agreement

DIGITAL CERTIFICATE-NON DISCLOSURE AGREEMENT

HCI name is given the facility to connect to the PhilHealth network and access applicable services offered by it, subject to the provisions of a digital certificate to be issued by PhilHealth. The said digital certificate will and shall contain the following policies:

1. **< HCI name>** acknowledges that it is aware of its legal obligation regarding PhilHealth policies and standards to not provide PhilHealth's data and programs especially if those consider confidential information or information that is important for the continued operation of the business.

2. **< HCI name>** shall not give or provide access to such information to unauthorized persons or entities.

3. **< HCI name>** shall store the digital certificate only in designated computers within its premises and accessed only by its authorized personnel.

4. **< HCI name>** will use the digital certificate exclusively for business purposes and prevent any unauthorized access to it with all resources and capabilities.

5. **< HCI name>** shall keep in confidentiality the digital certificate or any other form of security token/device that were issued to them in accessing PhilHealth Services.

6. **< HCI name>** shall similarly bind its employees under a binding formal contract wherein the latter shall undertake to observe the confidentiality and non disclosure undertakings of the HCI.

7. **< HCI name>** acknowledge liability of any breach of the non-disclosure agreement by any of its employee.

ANNEX C: Mandatory supporting documents

eClaims Module 2 PDF Attachment
Mandatory supporting document

Case Rate/ Benefit Type	Module 1: CEWS (YES eligible)	Module 1:CEWS (NO response)
• **Medical Case**	• Claim signature form • Claim form 3 (all hospital levels) • Diagnostic test result ➢ Dengue I & II (Platelet count, Hemoglobin/ Hematocrit) ➢ Pneumonia I & II (Chest x-ray result) ➢ CVA I (detailed neuro exam) ➢ CVA II (CT scan result, detailed neuro exam) ➢ AGE (Fecalysis &/or stool culture sensitivity) ➢ Typhoid fever (widal test or typhidot result)	• Claim signature form • Claim form 3 (all hospital levels) • Diagnostic test result as specified on the 2nd column (typhoid, AGE, Pneumonia I & II, Dengue I & II, CVA) • Any of the requirements requested for compliance in the PBEF slip (formerly tracking slip)
• **Surgical Case**	• Claim signature form • Operative record	• Claim signature form • Operative record • Any of the requirements requested for compliance in the (formerly tracking slip)
• **MCP/NSD**	• Claim signature form Claim form 3	• Claim signature form • Claim form 3 • Any the requirements requested for compliance in the (formerly tracking slip)
• **Newborn Care Package**	• Claim signature form	• Claim signature form • Any the requirements requested for compliance in the (formerly tracking slip)
• **TB DOTS**	• Claims signature form • NTP registry card • TB-Diagnostic committee certification (-) sputum	• Claims signature form • NTP registry card • TB-Diagnostic committee certification (-) sputum • Any the requirements requested for compliance in the (formerly tracking slip)
• **Malaria**	• Claim signature form • Malarial Smear Results	• Claim signature form • Malarial Smear results • Any the requirements requested for compliance in the (formerly tracking slip)

ANNEX D

PhilHealth
Your Partner in Health

CSF

(Claim Signature Form)

IMPORTANT REMINDERS:
PLEASE WRITE IN CAPITAL **LETTERS** AND **CHECK** THE APPROPRIATE BOXES. **Series #** ☐☐☐☐☐☐☐☐☐☐☐☐☐
All information required in this form are necessary and claim forms with incomplete information shall not be processed.
FALSE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CRIMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.

