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PHILHEALTH CIRCULAR
No. 2019-0002

FOR : **ACCREDITED HEALTH CARE PROVIDERS (HCPs), PHILHEALTH REGIONAL OFFICES (PROs), AND ALL OTHER CONCERNED**

SUBJECT : **Documentary Requirements for Claims Reimbursements and Medical Prepayment Review of Claims *(Revision 2)***

I. RATIONALE

The National Health Insurance Act of 2013 (RA 7875 as amended by RA 9241 and 10606) under Article VIII (Health Care Providers) Section 37 (Quality Assurance), provides that "the performance of medical procedures and the administration of drugs are appropriate, necessary and unquestionably consistent with accepted standards of medical practice and ethics. Drugs for which payments will be made shall be those included in the Philippine National Drug Formulary, unless explicit exception is granted by the Corporation."

PhilHealth, as the administrator of the National Health Insurance Program, is mandated to ensure that quality health services are provided to its beneficiaries. The Corporation may set standards, rules and regulation that will ensure quality of care, appropriate utilization of services, fund viability, member satisfaction and overall accomplishment of Program objectives. Furthermore, it is also incumbent upon the Corporation to protect the Program and set safeguards to ensure that reimbursement of services are correct, appropriate, and ethical.

In order to sufficiently measure and assess the quality of care, PhilHealth developed and implemented policy statements that defined the standards of care to ensure better health outcomes. These are based on clinical practice guidelines and acceptable/established standards of care. To complement efforts to improve quality, PhilHealth shall employ medical pre-payment review using Claim Form 4 (CF4) in order to assess the quality of care.

II. OBJECTIVES

To establish the guidelines on requiring the CF4 to facilitate systematic data collection and evaluation of claims for payment. The clinical and administrative data contained in the Claim Form 4 (CF4) together with the results of diagnostic tests will be vital to assess the quality of care delivered by health care providers (HCPs).

III. SCOPE

This policy shall cover All Case Rate (ACR) claims of eligible PhilHealth beneficiaries in PhilHealth accredited health care institutions, with exceptions indicated under General Guidelines of this issuance.

IV. DEFINITION OF TERMS

A. Medical Prepayment Review – The process of reviewing and evaluating clinical data before claims payment to determine compliance to Corporate policies and widely accepted medical practice.

B. Claim Form 4 (CF4) – Summary of pertinent clinical information of a patient/member during their hospitalization/episode of care that shall be utilized by PhilHealth to conduct evaluation and review of claims.

V. GENERAL GUIDELINES

A. All claims for reimbursement should be accompanied by the CF4 following the prescribed format (Annex A) and photocopies of the corresponding laboratory and imaging results. The Statement of Account shall still be submitted along with the said documents.

B. The CF4 shall replace the requirement for CTC of the complete clinical charts for four (4) conditions (pneumonia, urinary tract infection, acute gastroenteritis and sepsis) which was previously required under PhilHealth Circular No. 2017-0028.

C. eClaims compliant HCIs shall *submit* the above required documents *during claim application transmission using the module developed by their service provider.*

D. This policy shall not cover claims directly filed with PhilHealth and those involving confinements abroad. Likewise, this Circular shall not apply to the following packages/benefits as their current required documentary requirements shall still apply:

1. Z-Benefit packages;
2. Outpatient HIV/AIDS Treatment (RVS 99246);
3. Outpatient Malaria Package (RVS 87207);
4. Animal Bite Treatment (RVS 90375);
5. TB-DOTS (RVS 89221 and 89222);
6. Antenatal Care Package (ANC01);
7. Normal Spontaneous Delivery (NSD01);
8. Maternity Care Package (MCP01);
9. Newborn Care Package (RVS 99432);
10. Subdermal Contraceptive Implant Package (FP01);
11. Intrauterine Device Insertion Package (RVS 58300);
12. No-scalpel Vasectomy (RVS 55250);
13. Resuscitation Package (P0000); and
14. Referral Package (P0001)

E. Claims related to deliveries such as normal deliveries (NSD01, MCP01); Cesarean section (59620, 59513, 59514); other methods of deliveries (59409, 59411, 59612); and intrapartum monitoring (59403, ANC02) shall use Claim Form 3.

