Annex A

PDR-March2014

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
City State Bldg., 709 Shaw Blvd., Pasig City
Health Line 441-7444; www.philhealth.gov.ph

PROVIDER DATA RECORD
HEALTH CARE INSTITUTION

THE PRESIDENT & CEO
Philippine Health Insurance Corporation
Pasig City, Philippines

Sir/Madam:

I, _____, of legal age, _____ (Position/Designation) with address at _____ and the duly authorized representative to act for and in behalf of _____ (name of healthcare institution), hereby submits the following pertinent information and documentary requirements under Sec. 56 of the Implementing Rules and Regulations of RA 7875 as amended by RA 10606.

Name of Health Care Institution: (Please print legibly and provide appropriate spaces)

Accreditation Number/s		PhilHealth Employer Number	

Mailing/Billing Address:

No./St./Brgy.					
Municipality /City		Province:		ZIP Code	

Contact Information

Contact No.	Fax No.	Official Email Address: (mandatory)

Facility Head/ Medical Director/Chief of Hospital/Hospital Administrator	Accreditation No.

Contact Information of the Facility Head:

Contact Number	Email Address

A. Hospital:

☐ **General** ☐ **Specialty**

Hospital Level: ☐ Level 1 ☐ Level 2 ☐ Level 3

DOH-LTO No _____ Validity of DOH-LTO: _____

B. Other Health Facilities:

Primary Care Facilities

☐ With Inpatient Beds*
- ☐ Infirmary/Dispensary *
- ☐ Birthing Homes *

* DOH-LTO No. _____
* Validity of DOH-LTO _____

☐ Without Beds:

Medical Outpatient Package Providers
- ☐ Anti TB/DOTS Package **
- ☐ Maternity Care Package (MCP)
- ☐ Primary Care Benefit (PCB)
  - ☐ Outpatient Malaria
- ☐ Animal Bite Package ** _____

☐ MCP, DOTS** and PCB
☐ MCP and DOTS**
☐ MCP and PCB
☐ PCB and DOTS**

Specialized Outpatient Facility

☐ Ambulatory Surgical Clinic
* DOH-LTO No _____

☐ Freestanding Dialysis Clinic (FDC)*
* Validity of DOH-LTO: _____

Nature of Ownership

1. Government

☐ National - DOH retained
☐ DND / DOJ
☐ State Unitversities / College
☐ Others

☐ Local*
- ☐ Province
- ☐ Municipality
- ☐ City
- ☐ District

2. Private**

☐ Single Proprietor
☐ Partnership
☐ Corporation
☐ Others (Specify) _____

☐ Foundation
☐ Cooperative
☐ Civic organization

*Name of incumbent LC _____ **Name of owner/s _____

Type of Application: (Please check)

☐ **Initial Application**
☐ **Continuous Accreditation**
☐ **Re-accreditation***

* **Re-accreditation transactions**
- ☐ Transfer of location
- ☐ Change in facility classification
- ☐ Upgrading of hospital level
- ☐ Additional service
- ☐ Resumption of operation after closure/ cease operation

☐ Change of ownership
☐ Application after incurring a gap in accreditation regardless of length of gap
☐ Previous Continuous Accreditation was withdrawn

Profile Update
- ☐ Change in Facility Head/ Medical director/ COH
- ☐ Change in name
- ☐ change in contact Information

For PhilHealth Use Only

Remarks: _____

Date Received:	LHIO		By:	LHIO	
	PRO			PRO	
Date Evaluated:	LHIO		By:	LHIO	
	PRO			PRO	
Date Encoded:	LHIO/PRO (Receiving Module)		By:	LHIO	
	PRO (Data Entry)			PRO	

Control No. _____

OR No. _____
Date Paid: _____
Amount: _____