PART I - MEMBER AND PATIENT INFORMATION AND CERTIFICATION

1. PhilHealth Identification Number (PIN) of Member: ☐☐ – ☐☐☐☐☐☐☐☐☐ – ☐

2. Name of Member:
Last Name First Name Middle Name (example: Dela Cruz, Juan Jr., Sipag)

3. Member Date of Birth: ☐☐ – ☐☐ – ☐☐☐☐ (month-day-year)

4. PhilHealth Identification Number (PIN) of Dependent: ☐☐ ☐☐☐☐☐☐☐☐ ☐

5. Name of Patient:
Last Name First Name Middle Name (example: Dela Cruz, Juan Jr., Sipag)

6. Relationship to Member:
☐ Child ☐ Parent ☐ Spouse

7. Confinement Period
a. Date Admitted: ☐☐ – ☐☐ – ☐☐☐☐ (month-day-year)
c. Date Discharged: ☐☐ – ☐☐ – ☐☐☐☐ (month-day-year)

8. Patient Date of Birth: ☐☐ – ☐☐ – ☐☐☐☐ (month-day-year)

9. CERTIFICATION OF MEMBER:

Under the penalty of law, I attest that the information I provided in this Form are true and accurate to the best of my knowledge.

Signature Over Printed Name of Member
Date Signed (month-day-year)

Signature Over Printed Name of Member's Representative
Date Signed (month-day-year)

If member/ representative is unable to write, put right thumbmark. Member/ representative should be assisted by an HCI representative. Check the appropriate box:
☐ Member ☐ Representative

Relationship of the representative to the member:
☐ Spouse ☐ Child ☐ Parent
☐ Sibling ☐ Others, specify _____

Reason for signing on behalf of the member:
☐ Member is incapacitated
☐ Other reasons _____

PART II - EMPLOYER'S CERTIFICATION (for employed members only)

1.PhilHealth Employer No. (PEN): ☐☐ – ☐☐☐☐☐☐☐☐ – ☐ 2. Contact No.: _____

3. Business Name:
Business Name of Employer

4. CERTIFICATION OF EMPLOYER:

This is to certify that all monthly premium contributions for and in behalf of the member, while employed in this company, including the applicable three (3) monthly premium contributions within the past six (6) months period prior to the first day of this confinement, have been deducted/collected and remitted to PhilHealth, and that the information supplied by the member or his/her representative on Part I are consistent with our available records.

Signature Over Printed Name of Employer / Authorized Representative | Official Capacity / Designation | ☐☐ – ☐☐ – ☐☐☐☐ Date Signed (month-day-year)

PART III - CONSENT TO ACCESS PATIENT RECORD/S

I hereby consent to the examination by PhilHealth of the patient's medical records for the purpose of verifying the veracity of this claim.
I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim for reimbursement before PhilHealth.

Signature Over Printed Name of Member/ Patient/ Authorized Representative
☐☐ – ☐☐ – ☐☐☐☐
(Date Signed (month-day-year)

Relationship of the representative to the member/ patient:
☐ Spouse ☐ Child ☐ Parent
☐ Sibling ☐ Others, specify _____

Reason for signing on behalf of the member/ patient:
☐ Patient is incapacitated
☐ Other reasons _____

If patient/ representative is unable to write, put right thumbmark. Patient/ representative should be assisted by an HCI representative. Check the appropriate box:
☐ Patient ☐ Representative

PART IV - HEALTH CARE PROFESSIONAL INFORMATION

Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐ - ☐

Signature Over Printed Name

☐☐ - ☐☐ - ☐☐☐☐
Date Signed (month-day-year)

Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐ - ☐

Signature Over Printed Name

☐☐ - ☐☐ - ☐☐☐☐
Date Signed (month-day-year)

Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐ - ☐

Signature Over Printed Name

☐☐ - ☐☐ - ☐☐☐☐
Date Signed (month-day-year)

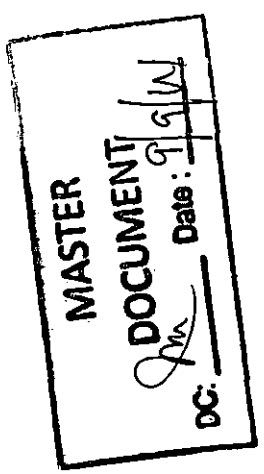
PART V - PROVIDER INFORMATION AND CERTIFICATION

I certify that services rendered were recorded in the patient's chart and health care institution records and that the herein information given are true and correct.