F. Improperly accomplished or illegible CF4 and/or incomplete attachments shall be returned to the HCP. To process the claim, a properly accomplished CF4 and its relevant supporting documents shall be re-filed to PhilHealth within 60 days from receipt of HCI. (Refer to Annex B).

G. The Corporation reserves the right to subject any and/or all claims application to medical prepayment review.

H. The Corporation shall penalize claims attended by any, but not limited to the following circumstances (Section 47.e, IRR of RA 7875, as amended by RA 9241 and RA 10606):

1. Over-utilization or under-utilization of services;
2. Unnecessary diagnostic and therapeutic procedures and intervention;
3. Irrational medication and prescriptions;
4. Fraudulent, false or incorrect information as determined by the appropriate office;
5. Gross, unjustified deviations from currently accepted standards of practice and/or treatment protocols;

6. Inappropriate referral practices;
7. Use of fake, adulterated or misbranded pharmaceuticals, or unregistered drugs; and
8. Failure to comply without justifiable cause with the pertinent provision of the law, IRR and any issuance of the Corporation.

I. The Corporation reserves the right to request certified true copies of the complete clinical charts when additional information is necessary. Non-compliance to the request shall result in denial of the claim.

VI. PENALTY CLAUSE

The Corporation may deny or reduce the payment of claims when such claims are attended by false or incorrect information and when the claimants fails without justifiable cause to comply with pertinent rules and regulation of this Act (Section 38 of RA 7875, as amended by RA 9241 and RA 10606).

VII. MONITORING AND EVALUATION

All HCPs 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. *2018-0019* re: HCP PAS (*Revision 2*).

VIII. TRANSITORY CLAUSE

To provide sufficient time for the HCIs to align their processes and update their systems, the Corporation is allowing a transition period for admissions between March 1 to 31, 2019 applicable to submission of Claim Form 4. Submission of other documents (e.g. Claim Form 1 and 2, SOA, etc) are not affected and shall follow existing rules and guidelines.

A. *Health care institutions whose eClaims systems are ready for transmission of CF4 may transmit encoded CF4s of admissions starting March 1, 2019.*

B. *All other HCIs shall use the offline application, which shall be provided by PhilHealth, to encode Claim Form 4 and transmit using existing applications:*

1. *Those still enhancing their eClaims: Submit encoded CF4 as attachment to claim application.*
2. *Those using PHICS or SClaims: Submit encoded CF4 as attachment to claim application.*
3. *Those manually submitting claim applications: Submit soft copy of encoded CF4 together with manually-transmitted claim application.*

C. *For admissions starting April 1, 2019 onwards:*

1. *HCIs with eClaims shall transmit encoded CF4.*
2. *HCIs with PHICS or SClaims shall continue to submit encoded CF4 as attachment to claim application.*
3. *HCIs that manually submit claim applications shall continue to submit encoded CF4 together with manually-transmitted claim application.*

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IX. SEPARABILITY CLAUSE

In the event any provision of this Circular or the application of any provision to any person or circumstance is declared invalid, the remainder of this Circular or the application of said provision to other person or circumstance shall remain to be valid and effective.

X. REPEALING CLAUSE

This issuance amends PhilHealth Circular No. 2017-0028, No. 35, s.2013 and No. 8, s.2015. All other previous issuances that are inconsistent with any of the provisions of this are hereby amended, modified or repealed accordingly.

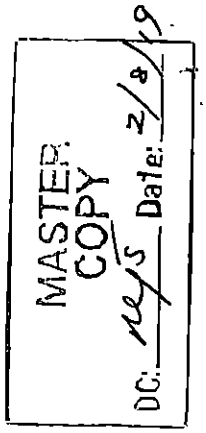
XI. DATE OF EFFECTIVITY

This Circular shall take effect for admissions starting *March* 1, 2019 onwards. This Circular shall be published in a newspaper of general circulation and shall be deposited thereafter with the National Administrative Register at the University of the Philippines Law Center.

