Republic of the Philippines
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PHILHEALTH CIRCULAR
No. 2017-0014

TO : ACCREDITED HEALTH CARE PROVIDERS (HCPs), PHILHEALTH REGIONAL OFFICES (PROs), AND ALL OTHERS CONCERNED

SUBJECT : **Submission of Statement of Account (SOA) *or its Equivalent* for All Case Rates Claims Reimbursement *(Revision 1)***

I. RATIONALE

As part of the review of All Case Rates (ACR) in the context of policy research, the statement of account (SOA) *or its equivalent* shall be required as attachment to PhilHealth claims application for ACR.

II. OBJECTIVE

To clarify the provisions and guide all accredited health care providers with a sample template of SOA or its equivalent containing its minimum requirements required in filing of claims.

III. SCOPE

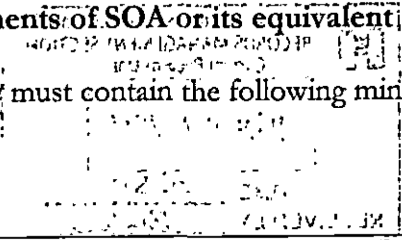
This policy shall cover claims for All Case Rates of eligible PhilHealth members and their qualified dependents in all PhilHealth accredited health care institutions.

IV. DEFINITION OF TERMS

1. *Statement of Account (SOA) - the Statement of Account (SOA) or its equivalent document issued on the day of the patient's discharge indicating hospital charges and professional fees. The equivalent documents include but not limited to:*
    a. *Billing Statement*
    b. *Patient Account Statement*
    c. *Patient Bill*
    d. *Medical Invoice*
2. *Health Care Institution (HCI) - refers to health facilities that are accredited with PhilHealth which include, among others, hospitals, ambulatory surgical clinics, TB-DOTS, freestanding dialysis clinics, primary care benefits facilities, and maternity care package providers (IRR NHI Act of 2013).*

V. GENERAL GUIDELINES

A. Minimum requirements of SOA or its equivalent



The SOA *or its equivalent* must contain the following minimum requirements:

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1. The SOA *or its equivalent* shall reflect the actual total *HCI charges and professional fees* minus the PhilHealth benefit for *both* the Health Care Institution (HCI) fee *and professional fees.* Part III item A of Claim Form 2. Certification of Consumption of Benefits and Consent to Access Patient Record/s must be consistent with that of the SOA of the patient;
2. The SOA *or its equivalent* should be duly signed by the member or his/her authorized representative (with printed name, relationship to member and contact number) confirming or concurring with the Statements therein relative to PhilHealth deductions;
3. The signatory in SOA *or its equivalent* must be the same person as the signatory in PhilHealth Claim Form 1 under Part III. Member Certification. In case the signatory in Claim Form 1 is different from the signatory in the SOA *or its equivalent*, information for authorized representative (name, relationship to member, contact number) should be indicated in the SOA *or its equivalent*;
4. The SOA *or its equivalent* should have the signature over printed name and position of the accountant or billing clerk *of the HCI.*
5. *The sample template of SOA or its equivalent (Annex A) containing its minimum requirements may be adopted. Also, HCIs shall be allowed to use their own SOA form/template as long as the minimum requirements are all stated therein.*
6. *The amount of discounts from various agencies shall be declared in the SOA or its equivalent.*

B. Inclusion and exclusion

1. *SOA or its equivalent shall only be required in filing of claims for the following:*
   a. *Peritoneal dialysis case rate – claims filed by HCIs and members/dependents who were confined abroad*
   b. *Animal Bite Treatment Package – claims filed by members/dependents who were confined abroad*
   c. *Benefit packages allowed in Birthing homes/Maternity clinics/Lying-in – claims filed by these HCIs with admission date starting October 1, 2017*
   d. *All other benefit case rates/ packages*
2. *SOA or its equivalent shall not be required in filing of claims for the following:*
   a. *TB DOTS Outpatient Package*
   b. *Outpatient Malaria Package*
   c. *Outpatient HIV/AIDS Treatment Package*
   d. *Z benefits*

