Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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Healthline 441-7444 www.philhealth.gov.ph

PHILHEALTH CIRCULAR
No. 011 - 2015

TO : **ALL MEMBERS OF THE NATIONAL HEALTH INSURANCE PROGRAM, ACCREDITED HEALTH CARE PROVIDERS, ALL PHILHEALTH OFFICES AND ALL OTHERS CONCERNED**

SUBJECT : **OUTPATIENT HIV/AIDS TREATMENT (OHAT) PACKAGE *(PhilHealth Circular 19, s 2010) REVISION 1***

I. RATIONALE

In support of the United Nation's Millennium Development Goal Number 6 to halt or reverse the incidence of Human Immuno-deficiency Virus (HIV)/Acquired Immune Deficiency Virus (AIDS) by 2015, PhilHealth through Board Resolution No. 1331, series of 2009 has approved the implementation of an outpatient HIV/AIDS treatment package. This benefit aims to increase the proportion of the population having access to effective HIV/AIDS treatment and patient education measures. *Guidelines for provider accreditation and benefit delivery are defined in PhilHealth Circular 19, s 2010. To align it with the "All Case Rate Policy" of the Corporation, the guidelines of the said circular are hereby amended.*

II. SCOPE AND COVERAGE

This issuance contains guidelines for reimbursement of Out-Patient HIV/AIDS Treatment (OHAT) Package. This shall apply to all accredited health care institutions that are designated by Department of Health as HIV/AIDS treatment hubs.

Italicized parts of this issuance reflect the amendments and additional guidelines of the OHAT Package.

III. GENERAL RULES

A. Accreditation of OHAT Providers

1. *There shall be* no separate accreditation for HIV/AIDS Treatment Hubs as OHAT Package providers, as long as *they are* PhilHealth accredited *health care institutions (HCIs).* In cases *when* there are gaps in facility accreditation, claims for the *said affected quarter/s* will not be paid. *Accreditation of HCIs shall be in accordance with PhilHealth Circular 54, s 2012, Provider Engagement thru Accreditation and Contracting of Health Services and subsequent issuances.*
2. *As prescribed by PhilHealth Circular 2, s-2014 (Enhanced Health Care Institution Portal), HCIs shall have the HCI Portal installed in their facility. To ensure confidentiality, the treatment hub shall have a dedicated HCI Portal user separate from the one used by the facility for its general admissions and other PhilHealth claims.*

3. HIV/AIDS treatment hubs are required to create a trust fund for reimbursement of OHAT Package.
4. *In line with PhilHealth Circular 31, s. 2013 (All Case Rates Policy No. 1) that professional services must be provided by accredited health care professionals, physicians in treatment hubs must be PhilHealth accredited starting January 1, 2016. Guidelines for accreditation of physicians are provided in PhilHealth Circular 10, s 2014 (The New Accreditation Process for Health Care Professionals and Guidelines for Credentialing and Privileging of Professionals). For initial accreditation, physicians shall submit to the nearest PhilHealth Local Health Insurance Office or Regional Office the following documents:*
   a. Properly accomplished Provider Data Record for professionals;
   b. Signed Performance Commitment;
   c. Updated PRC License or its equivalent;
   d. Two (2) pieces of 1x1 photo;
   e. Proof of payment of premium contribution; and
   f. *Certificate of completed residency training or specialty board certificate if applicable.*

B. Eligibility Rules for Members and Dependents

As stated in PhilHealth Circular 32, s. 2014 (Clarification in the application of qualifying to ensure entitlement to benefits), all members and their qualified dependents are eligible if their premium contributions are paid for at least three (3) months within the six (6) months prior to the first day of availment. The qualifying six months is inclusive of the confinement month.

