Annex B: Sample Medical Certificate

Notes to the Healthcare Provider:

This serves as the official medical certificate accepted by PhilHealth and shall be used as supporting document for claims reimbursement of COVID-19 Rapid Antigen Testing Benefit Package. By submitting this form, you have acknowledged that the personal information collected will be used in connection with this claim for reimbursement before PhilHealth.

Any accredited healthcare facility submitting claims may be required to provide additional information and will be notified when further information is required.

(TESTING CENTER LETTERHEAD)

The following sections are to be completed by the Physicians:

Name:			
Age:	Sex:	Birthdate:	Date Performed:
PhilHealth No.:			

Test Method Used: Rapid Antigen Test

Rapid Antigen Test Kit Brand: _____

Specimen used:

- ☐ Nasal
- ☐ Nasopharyngeal
- ☐ Oropharyngeal

Result: _____

Date of Result: _____

This is to certify that the aforementioned patient was tested for COVID-19 Rapid Antigen Test and the information provided herein is true and correct.

(Signature of Physician)
Name of Physician
PRC License No.