C. Filing of claims

1. The original or a certified true copy of the SOA *or its equivalent* shall be submitted together with the PhilHealth Claim Forms for claims application for ACR.
2. Part III- Certification of consumption of benefits and consent to access patient record/s of PhilHealth Claim Form 2 should be completely filled out together with the SOA *or its equivalent* as supporting document.
3. The accredited health care institution shall be obliged to provide assistance to facilitate member requests and concerns, consistent with PC No. 11, s-2008, page 2.
4. Claims with incomplete documents shall be returned to sender. Existing RTS rules shall apply.
5. Claims with incomplete entries shall also be returned to sender for completion.
6. *For directly filed claims, the original or certified true copy of the SOA or its equivalent shall be submitted together with the other required documents.*
7. *To reiterate, the member/patient should sign Part III - Certification of Consumption of Benefits and Consent to Access Patient Record/s of Claim Form 2 only when applicable charges have been*

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filled-out and must be consistent with that of the SOA or its equivalent.

8. *The SOA or its equivalent shall reflect the other funds sourced from various agencies that resulted in decrease amount in the out of pocket payment of the member.*

D. Confinement abroad

1. *To reiterate, the following are the requirements in filing of claims of patients confined abroad:*
   a. *Claim Form 1, properly and completely filled out*
   b. *Statement of Account or its equivalent*
   c. *Official Receipt or any proof of payment of hospital bills and professional fees from the HCI where the patient was confined*
   d. *Certification from the attending physician as to the final diagnosis, period of confinement and services rendered*
   e. *English translations from hospital or embassy for all documents*
2. *The above documents may be original or certified true copy.*
3. *Certification as true copy of the photocopy of the above documents shall be done by the PhilHealth member.*
4. *The certified true copy of documents may be scanned for submission to PhilHealth via email. Moreover, for claims with incomplete/inconsistent documents shall be returned to the sender (RTS) via email. If warranted, the original or certified true copy of documents shall be required to submit thru package mail.*
5. *The SOA or its equivalent stating some of the minimum requirements (e.g. name of patient, name of hospital, date of confinement, actual hospital charges, professional fees, any authorized HCI representative with signature) shall be acceptable.*

VI. PENALTY CLAUSE

The health care provider shall be subject to the rules on monitoring and evaluation of performance as stipulated in PhilHealth Circular No. 54, s-2012: Provider Engagement through Accreditation and Contracting for Health Services (PEACHeS) and PhilHealth Circular No. *2016-0026* re: Health Care Provider Performance Assessment System (HCP PAS) *Revision 1, without prejudice to the filing of any administrative or criminal charges against the same.*

VII. TRANSITORY CLAUSE

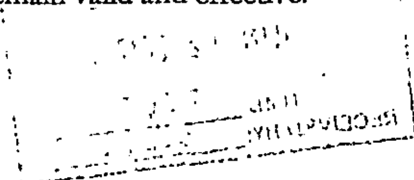
A. *Claims from Birthing homes/ Maternity clinics/ Lying-in shall not be required to attach SOA or its equivalent until September 30, 2017.*

B. *Admissions starting October 1, 2017, claims from Birthing homes/ Maternity clinics/ Lying-in shall be required to attach SOA or its equivalent in filing of claims. Otherwise, the claim shall be returned to the sender (RTS) for completion.*

C. *The minimum requirements of SOA or its equivalent (Annex A) shall be incorporated in the SOA or its equivalent required in filing of claims for admissions starting October 1, 2017. Otherwise, those HCIs forms/templates that do not comply with the minimum requirements of SOA or its equivalent shall be returned to the sender.*

VIII. SEPARABILITY CLAUSE

In the event that a part or provision of this Circular is declared unconstitutional or rendered invalid by any Court of Law or competent authority, those provisions not affected by such declaration shall remain valid and effective.