Sponsored, *Indigent* and Overseas Workers Program members are entitled to the package if the period of treatment falls within the validity periods of their membership as stated in the *MDR/PBEF.*

C. Availment of OHAT Package

1. The Outpatient HIV/AIDS Treatment (OHAT) Package shall be paid through a case *based* payment scheme. Annual reimbursement is set at thirty thousand pesos (Php 30,000.00).
2. *Only HIV/AIDS cases confirmed by STD/AIDS Central Cooperative Laboratory (SACCL) or Research Institute for Tropical Medicine (RITM) requiring treatment* shall be covered by the package.
3. Excluded in this OHAT Package are the following:
   a. Diagnosis of HIV/AIDS with no laboratory confirmation
   b. HIV/AIDS cases with no indication for anti-retroviral therapy
   c. Management of patients for pulmonary tuberculosis co-infection.
   d. Illness (opportunistic infections) secondary to HIV/AIDS that requires hospitalization
   e. HIV/AIDS cases requiring confinement are covered under the regular inpatient benefit of PhilHealth.
4. A separate package for TB-DOTS may be reimbursed in accredited TB-DOTS facilities. A member may avail of both the OHAT and TB-DOTS packages simultaneously.
5. *This package shall only be availed from PhilHealth accredited HCI that are DOH designated HIV/AIDS Treatment Hubs.*
6. Package shall be based on *the Policies and Guidelines on the Use of Antiretroviral Therapy among People Living with Human Immunodeficiency Virus (HIV) and HIV-exposed Infants prescribed by the Department of Health (DOH).* All treatment hubs in accredited facilities are required to follow the guidelines set by the DOH.

IV. SPECIFIC RULES

1. Covered items under this benefit are drugs and medicines, laboratory examinations *based on the specific treatment guideline* including Cluster *of Differentiation* 4 (CD4) level determination test, *viral load*

(if warranted) and test for monitoring of anti-retroviral *(ARV)* drugs toxicity and professional fees of providers.

2. The package will be released in four (4) quarterly payments *at* Php 7,500 pesos *per release* payable to the *health care institution. The treatment hub shall only file one claim for each patient per quarter regardless of the number of consultations. However, if there are no services provided (i.e. no consultation), there will be no payment for that quarter. For example:*

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Covered Period	January 1 to March 31	April 1 to June 30	July 31 to September 30	October 1 to December 31
Date/s consulted to treatment hub	• January 4 • March 30	• April 6	none	• November 30
Payment for the quarter	Php 7,500.00	Php 7,500.00	none	Php 7,500.00

3. *The rule of single period of confinement shall not apply to this Package. However,* only 1 claim per quarter may be filed and it is equivalent to Php7,500. Any other claim filed within the same *quarter* will be denied.
4. Each quarterly claim shall be charged one (1) day against the 45-day annual benefit limit or a *maximum* of 4 days per year
5. *When a patient* transfers from one treatment hub to another, the following rules shall apply:
   a. A referral letter to the receiving facility must be accomplished.
   b. The accredited facility that provided the services for the applicable quarter shall file the claim.
   c. If patient transfers within the same quarter, the referring facility shall file the claim. Claims for subsequent quarters shall be filed by the second facility.
   d. If there are no claims filed by the referring facility, claims filed by the referral facility within the applicable quarter shall be paid.

Claims Availment and Processing

1. Only DOH-designated treatment hubs in accredited facilities may file for reimbursement for the OHAT Package (see *Annex 2 for the updated list*).
2. *The consultation date or date when patient obtained the ARV drugs from the treatment hubs during the applicable quarter shall be considered as the admission date. If there are several consultations for that quarter, the health care provider shall choose any one of these as date of admission. The discharge date shall be the same as admission date.*
3. Claims for the OHAT Package must be submitted to PhilHealth within sixty (60) days *after the discharge date.*
4. Claims with incomplete requirements shall be returned to *sender (RTS)* for completion. *Claims re-filed with incomplete requirements shall be denied.*
5. The following documents are required for processing of claims:
   a. PhilHealth Benefit Eligibility Form (PBEF) OR other secondary documents required as proof of eligibility listed in PhilHealth Circulars 50, s-2012 and PC 1, s-2013 in cases when PBEF is not available.
   b. Duly accomplished PhilHealth Claim Form 1 (CF1). CF1 shall no longer be required when PBEF confirmed (as indicated by a "Yes") the patient's eligibility.
   For succeeding claims of employed members, CF1 without the employer's signature may be accepted if there is an updated Certificate of Premium Contributions issued by PhilHealth Local Health Insurance Offices/Branches attached to the claim.
   c. Duly accomplished PhilHealth Claim Form 2. *Instructions and example of which are attached as Annex 2 and Annex 3 of this Circular respectively.*

d.Other documents to be submitted:

Initial Claim	Succeeding Claims
• Photocopy of the following: 1. Confirmatory test results by SACCL or RITM 2. Health regimen booklet *that reflects the recent drug regimen* o Waiver and consent for release of confidential information (See *Annex 1*)	1. Photocopy of the health regimen booklet 2. Waiver and consent for release of confidential information (See *Annex 1*) ❖ Include referral letter in cases of transfer

6. For previously diagnosed cases but are filing for the first time, the claimant must still submit all the necessary laboratory test results together with the other requirements. This will be considered as the initial claim.
7. To ensure patient's rights to confidentiality, all claims for the OHAT Package shall be enclosed in a sealed envelope, marked **"CONFIDENTIAL"** and submitted to the PhilHealth Regional Office.
8. PhilHealth employees who will be directly involved in the processing of claims for HIV/AIDS shall sign a confidentiality agreement to further ensure patients' right to confidentiality.
9. All claims for OHAT Package *shall be evaluated and processed according to PhilHealth rules and guidelines on claims processing*
10. *In cases when claims were filed by the referring and receiving facility within the specific quarter, only claims from the referring facility shall be paid.*
11. *PhilHealth Out-patient HIV/AIDS Package shall use the Package Code and description below:*

Code	Description	RVU
99246	OUTPATIENT HIV/AIDS PACKAGE	Package

12. *As stated in PhilHealth Circular 03, s 2014, (Strengthening the Implementation of the No Balance Billing Policy) the No Balance Billing policy shall apply to member category identified by the Corporation who were treated in OHAT accredited government facilities.*
13. The disposition of PhilHealth payment *for OHAT* shall be:
    a. *Eighty percent (80%) for the facility to be used* as revolving fund for the delivery of the required service/s *such as, but not limited to* drugs, supplies, laboratory reagents, equipment (*including maintenance)*, site improvement, and referral fee and *other services necessary for the delivery of the required services.*
    b. *Twenty percent* (20%) *for the professional fee* that shall be divided among the HIV/AIDS Core Team (HACT) and other staff directly providing the services composed of, but not limited to the following: doctors, dentists, nurses, medical social workers, *counselors* and medical technologists.

V. Monitoring and Evaluation

1. *Monitoring of the utilization of the Outpatient HIV/AIDS Package shall be based on the Health Care Provider Performance Assessment System of the Corporation cit Circular no 31s-2014.*
2. *The treatment hubs are required to maintain a minimum set of information on each patient such as medical records/charts including referral letters that shall be readily available to PhilHealth during monitoring and evaluation*

VI. Effectivity

This Circular shall take effect fifteen (15) days after its publication in a newspaper of general circulation. Claims with admissions starting that date shall be evaluated and paid based on the aforementioned provisions.

VII. Repealing Clause

All other existing issuances and provisions of previous issuances inconsistent with this circular are hereby repealed and/or amended.

