Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
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www.philhealth.gov.ph

PHILHEALTH CIRCULAR
No. 2022 - 0004

TO : **ALL PHILHEALTH MEMBERS, ACCREDITED HEALTH CARE INSTITUTIONS/ PROVIDERS, PHILHEALTH REGIONAL OFFICES, BRANCHES, LOCAL HEALTH INSURANCE OFFICES AND ALL OTHERS CONCERNED**

SUBJECT : **COVID-19 Home Isolation Benefit Package (CHIBP) *(Revision 2)***

I. RATIONALE

To address the COVID-19 global pandemic, the President of the Philippines, through Republic Act No. 11469, also known as Bayanihan to Heal as One Act, and Presidential Proclamation No. 929 s. 2020 declared a State of Public Health Emergency. In response, PhilHealth developed COVID-19 benefits to cover for cases requiring community isolation, testing, and hospitalization. Amidst the recent surge of COVID-19 cases in the Philippines, there is a notable rise in *mild and moderate cases. According to the Department of Health (DOH), as of January 2022, 99% of active cases are considered either asymptomatic (3%), mild (95%) or moderate (1%). Less than 1% of active cases are either severe or critical.* Dealing with the surge situation requires *more efficient* management of *moderate (w/o pneumonia),* mild, and asymptomatic COVID-19 cases and hospital resources should *be better allocated to care for* COVID cases *that require admissions.*

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Given the aforementioned, PhilHealth, by virtue of *PhilHealth Board Resolution (PBR) No. 2684 s. 2022, enhanced the* home isolation package *initially created through* PBR No. 2621, s. 2021 *and* consistent with *DOH Department Memorandum No. 2022-0013 published on January 15, 2022.* The COVID-19 Home Isolation Benefit Package (CHIBP) will serve as an alternative for patients who meet the social and clinical criteria for home isolation and who do not want to stay in a Community Isolation Unit (CIU) and can instead receive health support directly in their homes.

II. OBJECTIVES

The following are the objectives of this package:

A. Support the rationalization of use of higher level facilities to focus on COVID-19 cases *requiring hospital admission;*

B. Incentivize facilities who can offer home isolation services; and

C. Provide an alternative option for isolation of COVID-19 positive, *moderate (w/o pneumonia),* mild, and asymptomatic patients who meet the social and clinical criteria for home isolation.

III. SCOPE

This PhilHealth Circular shall apply to all claims for home isolation services filed by *PhilHealth-accredited CHIBP providers.*

IV. DEFINITION OF TERMS

A. **Asymptomatic** - any patient who tested positive for RT-PCR but with no signs and symptoms of COVID-19 disease

B. **Barangay Health Emergency Response Team (BHERT)**[1] - a team established by Department of the Interior and Local Government (DILG) MC No. 2020-023 to help implement local prevention and mitigation, preparedness and response measures for COVID-19.

C. **Community Isolation Units (CIUs)**[2]– DOH certified publicly or privately-owned non-hospital facilities set-up in coordination with or by the national government or local government units to serve as quarantine facilities for COVID-19 cases, based on DOH guidelines. Examples of CIUs include LIGTAS COVID Centers and Mega LIGTAS COVID Centers.

D. **Health Facility (HF)**[3] – *Facilities which can either be* public or private, devoted primarily to the provision of services for health promotion, prevention, diagnosis, treatment, rehabilitation and palliation of individuals suffering from illness, disease, injury, disability, or deformity, or in need of obstetrical or other medical and nursing care.

E. **Isolation**[4] – the separation of ill or infected persons from others to prevent the spread of infection or contamination.

F. **Mild COVID-19**[5]– *COVID-19 case with* no pneumonia or hypoxia/desaturation, acute onset of fever and cough or any three or more of the following: fever, cough, coryza, sore throat, diarrhea, anorexia/nausea/vomiting, loss of sense of smell or taste, general weakness/body malaise/fatigue, headache, myalgia.