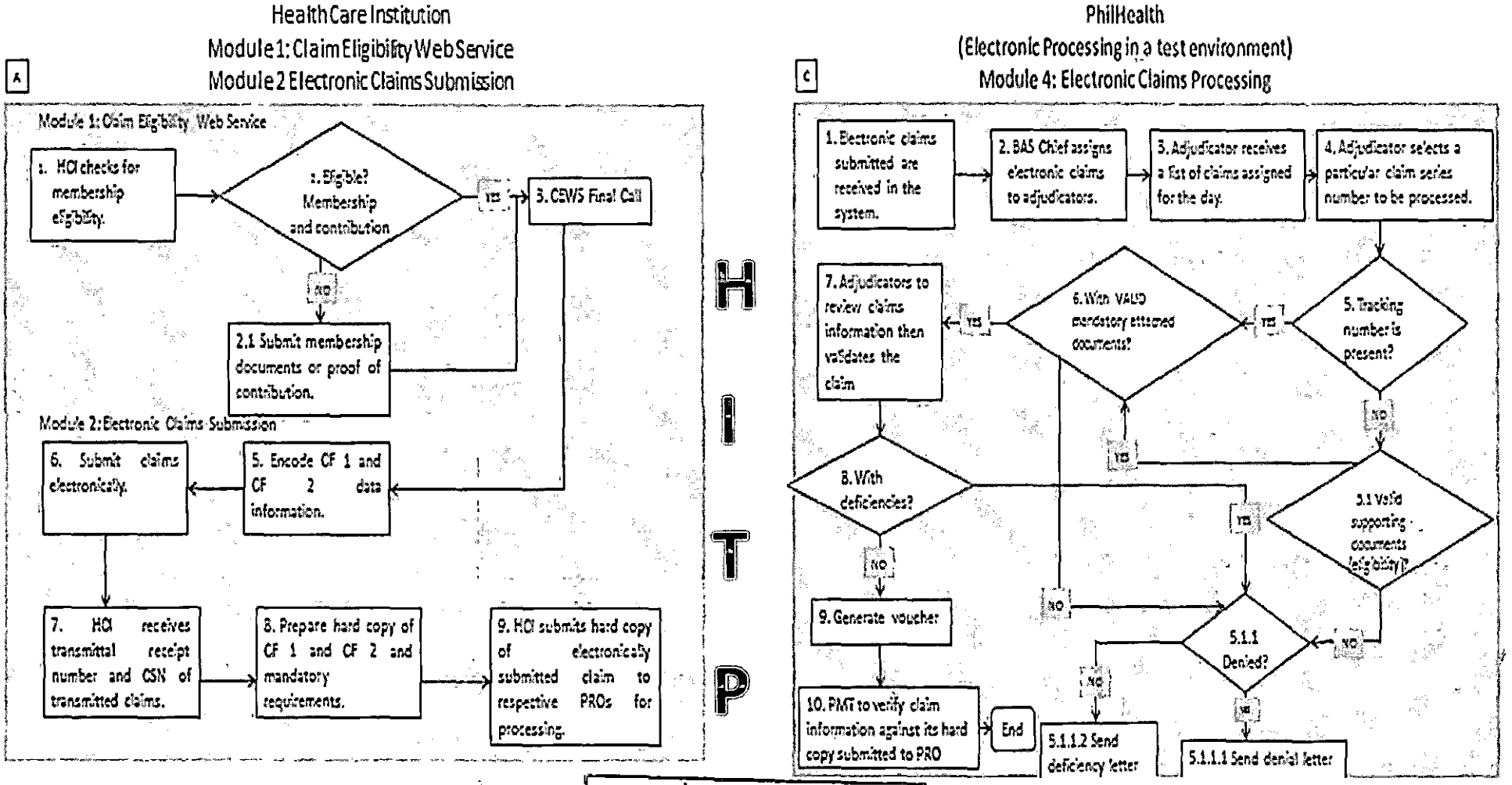
Signature Over Printed Name Authorized HCI Representative

Official Capacity / Designation

☐☐ ☐☐ ☐☐☐☐
Date Signed (month-day-year)