IX. Annexes

1. *Annex 1* – Waiver and consent for release of health information
2. *Annex 2* – List of accredited DOH-designated treatment hubs
3. *Annex 3 – Instructions on filing up Claim Form 2 (CF2)*
4. *Annex 4 – Sample Claim Form 2*

ALEXANDER A. PADILLA
President and CEO

Date signed: 06/08/2015

MASTER DOCUMENT
DC: ____ Date: 6/9/15

ANNEX I

WAIVER AND CONSENT FOR RELEASE OF CONFIDENTIAL PATIENT HEALTH INFORMATION

I, _____, with Patient Code No. _____
(NAME OF PATIENT)
of legal age, and presently undergoing anti-retroviral therapy hereby

authorize: _____
(NAME OF ATTENDING PHYSICIAN)

of _____
(NAME OF ACCREDITED HOSPITAL)
to release the following information from my medical records to PhilHealth:

- ☐ Photocopy of HIV test result
- ☐ Photocopy of confirmatory test result from RITM/SACCL
- ☐ Clinical Abstract
- ☐ Health Regimen Booklet
- ☐ Others: Specify _____

The above enumerated information is to be released strictly to the authorized representative of the Philippine Health Insurance Corporation (PhilHealth) for the purpose of benefits availment.

By signing below, I request that payment of PhilHealth benefits for the Outpatient HIV/AIDS Treatment Package be made on my behalf to the aforementioned hospital for services provided to me by the hospital and its staff.

I undertake to release PhilHealth and its employees from any and all liabilities relative to the release of the above-enumerated information.

_____	_____	_____
Name of Patient or Person Acting on Patient's Behalf	Signature	Date

Reasons for Signing on Patient's Behalf: _____

_____	_____	_____
Name of Attending Physician	Signature	Date

Witnesses:

_____	_____	_____
Print Name	Signature	Date

Revised: December 2009

Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

May 7, 2015

DEPARTMENT MEMORANDUM:
No. 2015 - 0139

FOR: **ALL DIRECTORS OF BUREAUS, SERVICES, and REGIONAL OFFICES, MEDICAL CENTER CHIEFS OF DOH-RETAINED HOSPITALS, DOH-ATTACHED AGENCIES, and DOH-DESIGNATED HIV TREATMENT HUBS, and KEY PARTNERS from the LOCAL GOVERNMENT UNITS, PRIVATE SECTOR and NON GOVERNMENT AND COMMUNITY-BASED ORGANIZATIONS, and OTHERS CONCERNED.**

SUBJECT: **Updated List of DOH-Designated Treatment Hubs and Satellite Treatment Hubs**

The Department of Health, through the National AIDS and STI Prevention and Control Program (NASPCP) under the Infectious Disease Office (IDO) of the Disease Prevention and Control Bureau (DPCB), continues to uphold its mandate to ensure universal access to antiretroviral therapy (ART) to all people living with HIV (PLHIV) needing treatment, in line with the achievement of Universal Health Care or Kalusugang Pangkalahatan.

Thus, antiretroviral drugs and other HIV services can already be accessed through the following DOH-Designated Treatment Hubs:

1. Baguio General Hospital and Medical Center
2. Ilocos Training and Regional Medical Center
3. Cagayan Valley Medical Center
4. Jose B. Lingad Memorial Regional Hospital
5. James L. Gordon Memorial Hospital
6. Philippine General Hospital
7. San Lazaro Hospital
8. Research Institute for Tropical Medicine
9. Makati Medical Center
10. The Medical City
11. Ospital ng Palawan
12. Bicol Regional Training and Teaching Hospital
13. Western Visayas Medical Center

14. Corazon Locsin Montelibano Memorial Regional Hospital
15. Vicente Sotto Memorial Medical Center
16. Gov. Celestino Gallarres Memorial Medical Center
17. Eastern Visayas Regional Medical Center
18. Southern Philippines Medical Center
19. Northern Mindanao Medical Center
20. Zamboanga City Medical Center
21. Butuan Medical Center
22. Caraga Regional Hospital

Likewise, the DOH expanded and decentralize ART services through the establishment of the Satellite Treatment Hubs. These aim to increase access and maximize coverage by bringing the services closer to the key populations in key geographic areas, thereby ensuring linkage to care and providing primary care services including provision of ART to PLHIV early in the course of the disease. The following are the established Satellite Treatment Hubs:

1. Quezon City Klinika Bernardo
2. Marikina City Health Office
3. Manila Social Hygiene Clinic
4. Cebu City Social Hygiene Clinic
5. General Santos City District Hospital
6. Dr. Rafael S. Tumbokon Memorial Hospital

This is for your information and for immediate dissemination.