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G. ***Moderate COVID-19 w/o pneumonia***[5] – *COVID-19 case with no pneumonia but with risk factors for progression; elderly (60 years old and above) and/or with comorbidities*

H. ***Pneumonia***[5]- *evidence of lower respiratory disease during clinical assessment (e.g. cough, fever plus crackles) and/or imaging (CXR, ultrasound, CT scan)*

I. **Teleconsultation**[6]–consultation done through telecommunications with the purpose being diagnosis or treatment of a patient, with the sites being remote from patient or physician.

V. POLICY STATEMENTS

A. Rules For Accreditation in Providing the COVID-19 Home Isolation Benefit Package (CHIBP)

1. PhilHealth-accredited Community Isolation Units (CIUs), Infirmaries, Hospitals, and

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[1] Joint Administrative Order No. 2020-0001: Guidelines on Local Isolation and General Treatment Areas for COVID-19 cases (LIGTAS COVID) and the Community-based Management of Mild COVID-19 Cases
[2] Ibid
[3] *Republic Act No. 11223 or The Universal Health Care Act (UHC)*
[4] Joint Administrative Order No. 2020-0001: Guidelines on Local Isolation and General Treatment Areas for COVID-19 cases (LIGTAS COVID) and the Community-based Management of Mild COVID-19 Cases
[5] *DOH Department Memorandum No. 2022-0002: https://doh.gov.ph/sites/default/files/health-update/dc2022-0002.pdf*
[6] Deldar, 2016; Van Dyk, 2014

Konsulta providers shall be allowed to provide the CHIBP.

2. Interested PhilHealth-accredited facilities shall submit additional documentary requirements as follows:

   a. Completely filled-out CHIBP Self-Assessment Tool (Annex A: CHIBP Self-Assessment Tool);

   b. Letter of Intent; (Annex B: Letter of Intent);

   c. Signed Performance Commitment as CHIBP provider (Annex C: Performance Commitment);

   d. Service Delivery Agreements (SDAs) and/or an Authorization Letter under the following conditions:

      d.1 PhilHealth Konsulta facilities and infirmaries shall include in their submission a signed SDA with a L1 to L3 hospital (Annex D: Certification of Service Delivery Agreement with a Referral Facility) for referral in accordance with PhilHealth policy on COVID-19 inpatient benefit or referral plan to include transportation arrangement;

      d.2 If the PhilHealth-accredited facility intends to engage the services of a telemedicine provider, the facility shall submit a signed Certification of Service Delivery Support with the telemedicine provider (Annex E: Certification of Service Delivery Support with a Qualified Telemedicine Provider); and,

      d.3 For facilities with no eClaims system (e.g. Konsulta providers), they should have an agreement with another PhilHealth-accredited provider that will file, submit claims and receive payments electronically on their behalf, in a way that is consistent with existing PhilHealth guidelines and procedures. The facility shall submit an authorization letter for the use of the eClaims system of their partner provider (Annex F: Authorization Letter for the Use of eClaims System).

3. A Health Facility (HF) previously accredited as a CHIBP provider shall indicate the CHIBP as one of its service capabilities in its Performance Commitment upon filing of application for continuous accreditation.

4. A currently accredited HF not previously accredited as a CHIBP provider but with intention to provide the package shall submit an application for re-accreditation *and will not be required to pay any* additional accreditation fees. The accreditation of the CHIBP provider shall coincide with the accreditation of the HF.

B. Benefit Package

1. The COVID-19 Home Isolation Benefit Package (CHIBP) shall include all identified services needed to effectively manage COVID-19 confirmed asymptomatic, mild and *moderate (without pneumonia)* cases needing isolation, based on existing relevant clinical practice guidelines and as approved by the Corporation (Annex G: COVID-19 Home Isolation Benefit Package Services).