ROY B. FERRER, M.D., MSc.
Acting President and Chief Executive Officer (CEO)

Date signed: 2/8/2019

SUBJECT : **Documentary Requirements for Claims Reimbursement and Medical Prepayment Review of Claims *(Revision 2)***



PhilHealth
Your Partner in Health

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CF4

(Claim Form 4)
August 2018

Series # |_|_|_|_|_|_|_|_|_|_|_|_|

IMPORTANT REMINDERS:
PLEASE FILL OUT APPROPRIATE FIELDS. 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 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.

I. HEALTH CARE INSTITUTION (HCI) INFORMATION

1. Name of HCI	2. Accreditation Number

3. Address of HCI

Bldg No. and Name/Lot/Block	Street/Subdivision/Village	Barangay/City/Municipality	Province	Zip Code

II. PATIENT'S DATA

1. Name of Patient

Last Name	First Name	Middle Name

2. PIN

3. Age

4. Sex ☐ Male ☐ Female

5. Chief Complaint

6. Admitting Diagnosis

7. Discharge Diagnosis

8. a. 1st Case Rate Code

8. b. 2nd Case Rate Code

9. a. Date Admitted: |_|_| - |_|_| - |_|_|_|_| (month - day - year)

9. b. Time Admitted: |_|_| : |_|_| ☐ AM ☐ PM (hour : min)

10. a. Date Discharged: |_|_| - |_|_| - |_|_|_|_| (month - day - year)

10. b. Time Discharged: |_|_| : |_|_| ☐ AM ☐ PM (hour : min)

III. REASON FOR ADMISSION

1. History of Present Illness:

2.a. Pertinent Past Medical History:

2.b. OB/GYN History
G ___ P ___ (___ - ___ - ___ - ___) LMP: _____ ☐ NA

3. Pertinent Signs and Symptoms on Admission (tick applicable box/es):

☐ Altered mental sensorium	☐ Diarrhea	☐ Hematemesis	☐ Palpitations
☐ Abdominal cramp/pain	☐ Dizziness	☐ Hematuria	☐ Seizures
☐ Anorexia	☐ Dysphagia	☐ Hemoptysis	☐ Skin rashes
☐ Bleeding gums	☐ Dyspnea	☐ Irritability	☐ Stool, bloody/black tarry/mucoid
☐ Body weakness	☐ Dysuria	☐ Jaundice	☐ Sweating
☐ Blurring of vision	☐ Epistaxis	☐ Lower extremity edema	☐ Urgency
☐ Chest pain/discomfort	☐ Fever	☐ Myalgia	☐ Vomiting
☐ Constipation	☐ Frequency of urination	☐ Orthopnea	☐ Weight loss
☐ Cough	☐ Headache	☐ Pain, _____(site)	☐ Others _____

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4. Referred from another health care institution (HCI): ☐ No ☐ Yes, Specify Reason _____

Name of Originating HCI _____

5. Physical Examination on Admission (Pertinent Findings per System)

General Survey ☐ Awake and alert ☐ Altered sensorium: _____

Vital Signs: BP: _____ HR: _____ RR: _____ Temp: _____

HEENT:

☐ Essentially normal	☐ Abnormal pupillary reaction	☐ Cervical lymphadenopathy	☐ Dry mucous membrane
☐ Icteric sclerae	☐ Pale conjunctivae	☐ Sunken eyeballs	☐ Sunken fontanelle

Others: _____

5. Physical Examination continued (Pertinent Findings per System)

CHEST/LUNGS: ☐ Essentially normal ☐ Asymmetrical chest expansion ☐ Decreased breath sounds ☐ Wheezes
☐ Lump/s over breast(s) ☐ Rales/crackles/rhonchi ☐ Intercostal rib/clavicular retraction
Others: _____