JANETTE P. LORETO-GARIN, MD, MBA-H
Secretary of Health

ANNEX 3 - INSTRUCTIONS HOW TO ACCOMPLISH CLAIM FORM 2 (CF2) FOR OHAT PACKAGE

Claim Form 2 shall be accomplished using capital letters and by checking the appropriate boxes. All items should be marked legibly by using ballpen only.

All dates should be filled out in MM-DD.YYYY format.

CF 2 Part/Item	Description	Instruction
Part I	PhilHealth Accreditation Number of Health Care Institution Name of Health Care Institution Address	Write the PhilHealth Accreditation Number, name of HCI and the address on the space provided.
Part II, item 1	Name of Patient	Write the complete name of the patient in this format: Last Name, First Name, Name Extension (if any), Middle Name.
Part II, item 2	Referred by another HCI	Tick yes if referred from another institution and write the name of referring HCI designated as treatment hub.
Part II, item 3	Confinement period	
	Date Admitted	The consultation date or the date during which the medicines were obtained during the applicable quarter shall be considered as the admission date.
	Date Discharged	The consultation date or the date during which the medicines were obtained during the applicable quarter shall be considered as the discharge date.
Part II, item 4	Patient disposition	Check the box "Improved"
Part II, item 5	Type of Accommodation	Leave the space blank.
Part II, item 6	Admission Diagnosis/es	Write "HIV/AIDS".
Part II, item 7	Discharge Diagnosis	Write 'Human Immuno-deficiency Virus – Acquired Immune Deficiency Syndrome".
	Diagnosis	Write the diagnosis of the patient.
	ICD 10 Code/s	Write the appropriate ICD 10 Code/s.
	RVS Code	Write the RVS Code 99246 corresponding to OHAT Package.
	Date of procedures	Leave the space blank.
Part II, item 8 g	Special consideration: For Out-patient HIV/AIDS Treatment Package	WRITE the Laboratory Number as listed in the confirmatory laboratory test result (e.g. R01-32-5476).

CF 2 Part/Item	Description	Instruction
Part II, item 9	PhilHealth Benefits	WRITE the RVS Code 99246 in the line for first case rate, leave the second case rate blank.
Part II, item 10	Professional Fees	Write the accreditation number and the name of the accredited HCP on the spaces provided. Affix the signature of the accredited HCP over his/her name then write the date as the space provided.
Part III Section A	Certification of Consumption of Benefits	TICK first box (PhilHealth benefit is enough to cover HCI and PF charges) if the patient did not have any out of pocket expense related to TB treatment (such as payment for medicine, laboratory and professional fee). Write the amount 7,500 in the space provided for Grand Total of the Total Actual Charges
Part III Section B	Consent to Access Patient Record/s	Print the name of the patient and affix his/her signature over the name. Write the date when this was signed. if the patient was unable to sign, tick the appropriate boxes.
Part IV	Certification of Health Care Institution	Print the name of the authorized person to fill out the claim and his/her designation. Affix his/her signature above the name. This person must review and verify all the entries before affixing his/her signature.

PhilHealth
Your Partner in Health

This form may be reproduced and is NOT FOR SALE

CF2
(Claim Form 2)
revised November 2013

Series # _____

IMPORTANT REMINDERS:
PLEASE WRITE IN CAPITAL LETTERS AND CHECK THE APPROPRIATE BOXES.
This form together with other supporting documents should be filed within sixty (60) calendar days from date of discharge.
All information, fields and tick boxes required in this form are necessary. Claim forms with incomplete information shall not be processed.
FALSE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CRIMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.