2. Testing and inpatient services for COVID-19 patients shall be covered by other applicable COVID-19 case rates.

3. The package shall be paid as a case rate *in the amount of Php 5,917.00* (see Annex H: CHIBP Package Rate and Rules on Co-pay). *Any modifications in the package rate shall be released through a PhilHealth Advisory.*

4. Healthcare workers identified to be part of the Home Isolation Team (see Annex A) shall be provided additional incentives (i.e. hazard pay) by the accredited health care facility. *The CHIBP provider can use its PhilHealth income from providing the package to incentivize BHERTs and other support staff at the providers' discretion.*

C. Availment of the Benefit Package for Home Isolation

1. *NHIP beneficiaries with a positive COVID-19 test result based on a PhilHealth approved confirmatory test shall be eligible to avail of the package as applicable based on PhilHealth Circular No. 2019-0010 on Granting of Immediate Eligibility to Members.*

   a. *Filipinos who are not yet registered under the program shall be eligible to the Package; provided, that the member complete and submit an accomplished PhilHealth Member Registration Form (PMRF) for the issuance of the PhilHealth Identification Number (PIN) or inclusion of the dependent upon availing of the benefit package. The patient, through the provider, shall submit the accomplished PMRF.*

   b. *Eligibility to the benefit package of a non-Filipino member or dependent shall be in accordance with the existing guidelines on the enrollment of foreign nationals whether employed or under the informal economy program.*

2. *Only results from PhilHealth-approved COVID-19 confirmatory test shall be accepted. Only tests with laboratory-generated results or a medical certificate (Annex I: Sample Medical Certificate) issued by the provider who administered the test within the applicable validity period (Annex G) shall be accepted as valid, unless otherwise indicated in a subsequent issuance.*

3. *To be eligible of the benefit, PhilHealth beneficiaries who are COVID-19 positive tested, through a CHIBP provider, shall accomplish appropriate forms as evidence that they meet* both the clinical and social criteria.

   a. The beneficiary shall be assessed by *any of the following:* the BHERT, *the CHIBP provider, or the Epidemiology and Surveillance Unit of the LGU or its equivalent. They shall check whether the patient meets the clinical criteria* using an assessment form (Annex J: Assessment Checklist of Clinical Criteria for COVID-19 Home Isolation Benefit Package).

   b. *The beneficiary shall review and attest that they meet the social criteria for home isolation using an attestation form (Annex K: Patient Forms). The beneficiary shall submit the signed attestation form prior receiving the home isolation kit.*

   c. The required assessment *forms can* be downloaded and printed *by the provider or the patient through the PhilHealth Website*. The PhilHealth Regional Office *or* Local Health Insurance Office *can* provide the printed forms to Local Government Units *(LGU)* in anticipation of cases where affected *beneficiaries* are not able to download and print the form (Annex L: Patient Pathway and Benefit Availment Process).

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4. Eligible beneficiaries may check the PhilHealth website for the list of CHIBP providers. *The period of isolation shall have to be in accordance with applicable guidelines issued by DOH with a minimum period of supportive care determined by PhilHealth (Annex G).*

5. In cases where the patient experiences clinical deterioration during the home isolation period, the facility shall refer the patient to a higher level facility in accordance with DOH

standards and guidelines. The accredited PhilHealth facility may file for CHIBP claim for patients transferred to higher facilities due to clinical deterioration even if the period of isolation is *below the prescribed isolation period.*

6. In the event that the patient expires due to COVID-19 in the course of home isolation, the accredited facility shall be eligible to file a claim for the CHIBP.

D. Claims Filing and Processing

1. All CHIBP claims shall be submitted electronically with complete documentary requirements (Annex M: Claims Requirement).

2. Direct filing of claims by the beneficiaries shall not be allowed.

3. All claims submitted shall be processed by PhilHealth within sixty (60) calendar days from receipt of claim provided that all requirements are submitted.

4. The filing period for claims shall be subject to prevailing PhilHealth policies and guidelines including special privileges granted during fortuitous events.

5. Claims with incomplete requirements or discrepancies shall be returned to the health facility (RTH) for compliance within 60 calendar days from receipt of notice.

6. The accredited facility may apply for motion for reconsideration for all denied claims based on existing PhilHealth policies.

E. Rules on Consultation, Patient Monitoring, and Teleconsultation

1. Informed consent (Annex K) must be secured from patients. The health care providers must apprise patients of their rights and inform them of the risks and limitations of telemedicine at the start of each teleconsultation.

