Annex C: Supplemental Provider Data Record

Part I - General Information			
Name of Facility:			
Address			
Address line 1:			
Address line 2:			
City/Municipality:		*Province:*	
Region:		*Postal Code:*	
Mobile No.:		*Landline No (Office):*	
Email Address:			
CIU Manager			
Last Name:		*Middle Initials:*	
First Name:		*Suffix:*	
Institutional Affiliation:			
Position:			
Catchment			
No. of Municipalities catered:			
Names of Municipalities catered:			
Referral Hospital 1			
Name of Facility			
Address line 1:			
Address line 2:			
City/Municipality:		*Province:*	
Region:		*Postal Code:*	
Referral Hospital 2 *(indicated N/A if no additional referral hospital)*			
Name of Facility			
Address line 1:			
Address line 2:			
City/Municipality:		*Province:*	
Region:		*Postal Code:*	
Referral Hospital 3 *(indicated N/A if no additional referral hospital)*			
Name of Facility			
Address line 1:			
Address line 2:			
City/Municipality:		*Province:*	
Region:		*Postal Code:*	
In cases where there are more than 3 referral hospitals, please attach another form and fill out the "refer all hospital" section.			
Service Capacity			
Accomodations			
Ward type:			
No. of beds in ward type accomodations:			
No of bathrooms for patients in ward type accomodations:			
Total No of toilets for patients in ward type accomodations:			
Total No of showers for patients in ward type accomodations:			
With cohorting for patients in ward accomodations (Y/N):			
Single Room:			
No. of beds in single rooms w/o ensuite bathrooms:			
No. of beds in single rooms with ensuite bathrooms:			
Human Resource			
Total no. of employed physicians:			
No. of physicians on duty/day:			
Total no. of employed nurses:			
No. of nurses on duty/day:			
Total no. of other health workers employed:			
List other types of health workers employed:			
Total no. of other non-health workers employed:			
List other types of non-health workers employed:			

I certify that the information submitted in this application is true and correct to the best of my knowledge.
I further understand that any false statements may result in denial or revocation of my accreditation.

For CIUS set up by Level 2 and Level 3 Hospitals
Further, in signing this document, I confirm that I have coordinated and secured explicit permission from LGUs of the municipality/municipalities identified above to serve as a CIU catering to their constituency.

XXX, CIU Manager

Part II - Authorization

This is to authorize (Name of the CIU facility) to use our eClaim system for the filing and submission of Covid-19 Community Isolation Benefit Package (CCIBP) claims using its own PhilHealth Accreditation Number (PAN) and cipher key. Further, all PhilHealth reimbursements for the CIU's filed claims shall be credited to the (name of partner institution) ACPS account and shall subsequently be disbursed to the said CIU based on agreed terms.

For this purpose, I hereby submit the following bank account information:

1. *Bank Name* _____
2. *Branch* _____
3. *Bank Account Name* _____
4. *Bank Account Number* _____
5. *Official HCI Email Address* _____
6. *Landline Number* _____
7. *Mobile Number* _____

(Partner Facility)

Signature over printed Name
Medical Director/Authorized Representative