Write the date that corresponds to the day of consultation in the Health Regimen Card as the date of admission and date of discharge

PART I - HEALTH CARE INSTITUTION (HCI) INFORMATION

1. PhilHealth Accreditation Number (PAN) of Health Care Institution: _____
2. Name of Health Care Institution: RESEARCH INSTITUTE AND TROPICAL MEDICINE
3. Address: Corporate Avenue (Building Number and Street Name) Muntinlupa City (City/Municipality) _____ (Province)

PART II - PATIENT CONFINEMENT INFORMATION

1. Name of Patient: Salazar (Last Name) Zareh Jane (First Name) _____ (Name Extension: JR/SR/III) _____ (Middle Name) (example: DELA CRUZ JUAN JR SIPAG)
2. Was patient referred by another Health Care Institution (HCI)? ☐ NO ☐ YES _____ (Name of Referring Health Care Institution) _____ (Building Number and Street Name) _____ (City/Municipality) _____ (Province) _____ (Zip Code)
3. Confinement Period: a. Date Admitted: 06 (month) - 20 (day) - 2014 (year) b. Time Admitted: 10 (hour) : 00 (min) ☑ AM ☐ PM
   c. Date Discharged: 06 (month) - 20 (day) - 2014 (year) d. Time Discharged: 11 (hour) : 00 (min) ☑ AM ☐ PM
4. Patient Disposition: (select only 1)
   ☑ a. Improved
   ☐ b. Recovered
   ☐ c. Home/Discharged Against Medical Advise
   ☐ d. Absconded
   ☐ e. Expired, Date: _____ (month) - _____ (day) - _____ (year) Time: _____ (hour) : _____ (min) ☐ AM ☐ PM
   ☐ f. Transferred/Referred _____ (Name of Referral Health Care Institution) _____ (Building Number and Street Name) _____ (City/Municipality) _____ (Province) _____ (Zip Code)
   Reason/s for referral/transfer: _____
5. Type of Accommodation: ☐ Private ☐ Non-Private (Charity/Service)
6. Admission Diagnosis/es:

Write OHAT on the related procedures with corresponding RVS code

7. Discharge Diagnosis/es: (use additional CF2 if necessary):

	Diagnosis	ICD-10 Code/s		Related Procedure/s (if there's any)	RVS Code	Date of Procedure	Laterality (check applicable boxes)
a.	HIV/AIDS		i.	OHAT PACKAGE	99246	NA	☐ Left ☐ Right ☐ Both
			ii.				☐ Left ☐ Right ☐ Both
			iii.				☐ Left ☐ Right ☐ Both
b.			i.				☐ Left ☐ Right ☐ Both
			ii.				☐ Left ☐ Right ☐ Both
			iii.				☐ Left ☐ Right ☐ Both
c.			i.				☐ Left ☐ Right ☐ Both
			ii.				☐ Left ☐ Right ☐ Both
			iii.				☐ Left ☐ Right ☐ Both
d.			i.				☐ Left ☐ Right ☐ Both
			ii.				☐ Left ☐ Right ☐ Both
			iii.				☐ Left ☐ Right ☐ Both

8. Special Considerations:
   a. *For the following repetitive procedures, check box that applies and enumerate the procedure/session dates (mm-dd-yyyy). For chemotherapy, see guidelines.*
   ☐ Hemodialysis _____ ☐ Blood Transfusion _____
   ☐ Peritoneal Dialysis _____ ☐ Brachytherapy _____
   ☐ Radiotherapy (LINAC) _____ ☐ Chemotherapy _____
   ☐ Radiotherapy (COBALT) _____ ☐ Simple Debridement _____
   b. *For Z-Benefit Package* Z-Benefit Package Code: _____
   c. *For NCP Package (enumerate four dates (mm-dd-yyyy) of pre-natal check-ups)*
   1 _____ 2 _____ 3 _____ 4 _____
   d. *For TB DOTS Package* ☐ Intensive Phase ☐ Maintenance Phase
   e. *For Animal Bite Package (write the dates (mm-dd-yyyy) when the following doses of vaccine were given)* NOTE: Anti Rabies Vaccine (ARV), Rabies Immunoglobulin (RIG
   Day 0 ARV _____ Day 3 ARV _____ Day 7 ARV _____ RIG _____ Others (Specify) _____
   f. *For Newborn Care Package* ☐ Essential Newborn Care ☐ Newborn Hearing Screening Test ☐ Newborn Screening Test For Newborn Screening, please attach NBS filter Strip
   For Essential Newborn Care, (Check applicable boxes)
   ☐ Immediate drying of newborn ☐ Timely cord clamping ☐ Weighing of the newborn ☐ BCG Vaccination ☐ Hepatitis B vaccination
   ☐ Early skin-to-skin contact ☐ Eye prophylaxis ☐ Vitamin K administration ☐ Non-separation of mother/baby for early breastfeeding initi
   g. *For Outpatient HIV/AIDS Treatment Package* Laboratory Number: RC1-32-5476