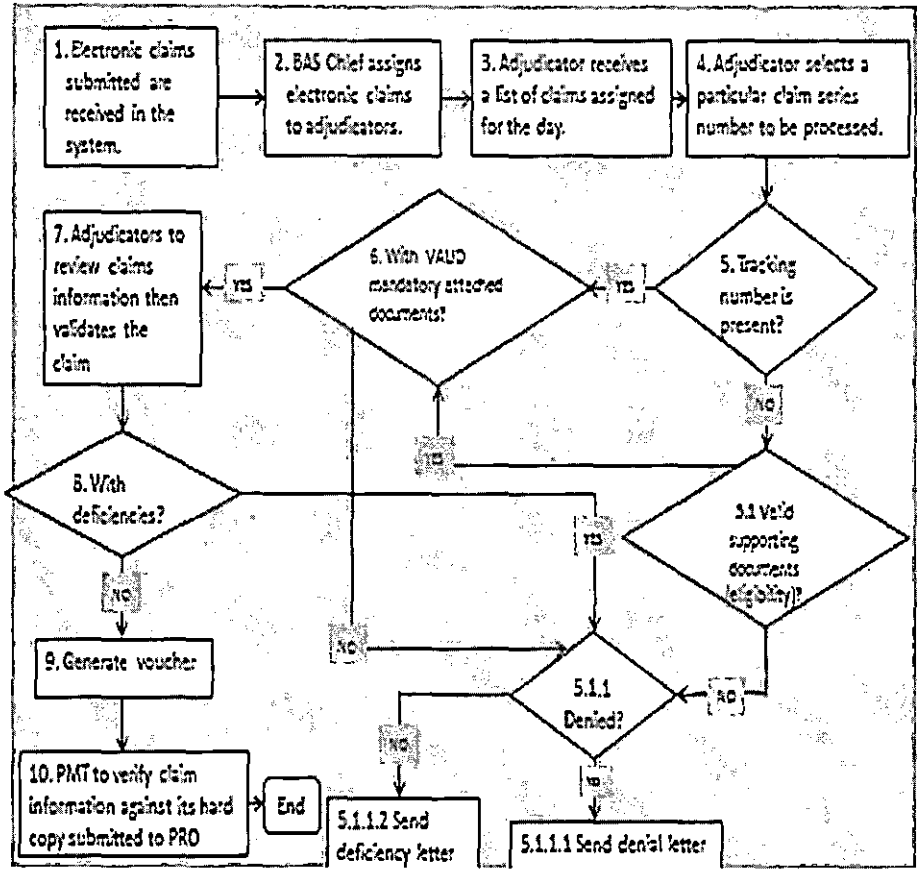


ANNEX E: Process Flow Electronic Claim Review and Processing



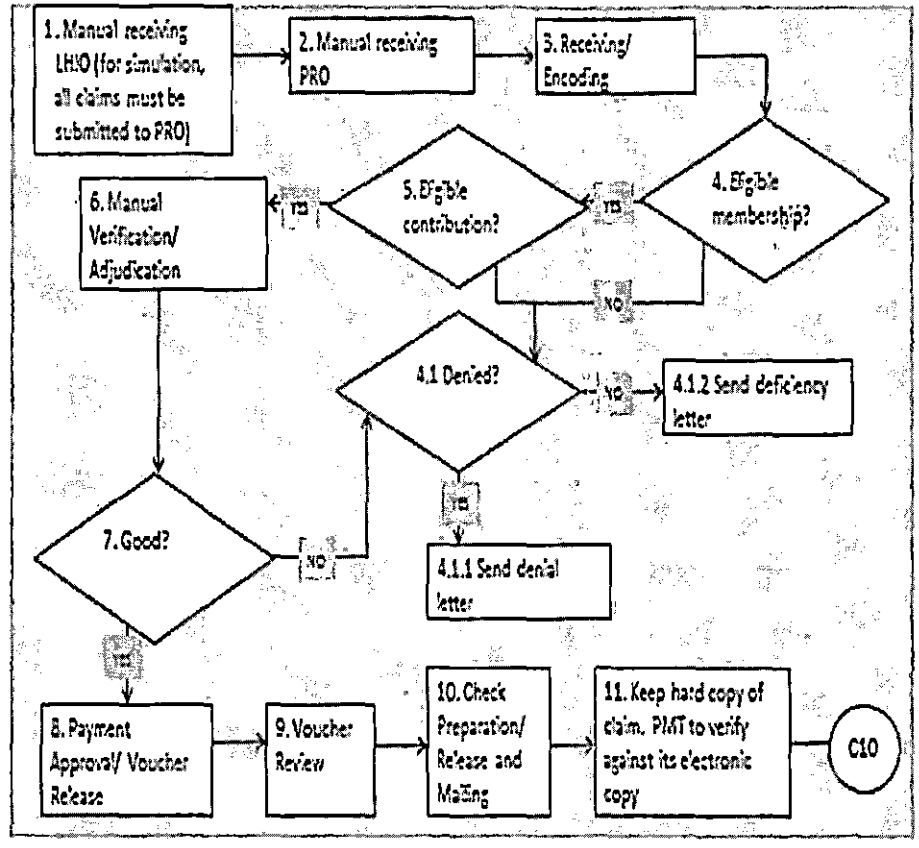
PhilHealth
(Electronic Processing in a test environment)
Module 4: Electronic Claims Processing