CVS: ☐ Essentially normal ☐ Displaced apex beat ☐ Heaves and/or thrills ☐ Pericardial bulge
☐ Irregular rhythm ☐ Muffled heart sounds ☐ Murmur
Others: _____

ABDOMEN: ☐ Essentially normal ☐ Abdominal rigidity ☐ Abdomen tenderness ☐ Hyperactive bowel sounds
☐ Palpable mass(es) ☐ Tympanitic/dull abdomen ☐ Uterine contraction
Others: _____

GU (IE): ☐ Essentially normal ☐ Blood stained in exam finger ☐ Cervical dilatation ☐ Presence of abnormal discharge
Others: _____

SKIN/EXTREMITIES: ☐ Essentially normal ☐ Clubbing ☐ Cold clammy skin ☐ Cyanosis/mottled skin
☐ Edema/swelling ☐ Decreased mobility ☐ Pale nailbeds ☐ Poor skin turgor
☐ Rashes/petechiae ☐ Weak pulses
Others: _____

NEURO-EXAM: ☐ Essentially normal ☐ Abnormal gait ☐ Abnormal position sense ☐ Abnormal/decreased sensation
☐ Abnormal reflex(es) ☐ Poor/altered memory ☐ Poor muscle tone/strength ☐ Poor coordination
Others: _____

IV. COURSE IN THE WARD (Attach photocopy of laboratory/imaging results) ☐ Check box if there is/are additional sheet(s).

Date	DOCTOR'S ORDER/ACTION

MASTER COPY Date: 2/8/19 DC: MS

SURGICAL PROCEDURE/RVS CODE (Attach photocopy of OR technique):

V. DRUGS/MEDICINES ☐ Check box if there is/are additional sheet(s).

Generic Name	Quantity/Dosage/Route	Total Cost	Generic Name (cont)	Quantity/Dosage/Route (cont)	Total Cost (cont)

VI. OUTCOME OF TREATMENT

☐ IMPROVED ☐ HAMA ☐ EXPIRED ☐ ABSCONDED ☐ TRANSFERRED Specify reason: _____

VII. CERTIFICATION OF HEALTH CARE PROFESSIONAL

Certification of Attending Health Care Professional:

I certify that the above information given in this form, including all attachments, are true and correct.

_____
Signature over Printed Name of Attending Health Care Professional

month ___ day ___ year ____
Date Signed

GUIDELINES ON THE PROPER ACCOMPLISHMENT OF PHILHEALTH CLAIM FORM 4 (Feb 8, 2019)

I. GENERAL GUIDELINES:

1. CF4 shall be accomplished using capital letters and by checking/ticking the appropriate boxes.

2. The information in CF4 should be the same as that in the patient's chart and all other claim forms submitted to PhilHealth.

3. All required information should be encoded in the CF4.

4. All ACR claims shall require CF4 including hemodialysis, chemotherapy, and outpatient procedures (i.e., cataract surgeries and laparoscopies). Refer to list of exclusions in PhilHealth Circular no.7 s-2018 and its revisions.

5. Claims involving repetitive procedures such as dialysis (hemo- and peritoneal), radiotherapy (LINAC and COBALT), blood transfusion, brachytherapy, and chemotherapy may be filed one time, thus use one CF4 only. In filling-out the dates, the first treatment session shall be the date of admission (item no. 7a) while the date of filing should be after the last treatment session. Important, the dates in CF4 should be consistent with CF2.

6. All conditions and procedures under the List of Medical and Procedure Case Rates shall use CF4 in filing of claims. The HCI shall indicate it in the appropriate box in CF4 as shown below:

a) If there is one mentioned condition or procedure as indicated in item 6.a (1st case rate), submit one CF4.

