



LOGO

Letterhead of the referral facility

ANNEX D.1

CERTIFICATION OF SERVICE DELIVERY SUPPORT

(Laboratory and Diagnostic Services)

This is to certify that our institution is PhilHealth accredited/DOH licensed and is contracted referral facility and/or service provider in behalf of **(Name of referring facility)** for the PhilHealth Konsulta Package from **(period of engagement)**. As a Service Delivery partner, we shall provide the following services:

- Laboratory
 - CBC w/ Platelet count
 - Fasting **or** Random Blood Sugar
 - Fecal Occult Blood
 - Fecalalysis
 - Lipid Profile
 - HbA1c
 - Oral Glucose Tolerance Test (OGTT)
 - Pap Smear/VIA
 - Sputum Microscopy
 - Urinalysis
 - Creatinine
- Diagnostic
 - Chest X-Ray
 - ECG

Further, this institution shall not charge any fees directly from the referred patient but shall create the billing and payment arrangement with **(Name of referring facility)** for services provided.

This certification is being issued for PhilHealth accreditation and monitoring purposes.

CERTIFIED BY:

CONCURRED BY:

Referral Facility

Referring Facility

Medical Director/Administrative Officer
Signature over printed name and designation

Medical Director/Administrative Officer
Signature over printed name and designation

Date Signed: _____

Date Signed: _____