Waiver for Directly Filed Claims for SARS-CoV-2 Testing Package

[PHILHEALTH ACCREDITED SARS-CoV-2 TESTING LABORATORY/HCP LOGO]

___________
(Date)

To PhilHealth:

This is to certify that based on our records, ____________________________________________,
(Patient’s last name, first name, name extension, middle name)
who was tested for SARS-CoV-2 at ________________________________________________,
(Name of PhilHealth accredited SARS-CoV-2 testing laboratory/HCP)
on ________________________________________________
(Date/s of test/s mm/dd/yyyy)

had no PhilHealth deductions for the laboratory charges and reader’s fees upon the conduct of the test
procedure/s. All charges to the amount of ________________________________________________
(Amount in words)

(Php_____________________ ) were fully paid by the patient/member under Official Receipt No/s.

__________________________________________________________________________________.

PhilHealth benefits for SARS-CoV-2 testing were not availed of or was not deducted from the
actual charges for the following reason/s:

__________________________________________________________________________________

(Reason/s)

This waiver is being issued upon the request of ____________________________________________,
(Patient’s/member’s last name, first name, name extension, middle name)
for whatever legal purpose it may serve.

(Signature over printed name of the authorized testing laboratory/HCP representative)

(Designation of the authorized testing laboratory/HCP representative) (Date signed)

Conforme:

(Signature over printed name of the patient/member/authorized representative) (Date signed)