Write the Laboratory Number indicated in the HIV screening result

Write the RVS code of OHAT as the first case rate

9. PhilHealth Benefits
   ICD 10 or RVS Code: a. First Case Rate 99426 b. Second Case Rate NA

10. Professional Fees / Charges (Use additional CF2 if necessary):

Accreditation Number / Name of Accredited Health Care Professional / Date Signed	Details
Accreditation No.: ____-__________-__ Signature Over Printed Name Date Signed: __-__-____ (month, day, year)	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P ________
Accreditation No.: ____-__________-__ Signature Over Printed Name Date Signed: __-__-____ (month, day, year)	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P ________
Accreditation No.: ____-__________-__ Signature Over Printed Name Date Signed: __-__-____ (month, day, year)	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P ________

Write the amount of OHAT package if the 1st Tick box is checked (The amount is paid in full to facility)

PART III - CERTIFICATION OF CONSUMPTION OF BENEFITS AND CONSENT TO ACCESS PATIENT RECORD/S

NOTE: Member/Patient should sign only after the applicable charges have been filled-out

A. CERTIFICATION OF CONSUMPTION OF BENEFITS

☑ PhilHealth benefit is enough to cover HCI and PF charges.
No purchases of drugs/medicines, supplies, diagnostics, and co-pay for professional fees by the member/patient.

	Total Actual Charges*
Total Health Care Institution Fees	
Total Professional Fees	
Grand Total	7,500

☐ The benefit of the member/patient was completely consumed prior to co-pay OR the benefit of the member/patient is not completely consumed BUT with purchases/expenses for drugs/medicines, supplies, diagnostics and others.

a.) The total co-pay for the following are:

	Total Actual Charges*	Amount after Application of Discount (i.e., personal discount, Senior Citizen/PWD)	PhilHealth Benefit	Amount after PhilHealth Deduction
Total Health Care Institution Fees				Amount P ________ Paid by *(Check all that applies)*: ☐ Member/Patient ☐ HMO ☐ Others (i.e., PCSO, Promissory note, etc.)
Total Professional Fees *(for accredited and non-accredited professionals)*				Amount P ________ Paid by *(Check all that applies)*: ☐ Member/Patient ☐ HMO ☐ Others (i.e., PCSO, Promissory note, etc.)

b.) Purchases/Expenses NOT included in the Health Care Institution Charges

Total cost of purchase/s for drugs/medicines and/or medical supplies bought by the patient/member within/outside the HCI during confinement	☐ None ☐ Total Amount P ________
Total cost of diagnostic/laboratory examinations paid for by the patient/member done within/outside the HCI during confinement	☐ None ☐ Total Amount P ________

**NOTE: Total Actual Charges should be based on Statement of Account (SoA)*

B. 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.

Zarah Jane Salazar
Zarah Jane Salazar
Signature Over Printed Name of Member/Patient/Authorized Representative

Date Signed: 06-20-2014 (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 - CERTIFICATION OF HEALTH CARE INSTITUTION

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.

Yolanda Crisostomo
Yolanda Crisostomo
Signature Over Printed Name of Authorized HCI Representative

Hospital Administrator
Official Capacity / Designation

Date Signed: 06-20-2014 (month, day, year)