C



PhilHealth
(Manual Processing of Claims)

B



ANNEX F: Evaluation Tool for eClaims System simulation

Name of HCI: _____
Accredited Health IT Provider: _____
Dates covered: _____

MODULE 1: CLAIMS ELIGIBILITY WEB SERVICE

	Able to display data in conformance to PBEF Format "YES" on Final Call		
	YES (%)	NO (%)	REMARKS
CEWS Tracking Number			
Name of Health Care Institution			
HCI Accreditation Number			
PhilHealth Identification Number *Display the 12 digit PIN*			
Name of Member			
Member's Sex			
Member's Date of Birth			
Member Category			
Name of Patient			
Date admitted			
Date discharged			
Patient's Sex			
Patient's Date of Birth			
With 3 monthly contributions within the past 6 months (3/6)			
With 9 monthly contributions within the past 12 months (9/12)			
Number of days remaining from the 45 days benefit limit *Actual remaining days*			

MODULE 1: CLAIMS ELIGIBILITY WEB SERVICE

	Able to display data in conformance to PBEF Format "NO" on Final Call		
	YES (%)	NO (%)	REMARKS
CEWS Tracking Number			
Name of Health Care Institution			
HCI Accreditation Number			
PhilHealth Identification Number No records found			
Name of Member			
Member's Sex			
Member's Date of Birth			
Member Category			
Name of Patient			
Date admitted			
Date discharged			
Patient's Sex			
Patient's Date of Birth			
With 3 monthly contributions within the past 6 months (3/6)			
Number of days remaining from the 45 days benefit limit Exhausted 45 days allowable limit			

MODULE 1: CLAIMS ELIGIBILITY WEB SERVICE

	Documentary requirements/ supporting documents attached are **complete**		Documentary requirements/ supporting documents attached are **valid**		Documentary requirements/ supporting documents attached **accurately matches with its hard copy**		
	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)	Remarks
A. Test for contribution							
1. Sponsored • Updated PhilHealth ID Card • 4Ps ID • Proof of Payment of Premium Contribution							
2. IPP • Proof of Payment of Premium Contribution							
3. OFW • Proof of Payment of Premium Contribution							
4. Employed • Proof of Payment of Premium Contribution • Properly accomplished CF 1							
5. Lifetime Member • Valid Lifetime Member ID							
B. Test for dependency							
1. Please submit: Member's Birth Certificate • Discrepancy- Member's Last Name/ First Name/ Middle Name/ Suffix/ Birth Date							
2. Please submit: Patient's Birth Certificate • Undeclared dependent-child							