To illustrate:

6.a 1st case rate code J46 (Acute severe asthma)*	Use one CF4 only
6.b 2nd case rate code (blank)*	

**to facilitate explanation of guideline, the description of code is written but not during actual filing (code only)*

b) If there are two mentioned conditions ---both conditions belong to the List of Medical and Procedure Case Rates, indicated in items 6.a (1st case rate) and 6.b (2nd case rate), where the latter is allowed as 2nd case rate. The HCI shall submit only one CF4 for both conditions.

To illustrate:

6.a 1st case rate code C50.1 (Malignant neoplasm of central portion of breast)*	Use one CF4 only
6.b 2nd case rate code 96408 (Chemotherapy administration)*	

**to facilitate explanation of guideline, the description of code is written but not during actual filing (code only)*

c) If there are two mentioned conditions ---first condition belongs to the List of Medical and Procedure Case Rates, indicated in item 6.a (1st case rate) and second condition in item 6.b (2nd case rate) belongs to the list of exemptions from CF4. The HCI shall submit CF4 only for both conditions.

To illustrate:

6.a 1st case rate code P36.9 (Bacterial sepsis of newborn, unspecified)*	Use one CF4 only
6.b 2nd case rate code 99432 (Newborn Care Package)*	

**to facilitate explanation of guideline, the description of code is written but not during actual filing (code only)*

d) If there are two mentioned conditions ---first condition belongs to the list of exemptions from CF4, indicated in item 6.a (1st case rate) and second condition belongs to the List of Medical and Procedure Case Rates indicated in item 6.b (2nd case rate), the HCI shall submit CF4 PLUS the required document for the exempted condition (e.g. CF3).

To illustrate:

6.a 1st case rate code 59514 (Cesarean delivery)*	CF3 Part I – fill-out item nos. 1, 2, 4, 5 only Part II – fill-out all items
6.b 2nd case rate code I60.9 (Subarachnoid hemorrhage)*	CF4

**to facilitate explanation of guideline, the description of code is written but not during actual filing (code only)*

7. If there are items that do not apply, indicate N/A.

8. All dates should be filled-out following this format: MONTH-DAY-YEAR (MM-DD-YYYY).

Illustration: December 25, 2013 should be written as **12 - 25 - 2013**

II. SPECIFIC GUIDELINES:

A. Claim Form 4 (CF4) is divided into seven (7) parts:

□ **Part I – Health Care Institution Information** requires information about the facility to ascertain the identity and eligibility under the Program.

□ **Part II – Patient's Data** requires information about the patient to ascertain patient identity and encounter.

□ **Part III – Reason for Admission** provides the clinical information about the patient's condition during admission.

□ **Part IV – Course in the Ward** provides a description of the care received by the patient during confinement or episode of care. This section includes results of laboratory tests and/or imaging procedures, as applicable.

□ **Part V – Drugs and Medicines** provides a list of medicines or drugs ordered by the physician(s) and received by the patient during confinement and/or prescribed during outpatient consultation. This section includes information on the quantity, dosage, and route of administration of medicines or drugs ordered/prescribed. It also includes the total cost per medicine/drug.

□ **Part VI – Outcome of Treatment** provides information about the result of care or the patient's decision to leave the hospital before the end point of care (when applicable).

□ **Part VII – Certification of Health Care Professional** provides a guarantee by the attending health care professional or physician regarding the information provided. This section includes the date when the data in the form was provided and/or reviewed.

III. THE TABLE BELOW EXPLAINS THE PROPER WAY OF ACCOMPLISHING CF4:

Part I - Health Care Institution (HCI) Information

Item no.	Description and Instruction
1	**Name of HCI** Indicate the name of the health care institution as it appears in the DOH License to Operate (LTO).
2	**Accreditation Number** Indicate the PhilHealth accreditation number of the health care institution.
3	**Address of HCI** Indicate the mailing address of the health care institution, indicating the No., Building Name, Lot/Block/Building Number, Street, Subdivision/Village Barangay, City/Municipality, Province, and Zip Code. The name of sitio/purok/poblacion (if applicable) of the mailing address should be indicated before the barangay.

