Sample Template of the Statement of Accounts (SOA)

The following is the sample template of Statement of Account with sample entries.

Statement of Accounts

<HCI Logo> SOA Reference No.: _____

<Name of Health Care Institution>
Address
Contact No./s

Patient Name: XXX YYY Age: 60 y/o
Address: Purok A, B City
Final Diagnosis (in ICD-10): acquired immunodeficiency syndrome (B24)
Other Diagnosis (in ICD-10): Hypertension (I10)

Date and Time Admitted: Dec. 1, 2021
Date and Time Discharged: Dec. 1, 2021

Summary of Fees

Fee Particulars	Amount	Discount	PhilHealth	Other Funding Sources	Balance
Drugs and Medicines Note: # 1 bottle Dolutegravir 50 mg/tab (Note: 30 tabs per bottle, delivered via courier November 26, 2021)	2,100.00	420.00	1,680.00	0	0
Laboratory and Diagnostics Notes: Chest x-ray (Dec 1, 2021) SGOT (Dec. 1, 2021) SGPT (Dec.1, 2021)	1,500.00	300.00	1,200.00	0	0
Medical Supplies none	0	0	0	0	0

MASTER COPY Date: 12/17/2021 DC: bm

Fee Particulars	Amount	Discount	PhilHealth	Other Funding Sources	Balance
Others Note: Courier (November 26, 2021)	200.00	0	200.00	0	0.00
Professional Fees	1,600.00	320.00	1,280.00	0	0.00
TOTAL	**5,400.00**	**1,040.00**	**4,360.00**	**0**	**0.00**

Summary of Professional Fees

Physician Accreditation Number	Physician Name	Amount	Discount	PhilHealth	Other Funding Sources	Balance
123456	Dr. MMM RRR	800.00	160.00	640.00	0.00	0.00
123457	Dr. NNN LLL	800.00	160.00	640.00	0.00	0.00
TOTAL		**1,600.00**	**320.00**	**1,280.00**	**0.00**	**0.00**

Itemized Billing of Facility Charges

MASTER COPY
DC: Ben Date: 12/17/2021

Service Date	Item Name	Unit of Measurement	Price	Quantity	Amount
November 26, 2021	Dolutegravir 50 mg per tablets, 30 tables per bottle	Bottle	2,100.00	1	2,100.00
December 1, 2021	Chest x-ray, PA	Test	700.00	1	700.00
December 1, 2021	SGOT	Test	400.00	1	400.00
December 1, 2021	SGPT	test	400.00	1	400.00

Service Date	Item Name	Unit of Measurement	Price	Quantity	Amount
November 26, 2021	Courier	delivery	200.00	1	200.00
TOTAL					**3,800.00**

Prepared By:

_____
Billing Clerk/Accountant
(Signature over printed name)
Date signed: _____
Contact no.: _____

Conforme:

_____
Patient/Authorized Representative
(Signature over printed name)
Relationship of authorized representative to patient: _____
Date signed: _____
Contact no.: _____

Note: The information on the statement of account and what is encoded on Part III and Part II# 10 (for professional fee) of Claim Form 2 should be the same. The specific details of the items in the SOA should be written/encoded in the itemized billing.