	Documentary requirements/ supporting documents attached are **complete**		Documentary requirements/ supporting documents attached are **valid**		Documentary requirements/ supporting documents attached **accurately matches with its hard copy**		
	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)	Remarks
• Discrepancy- Patient's Last Name/ First Name/ Middle Name/ Suffix/ Birth Date							
3. Please submit: Member's Birth Certificate and Patient's Birth Certificate • Undeclared dependent-parent							
4. Please submit: Marriage Certificate • Undeclared dependent-spouse							
5. Please submit: Legal Adoption Papers • Undeclared dependent-parent • Undeclared dependent-child							
6. Please submit Updated Medical Certificate of Patient • Child dependent 21 above • Parent dependent below 60							

MODULE 1: CLAIMS ELIGIBILITY WEB SERVICE

	Actual count
Total number of claims tagged as with attached documents on dependency and contribution	
Total number of claims and attached documents	

MODULE 2: ELECTRONIC CLAIMS SUBMISSION

	Actual count
Total number of claims transmitted per HCI	
Total number of claims listed in the electronic transmittal	

	Actual count
Total number of claims sent by batch	
Total number of claims sent individually	

	Actual count
Total number of claims sent from 8:00 am to 5:00 pm from Mondays to Fridays	
Total number of claims sent beyond office hours 5:00 pm onwards during Saturdays to Sundays	

MODULE 2: ELECTRONIC CLAIMS SUBMISSION

	Claim data information transmitted by HCI are encoded completely		
	YES (%)	NO (%)	REMARKS
CF 1 (Part I)			
PIN of member			
Member's name, date of birth, contact information/s and complete mailing address			
If patient is the member, in item no. 6, tick the box "Yes" and proceed to encode Part III			
If patient is a dependent, in item no. 6, tick the box "No" and proceed to encode Part II			
CF 1 (Part II)			
PhilHealth Identification Number of dependent if available.			
Dependent's name and date of birth			
Tick the appropriate box in Item no. 4			
CF 1 (Part III)			
Confirmation of signature of the member and date signed			
OPTIONAL: • Confirmation of signature of the patient's representative and date signed			
• Relationship of the representative to the patient			
• Reason for signing on behalf of the patient			

	Claim data information transmitted by HCI are encoded completely		
	YES (%)	NO (%)	REMARKS
• Confirmation if with thumb mark of patient/ representative			
CF 1 (Part IV) if employed member			
PhilHealth Employer's Number			
Contact Number			
Business name			
Confirmation of employer/ authorized representative signature and date signed			
Employer			
Employer/ authorized representative official capacity/ designation			
Health Care Institution, Confinement and other information			
Accreditation Code			
Name			
Category			
Classification			
Accreditation Period			
Admission Date			
Discharge Date			
Received Date			

MODULE 2: ELECTRONIC CLAIMS SUBMISSION

	Claim data information transmitted by HCI are encoded **completely**		Claims data information **accurately matches its hard copy**		
	YES (%)	NO (%)	YES (%)	NO (%)	REMARKS
CF 2 (Part I)					
PhilHealth Accreditation Number (PAN)					
Name and Address of HCI					
CF 2 (Part II)					
Name of Patient					
For referred by another HCI, encode the Accreditation Code of the referring HCI					
Confinement Period including time of admission and discharge					
For patient disposition, tick the appropriate box in Part II no. 4. • For expired (death), encode the date, time of death and co-claimant.					
• For transferred/ referred, encode the Accreditation Code of the referral (receiving) HCI. Also, encode the reason/s for referral. Consult the BAS Chief for any questions regarding the reason for referral (e.g. spelling, non-legible writings)					
Type of accommodation					

	Claim data information transmitted by HCI are encoded **completely**		Claims data information **accurately matches its hard copy**		
	YES (%)	NO (%)	YES (%)	NO (%)	REMARKS
OPTIONAL Admission diagnosis; Item no. 7, regarding the Discharge Diagnosis, encode the ICD-10, RVS codes, Date of operation and laterality declared. DO not encode the free text.					
Item no. 8 tick the checkbox that corresponds to the type of claim • Letter a; tick the checkbox then check the appropriate repetitive procedure being claimed and encode the session dates.					
• Letter b; tick Z-benefit checkbox then encode the package code					
• Letter c; tick the checkbox for MCP and encode the dates of pre-natal check-ups					
• Letter d; tick the checkbox for TB DOTS Package and the declared phase					