Part II - Patient's Data

Item no.	Description and Instruction

1	**Name of Patient** Indicate complete name of the member in the format of: last name, first name, name extension and middle name. Extensions such as (but not limited to the following) Jr., Sr., III should be indicated after the first name. If there are no name extensions, please write N/A. *Illustration:* *Name with Suffix: The name* **Juan Sipag Dela Cruz, Jr.** *should appear as*

DELA CRUZ	**JUAN**	**JR.**	**SIPAG**
Last name	*First Name*	*Extension*	*Middle Name*

2	**PhilHealth Identification Number (PIN)** Indicate the PhilHealth Identification Number (PIN), a 12 digit number, as reflected in the PhilHealth Number Card/Identification Card/Member Data Record (MDR) in the 2-9-1 format. The PIN encoded in this item refers to the **PIN of the patient** – member PIN if primary member and dependent PIN if dependent. If patient is a dependent and has no assigned PIN yet, PIN of primary member should be encoded. *Illustration: 07-123456789-1*
3	**Age** Indicate the age of the patient upon admission in years. For very young children (including newborn), the age may be in months/weeks/days/hours (as appropriate) with the appropriate label (e.g., 25 days, 3 months or 48 hours).
4	**Sex** Indicate male or female. Check appropriate box.
5	**Chief Complaint** It is the concise statement of the patient as he/she describes his/her symptom, problem, condition, return, or other factor that prompted the confinement or medical encounter. Important note: For special cases like chemotherapy, may indicate as chief complaint "chemotherapy session for breast cancer"; radiotherapy treatment, write "radiotherapy session for prostate cancer; or hemodialysis treatment, write "hemodialysis" or extracorporeal dialysis."
6	**Admitting Diagnosis** Indicate the initial impression or working diagnosis as documented by the attending physician based on assessment upon admission.

7	**Discharge Diagnosis** Indicate the final diagnosis of attending physician just before patient leaves the hospital. For purposes of CF4, the discharge diagnosis refers to the identified nature and cause of a disease or injury through evaluation of patient history, physical examination, and review of laboratory/imaging data.
8.a	**1st Case rate code** Indicate the appropriate ICD-10 or RVS code in item 6.a. Rates or amounts are not needed. **1st case rate** is defined as the case rate claimed by Health Care Institutions (HCIs) for PhilHealth reimbursement which represents/covers the medical condition of the patient with the most resources used, not necessarily the main condition (source: PC no. 35 s-2013).
8.b	**2nd Case rate code** Indicate the appropriate ICD-10 or RVS code in item 6.b. Rates or amounts are not needed. **2nd case rate** is defined as the case rate claimed by HCIs for PhilHealth reimbursement which represents/covers the medical condition of the patient with the second most resources used (source: PC no. 35 s-2013).
9.a	**Date admitted** Indicate the date of admission in the hospital in the format of: month-day-year.
9.b	**Time admitted** Indicate the time of admission in the hospital in the format of: hour-minute. Check if AM or PM.
10.a	**Date Discharge** Indicate the date when patient leaves the hospital in the format of: month-day-year.
10.b	**Time discharge** Indicate the time when patient leaves the hospital in the format of: hour-minute. Check if AM or PM.

Part III – Reason for Admission

Item no.	Description and Instruction
1	**History of Present Illness** A concise statement about the history for the medical encounter arranged in chronological order.
2.a	**Pertinent Past Medical History** Indicate all pertinent diagnosed condition(s) in the past including previous hospitalizations and surgeries of the patient.
2.b	**OB/GYN History** Indicate obstetric code and date of last menstrual period (LMP) in the format of: month-day-year. If the item does not apply, tick N/A.
3	**Pertinent signs and symptoms** Indicate all pertinent signs and symptoms upon admission. This is equivalent to review of systems (ROS). May use 'Others' if other than those specified in CF4.
4	**Referred from another HCI:** To be filled-out only when patient came from another health facility for a stated reason in the referral form/clinical chart (or any equivalent). Check appropriate tick box. If yes, indicate the reason(s) for referral and identity of originating HCI.
5	**Physical Examination** Indicate all pertinent PE findings on admission. If there are no findings, check *Essentially normal*. For additional notes and laterality (when applicable), may indicate as side note beside each box.