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IX. REPEALING CLAUSE

This Circular supersedes PC No. 2016-005 entitled Submission of Statement of Account (SOA) for All Case Rates Claims Reimbursement. All provisions of previous issuances that are inconsistent with any of the provisions of this Circular for this particular circumstance wherein the same is exclusively applicable, are hereby amended, modified or repealed accordingly.

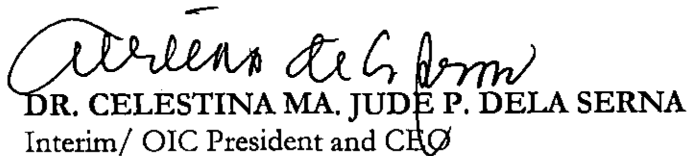
X. DATE OF EFFECTIVITY

The new provisions in this Circular shall be effective for all claims with admission dates starting October 1, 2017. It shall be published in any newspaper of general circulation and shall be deposited thereafter with the National Administrative Register at the University of the Philippines Law Center.

XI. ANNEX

Annex A – Sample template of Statement of Account (SOA) *or its equivalent* with minimum requirements

The sample template of SOA *or its equivalent* shall be available under downloads at www.philhealth.gov.ph



DR. CELESTINA MA. JUDE P. DELA SERNA
Interim/ OIC President and CEO

Date signed: 6/1/17

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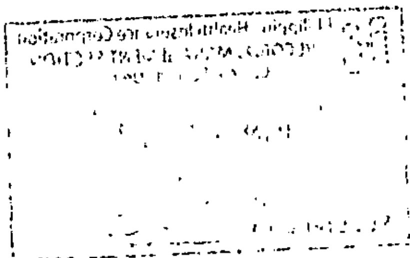


Annex A

STATEMENT OF ACCOUNT

<HCI logo>

SOA Reference No.: ___________

Name of Health Care Institution

Address
Contact No/s.

Patient name: ______________________ Age: ____
Address: ______________________
Final Diagnosis: ______________________
Other Diagnoses: 1.______________________
2.______________________
3.______________________

Date & Time Admitted: __________
Date & Time Discharged: __________
First Case Rate: __________
Second Case Rate: __________ (if applicable)

SUMMARY OF FEES

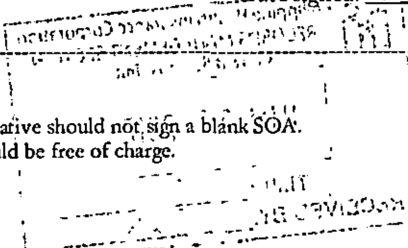
Particulars	Actual charges	Amount of Discounts			PhilHealth benefits		Out of Pocket of Patient
		VAT exempt	Senior Citizen/ PWD	Place √ ___ PCSO ___ DSWD ___ DOH (MAP) ___ HMO ___ Others: ______	First Case Rate amount	Second Case Rate amount	
HCI fees							
Room and Board							
Drugs and Medicines							
Laboratory & Diagnostics							
Operating Room fee							
Supplies							
Others: pls. specify							
Subtotal	P	P	P	P	P	P	P
Professional fee/s							
1. (name of doctors)							
2.							
3.							
4.							
5.							
Subtotal	P	P	P	P	P	P	P
Total	P	P	P	P	P	P	P

Prepared by:

____
Billing Clerk/Accountant
(Signature over printed name)
Date signed: __________
Contact no.: __________

Conforme:

____
Member/Patient/Authorized representative
(Signature over printed name)
Relationship to member of authorized representative: __________
Date signed: __________ Contact no. __________



NOTE:
1. Fill out the form legibly.
2. The member/patient/authorized representative should not sign a blank SOA.
3. Printed copy of SOA or its equivalent should be free of charge.

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