



Letterhead of the Referral Facility

Annex C

CERTIFICATION OF SERVICE DELIVERY SUPPORT

(Inpatient Care)

This is to certify that our facility is PhilHealth accredited and is the referral facility and/or service provider in behalf of (Name of referring facility) for the COVID-19 Home Isolation Benefit Package (CHIBP) from (period of engagement). As a service partner, we shall provide the following services:

**Hospital**

- Management of patient needing inpatient care including laboratory and diagnostic services (as needed)
- Conduction of patient from home to hospital and vice versa, and as necessary

Further, this facility shall not charge any fees directly from the referred patient.

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: \_\_\_\_\_