	Claim data information transmitted by HCI are encoded **completely**		Claims data information **accurately matches its hard copy**		
	YES (%)	NO (%)	YES (%)	NO (%)	REMARKS
• Letter e; tick the checkbox for Animal Bite Package then encode the dates when the following doses were given Day 0- Day 3- Day 7- RIG- Others					
• Letter f; tick the checkbox for NCP then check the declared service/s done for the Newborn Care Package (Essential Newborn Care- Newborn Hearing Screening Test- Newborn Screening Test). Encode the Filter Card number (Optional)					
• Letter g; tick the checkbox for OHAT package and encode the laboratory number					
Item No. 9 regarding PhilHealth Benefits, encode the ICD or RVS of the condition or procedure claimed					

	Claim data information transmitted by HCI are encoded **completely**		Claims data information **accurately matches its hard copy**		
	YES (%)	NO (%)	YES (%)	NO (%)	REMARKS
Item no. 10, Accreditation No. of Attending Professional HCP. Tick the appropriate box on Co-pay. If with Co-pay, encode the amount/s. Encode date signed					
CF 2 (Part III Certification of Consumption of Benefits)					
Checkbox if PhilHealth benefit is enough to cover HCI and PF charges • Total HCI Fees					
• Total Professional Fees					
• Grand Total					
Checkbox if the benefit of the member/ patient was completely consumed prior to co-pay.. • For total co-pay, *Total HCI Fees for actual charges for discount, for PhilHealth benefit, Amount after PhilHealth deduction, and checkbox for the Payee					

	Claim data information transmitted by HCI are encoded **completely**		Claims data information **accurately matches its hard copy**		
	YES (%)	NO (%)	YES (%)	NO (%)	REMARKS
*Total Professional Fees for actual charges, for discount, for PhilHealth benefit, Amount after PhilHealth Deduction, and checkbox for the payee					
• For purchases/ expenses not included in HCI Charges, *Checkbox and Textbox for None and Total Amount on Total Cost of purchases for drugs/ medicines bought by patient					
*Checkbox and textbox for none and total amount on total cost of diagnostic/ laboratory examinations paid by the patient/ member					
Confirmation if properly checked					
CF 2 (Part III Consent to Access Patient Records)					
Confirmation of signature of the patient and date signed					

	Claim data information transmitted by HCI are encoded **completely**		Claims data information **accurately matches its hard copy**		
	YES (%)	NO (%)	YES (%)	NO (%)	REMARKS
Optional • Confirmation of signature of the authorized representative and date signed					
• Relationship of the representative to the patient					
• Reason for signing on behalf of the patient					
• Confirmation if with thumb mark of patient/ representative					
CF2 (Part IV)					
Confirmation of signature of the HCI representative, Official Capacity/ Designation, and date signed					

MODULE 3: CLAIMS STATUS VERIFICATION

	Able to display claim status		
	YES (%)	NO (%)	REMARKS
In process a. Process stage b. Process date			
Returned a. Deficiency b. Requirements			
Denied Denial Reason/s			
With Voucher a. Voucher Number b. Voucher Date			

MODULE 4: ELECTRONIC CLAIMS PROCESSING

	Actual count									
	Week 1					Week 2				
	Day 1	Day 2	Day 3	Day 4	Day 5	Day 1	Day 2	Day 3	Day 4	Day 5
Total number of electronic claims assigned per adjudicator per day										
Total number of electronically processed claims per day										

	Actual count
TAT of manual processing of hard copy	
TAT of processing its electronic claim	