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2. The initial encounter to determine whether the patient is clinically eligible for home isolation shall be conducted by *any member of the home isolation team either* through face-to-face consultations *or teleconsultations, at the discretion of the healthcare worker, in full recognition of the associated risks.*

3. *The policy* shall allow for subsequent consultations and daily monitoring (Annex N: Home Isolation Patient Monitoring Sheet) of patients for home isolation *to be conducted* through teleconsultation, either through telephony or video consultations, *or through face-to-face consultations, at the discretion of the provider.*

4. The provision of teleconsultations shall be done in accordance with prevailing DOH rules and guidelines in telemedicine practice (DOH-UP JMC 2020-0001) and shall be compliant with data privacy laws.

F. Monitoring and Evaluation

1. All PhilHealth-accredited facilities claiming for this benefit package shall be subject to the rules on monitoring prescribed by PhilHealth.

2. Feedback mechanisms on the package implementation shall be established to address implementation issues and concerns.

3. PhilHealth shall conduct a periodic review of this policy and specific provisions shall be revised as needed.

4. The accredited facility shall keep the patient's medical chart and monitoring sheet. These records must be made available upon the request of PhilHealth.

G. **Annexes** ***(to be posted on the PhilHealth website)***

1. Annex A: CHIBP Self-Assessment Tool
2. Annex B: Letter of Intent
3. Annex C: Performance Commitment
4. Annex D: Certification of Service Delivery Agreement with a Referral Facility
5. Annex E: Certification of Service Delivery Agreement with a Qualified Telemedicine Provider
6. Annex F: Authorization Letter for the Use of eClaims System
7. Annex G: COVID-19 Home Isolation Benefit Package Services
8. Annex H: CHIBP Package Rate and Rules on Co-pay
9. Annex *I*: *Sample Medical Certificate*
10. Annex *J*: Assessment Checklist of Clinical Criteria for COVID-19 Home Isolation Benefit Package
11. Annex *K*: *Patient Forms*
12. Annex *L*: Patient Pathway and Benefit Availment Process
13. Annex *M*: Claims Requirement
14. Annex N: Home Isolation Patient Monitoring Sheet

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VI. PENALTY CLAUSE

Any violation of this PhilHealth Circular, terms and conditions of the Performance Commitment, and all existing related PhilHealth Circulars and directives shall be dealt with accordingly.

The non-deduction of PhilHealth benefits by the healthcare facility shall be subjected to validation, evaluation, and further action based on existing PhilHealth policies and quasi-judicial procedures.

VII. TRANSITORY PROVISION

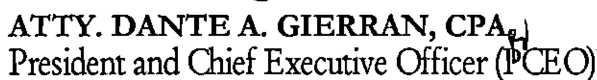
Manual submission of claims shall be allowed until such time that a notification of termination is released through a PhilHealth Advisory.

VIII. REPEALING CLAUSE

This policy *revises* PhilHealth Circular No. 2022-0002 titled "COVID-19 Home Isolation Benefit Package *(Revision 1)*."

IX. DATE OF EFFECTIVITY

This PhilHealth Circular shall take effect immediately after publication in any newspaper of general circulation or Official Gazette. A copy thereof shall be deposited thereafter with the Office of the National Administrative Register at the University of the Philippines Law Center.



ATTY. DANTE A. GIERRAN, CPA
President and Chief Executive Officer (PCEO)

Date signed: 03-03-2022

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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PhilHealth COVID 19 Home Isolation Benefit Package(CHIBP) Self-Assessment/Accreditation Survey Tool for

Name of Facility: ____________________
Address: ____________________
Contact Number: ____________________ **Email:** ____________________

Ownership of Health Facility: ☐ Government ☐ Private
Date of Assessment: (MM/DD/YY): __________

Type of Health Facilities:
☐ Hospital OPD Dept./Section (Level ________)
☐ Infirmary OPD Dept./Section
☐ CIU
☐ Konsulta Provider
PhilHealth Accreditation Number ____________________
Accreditation Validity ____________________