Part IV – Course in the Ward

Description and Instruction
Date and Doctor's Order/Action a) Enumerate all relevant activities/actions taken during episode of care arranged in chronological order (i.e., start from date of admission). The date for each activity should be indicated in the appropriate space provided for. This section also includes notes of patient's progress and corresponding action(s) taken by appropriate health care professional(s). b) For day surgeries and repetitive procedures, may indicate only the essential orders of

attending physician(s). State any key changes in patient's condition, if any. For repetitive procedures, especially those with multiple sessions in one claim, pertinent event in each procedure date should be reflected in this section. If there are no significant events during the session/encounter, may indicate "No reportable or pertinent incidents during the procedure/session" or a similar statement.

c) Please attach copies of pertinent laboratory and/or imaging results to support the management during episode of care and final diagnosis during discharge.

Surgical Procedure/RVS code

a) Indicate the description of operation/procedure including RVS code, if there is a procedure done. Attach copy of Operative Room (OR) Record.

Illustration:
Repair of wound, extraocular muscle, tendon and/ or Tenon's capsule - 65290

b) The operative room (OR) record/technique shall not be required as attachment for the following repetitive procedures only:

	Name of Procedure	RVS code	
1.	Blood transfusion	36430	
2.	Clinical brachytherapy	77761 77776	77781 77789
3.	Chemotherapy	96408	
4.	Dialysis other than Hemodialysis	90945	
5.	Hemodialysis	90935	
6.	Radiotherapy (Cobalt or Linear Accelerator)	77401	
7.	Other: Intensity Modulated Radiotherapy (IMRT)	77418	

Part V – Drugs and Medicines

Description and Instruction
Select from the drop-down the medicines/drugs prescribed to the patient (in generic name) including quantity (actual number of drug) and form, dosage, frequency and route of administration. Also, indicate the total cost per medicine used during confinement (computation: unit cost x number of tab/pills/vials/ampules used).

To illustrate:

Generic name	Quantity/Dosage/Route	Total Cost
Paracetamol	10 tablets, 500 mg per tablet, 1 tab every 4 hours, oral	Php 10.00 (P1 x 10 tabs)*
Tobramycin	1 bottle, 0.3% ophthalmic solution, 1 drop every 4 hours	Php 370.00 (P185 x 2 bottles)*
Mupirocin	1 tube, 2% cream, TID, topical	Php 470.00 (P470 x 1 tube)*

**to facilitate explanation of guideline, the computation is shown but not during actual filing (total cost only)*

Part VI – Outcome of Treatment

Description and Instruction
Check appropriate box based on the status of patient upon discharge. If patient was transferred to another facility, indicate the reason for transfer. The outcome of treatment may be classified as any one of the following: a) Improved – patient has recovered or near recovery upon discharge. b) HAMA – Home Against Medical Advice. It occurs when a patient decides to leave the hospital against the opinion of the managing physician. This form of discharge may be carried out by the patients, their relatives (in the case of adult patients with competency problems) or their parents (in the case of children). This is also known as discharge against medical advice (DAMA) c) Expired – patient died during the episode of care/confinement period. d) Absconded – patient deliberately left the health care facility without prior knowledge of attending physician and relevant personnel in the HCI. e) Transferred – patient was physically brought to another health care facility for a specific care.

Part VII – Certification of Health Care Professional

Description and Instruction
The attending health care professional shall affix his/her signature certifying that all information provided are true and accurate. He/she should also indicate the date of signing the form. *Note: For salaried physicians in government and private training hospitals, the medical director, hospital administrator, or chief of clinics, may sign in lieu of the attending physician. SOURCE: PhilHealth Circular No. 14, s-2008.*