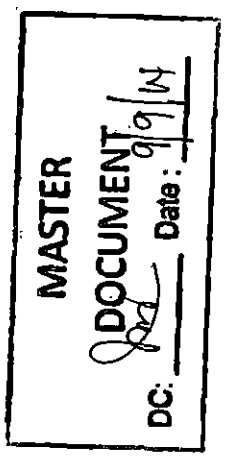
MODULE 4: ELECTRONIC CLAIMS PROCESSING

	Total number of deficiencies
	Actual count
CF 1 (Part I)	
PIN and birthday of the member does not match the membership data in PHIC database upon verification	
CF 1 (Part II)	
In item no. 5, the box ticked was "no" but there is/ are no attached supporting document/s	
Discrepancy/ ies of the attached document/s with Part I data (e.g. Names declared in Part I are not present in the attached marriage)	
CF 1 (Part III)	
No signature/s or thumb mark	
CF 1 (Part IV)	
Discrepancy between PEN and business name of employer. Validation showed business name has no record with PHIC	
No signature of employer/ authorized representative	
Date signed not reflected	
For EPRS generated CF 1, Signature of employer/ authorized representative shall not be required	

MODULE 4: ELECTRONIC CLAIMS PROCESSING

	Total number of deficiencies
	Actual count
CF 2 (Part I)	
One (1) or more field/s not filled-up	
CF 2 (Part II)	
One (1) or more applicable field/s not filled up (if not available in CF 1).	
RTS if Part II, Nos. 3 and 5a are not filled up, only in cases of referring/ referral patients	
If the PIN and name of patient is different from that declared in CF 1	
For item no. 7, rows 1 to 4, Medical cases have no ICD- 10 and/or surgical cases have no RVS	
For item no. 7, row 5, discrepancy/ies on the date of operation on said portion against the date of operation in the attached Operating Room Technique/ Record	
CF 2 (Part III)	
Item A; SOA amount not indicated. For member with co-pay, no indicated amount	
Item B; No signature of patient/ authorized representative. For patient/ representative unable to write, no thumb mark in the designated box	
CF 2 (Part IV)	
No signature and date signed	

	Actual count
Total number of good claims (with voucher generated)	
Total number of deficient claims	
Total number of denied claims	



LOG REPORT/S

	Actual count
Total number of times a query is made in Module 1	
Total number of times a query is made in Module 1 generating a YES response	
Total number of times a query is made in Module 1 generating a NO response	
Total number of times a query is made in Module 3	

HITP SERVICES

	YES	NO	REMARKS
HITP provided assistance in acquiring/ installation of digital certificates			
HITP provided front end for modules 1 to 3 of the eClaims System			
HITP provided capability building and familiarization on the eClaims System for HCI users			

HITP SERVER AND STORAGE FACILITY

	YES	NO	REMARKS
Server and storage facility is secured and met international standards for redundancy and data loss prevention prior to the initial roll-out of the eClaims System			

SYTEM CONNECTIVITY

	YES	NO	REMARKS
Transmission of an electronic claim is fast and efficient. *Measure transmission in terms of speed*			

TECHNICAL SUPPORT

	A dedicated and functional telephone line for technical concerns of HCI clients from 8:00 am to 5:00 pm, Monday to Friday
	Actual count
Number of phone requests endorsed to HITPs	
Number of phone requests acted upon by HITPs	
	A dedicated and functional e-mail address for technical concerns of HCI clients from 8:00 am to 5:00 pm, Monday to Friday
Number of e-mail requests endorsed to HITPs	
Number of e-mail requests acted upon by HITPs	

ADAPTABILITY/ FLEXIBILITY OF HITP ON SYSTEM UPDATES

	YES	NO	REMARKS
HITPs are able to regularly update their products and services to ensure conformity with recent PhilHealth policies			

DATA PRIVACY PROVISION/S

	YES	NO	REMARKS
HCI user is aware of and follows policies and procedures in addressing patients' needs for confidentiality			
HITP provides a system that maintains the confidentiality of information between HCIs and HITPs; HITPs and PHIC			
HITP provides measures to ensure the integrity of the data from encoding to transmission of claims			
As sole owner of the data, HITP turns over all data to HCI and delete, not retain any data or copy thereof. Data sanitations performed by PHIC to HITP data center			

HCI CLIENT SATISFACTION

	YES	NO	REMARKS
HCI Client is satisfied of the HITP, in terms of system, technical support provided At least _____% of rating			
HCI clients are informed of the cause of any delay in the delivery of services			
HCI clients are satisfied with the actual waiting time to resolve/ trouble shoot of errors encountered			