MINIMUM ACCREDITATION REQUIREMENTS	Applicant Please check (√) the box corresponding to your answer		PhilHealth Surveyor Please mark with check (√) if present (indicate evidence provided: photos,videos/virtual observation), or mark with X if absent		REMARKS
	Yes	No	Yes	No	
1. DOH license (for hospitals and infirmaries) 2. Updated Signed performance commitment					
3. **Home Isolation Team** - employed or contracted by the facility 3.1. Certification of Employment/Contract Arrangement 3.2. Telephone number:__________ 3.3. Email address: __________ 4. Schedule of duties					
5. At least one (1) Physician with valid PRC License and with updated PhilHealth Accreditation and at least one (1) Nurse with valid PRC License					*identify details in the declaration of Home Isolation Benefit Team
6. General Infrastructure of Provider (Provide evidence: Photos, videos, virtual observation) 6.1. Dedicated room and IT equipment for daily operation 6.2. Functional Toilet (*for employees) 6.3. Fire safety provision					If any ONE of the items is missing, mark NO.
7. **Home isolation kit** (shall ensure availability once accreditation is granted) 7.1. 1 liter 70% alcohol 7.2. 5 pcs. Face mask 7.3. 1 pulse oximeter 7.4. 1 digital thermometer 7.5. Drugs and medications (18 pcs. Paracetamol, 12 pcs. Lagundi tablets or equivalent, 6 sachets oral rehydration salts, 10 pcs Vitamin D and 10 pcs Vitamin C, and Zinc or 2 bottles) 7.6. Authorization and Consent to Participate in Teleconsultation					
8. Rapid Antigen Test (shall ensure availability once accreditation is granted) 8.1. Trained staff to conduct Rapid Antigen Test* 8.2. Brand of RAT available:__________					*in the declaration of Home Isolation Benefit Team
9. **OTHER REQUIREMENTS**					
9.1. Referral Plan – Functional referral system from the community to higher level of health care facility, as applicable					
9.2. Service Delivery Agreement (MOA/Contract) with referral facility, as applicable					
9.3. Service Delivery Agreement with a qualified telemedicine provider (optional)					
9.4. Health facility has functional medical record (CIU and Konsulta providers only)					

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Home Isolation Benefit Team					
No	Healthcare workers	Name	PRC License	PhilHealth Accreditation No. (If applicable)	Trained to conduct RAT (Y/N)
1	Physician				
2	Physician				
3	Physician				
4	Physician				
5	Physician				
6	Nurse				
7	Nurse				
8	Nurse				
9	Nurse				
10	Nurse				

Please append a secondary copy of the sheet if the space provided is not sufficient.

I HEREBY CERTIFY that the information provided in this form is complete, true and correct to the best of my knowledge.

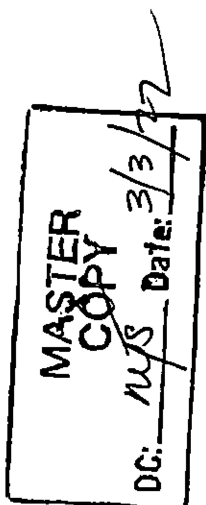
FURTHER, I HEREBY ACKNOWLEDGE that I give my consent to PhilHealth to collect, use and process my personal information. I understand that my consent does not preclude the existence of other criteria for lawful processing of personal data, and does not waive any of my rights under the Data Privacy Act of 2012 and other applicable laws.

Prepared by:

Designation

Attested by:

Head of Facility/ Medical Director/ Chief of Hospital
(Signature over printed name and date signed)



HEALTH FACILITY (HF) LOGO
HF Name
HF Address

LETTER OF INTENT

____
(Name of Regional Vice President)

____
(Address of PhilHealth Regional Office)

RVP___________________,

We, the ______(Name of HF)__________ with address at __________________________, is applying to become a provider of the COVID 19 Home Isolation Benefit Package (CHIBP).

We have read and understood the policies and guidelines on the CHIBP stated in the PhilHealth Circulars and other applicable PhilHealth issuances. We fully agree with the conditions set to qualify as an accredited CHIBP provider.

____
(Signature over Printed Name)
Medical Director/Medical Center Chief/ Head of facility
Name of Health Facility

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(Letterhead of Healthcare Provider)

Date: ____________________

PHILIPPINE HEALTH INSURANCE CORPORATION
17th Flr., City State Centre Bldg.,
Shaw Blvd., Pasig City

SUBJECT : Performance Commitment for HCI *(Rev 3)*

Sir/Madam:

To guarantee our commitment to the National Health Insurance Program (NHIP), we respectfully submit this Performance Commitment.

