Letterhead of the Referral Facility

Annex D

CERTIFICATION OF SERVICE DELIVERY SUPPORT

(Telemedicine)

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 of the following services:

Teleconsultation service

- ◯ Videoconferencing
- ◯ Telephony
- ◯ Telereferral

Further, this facility shall while ensuring strict compliance to the data privacy law and shall not charge any fees directly from the referred patient but shall create 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:

Referral Facility

_____

Medical Director/ Administrative Officer
(Signature over printed name and designation)

Date Signed: _____

CONCURRED BY:

Referring Facility

_____

Medical Director/ Administrative Officer
(Signature over printed name and designation)

Date Signed: _____