## 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)