And for the purposes of this Performance Commitment, we hereby warrant the following representations:

A. REPRESENTATION OF ELIGIBILITIES

1. That we are a duly registered/licensed/certified health care facility capable of delivering the services expected from the type of healthcare provider that we are applying for.
2. That we are a member in good standing of the Philippine Hospital Association. (for hospitals and infirmaries only).
3. a. For single HCI

   That we are owned by ____________________
   and managed by ____________________
   and doing business under the name of ____________________
   with License/Certificate No. ____________________

   b. For Health Systems/ HCI groups

   That the following facilities, as guaranteed by the heads of facilities listed in the following table, are capable of delivering the services expected from the type of healthcare provider that we are applying for:

Name of Facility	Type of facility (hospital, RHU/HC, Birthing home/Lying-in, ASC, dialysis clinic (HD/PD), TB-DOTS, ABTCs, DRTC, OHAT, etc.)	Hospital Level (if applic-able)	License Number/ Certificate Number (if applicable)	Management (if different from the LGU)

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That all professional health care providers in our facility, *as applicable*, are PhilHealth accredited, possess proper credentials and given appropriate privileges in accordance with our policies and procedures.

B. COMPLIANCE TO PERTINENT LAWS/RULES & REGULATIONS/ POLICIES/ADMINISTRATIVE ORDERS AND ISSUANCES

Further, we hereby commit ourselves to the following:

4. That our officers, employees, and other personnel are members in good standing of the NHIP.
5. That, as responsible owner(s) and/or manager(s) of the institution, we shall be jointly and severally liable for all violations committed against the provisions of Rep. Act No. 7875 , as amended, including its Implementing Rules and Regulations (IRR) and PhilHealth policies issued pursuant thereto.
6. That we shall promptly inform PhilHealth prior to any change in the ownership and/or management of our institution.
7. That any change in ownership and/or management of our institution shall not operate to exempt the previous and/or present owner and/or manager from liabilities for violations of Rep. Act No. 7875, as amended, and its IRR
8. That we shall maintain active membership in the NHIP as an employer not only during the entire validity of our participation in the NHIP as a Health Care Institution (HCI) but also during the corporate existence of our institution.
9. That we shall abide with all the implementing rules and regulations, memorandum circulars, special orders, advisories and other administrative issuances by PhilHealth affecting us.
10. That we shall abide with all administrative orders, circulars and such other policies, rules and regulations issued by the Department of Health and all other related government agencies and instrumentalities governing the operations of HCIs in participating in the NHIP.
11. That we shall adhere to pertinent statutory laws affecting the operations of HCIs including but not limited to the Senior Citizens Act (R.A10645), the Breastfeeding Act (R.A. 7600), the Newborn Screening Act (R.A. 9288), the Cheaper Medicines Act (R.A. 9502), the Pharmacy Law (R.A. 5921), the Magna Carta for Disabled Persons (R.A. 9442), and all other laws, rules and regulations that may hereafter be passed by the Congress of the Philippines or any other authorized instrumentalities of the government.
12. That we shall promptly submit reports as may be required by PhilHealth, DOH and all other government agencies and instrumentalities governing the operations of HCIs.
13. That we shall facilitate distribution of the professional fee component of the PhilHealth payment/reimbursement to the concerned professionals not exceeding thirty (30) calendar days upon receipt of the reimbursement or at a time frame as agreed upon by the HCI and their professionals.
14. That being a government-owned health care institution, we shall maintain a trust fund for the PhilHealth reimbursements in compliance to Section 34-A of Republic Act 10606 which provides that "revenues shall be used to defray operating costs other than salaries, to

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maintain or upgrade equipment, plant or facility, and to maintain or improve the quality of care.

C. CONDUCT OF CLINICAL SERVICES, RECORDS, PREPARATION OF CLAIMS AND UNDERTAKINGS OF PARTICIPATION IN THE NHIP

15. a. For single HCI:

That we are duly capable of delivering the following services for the duration of the validity of this commitment (please check appropriate boxes):

- ☐ Primary Care Facility
- ☐ Level 1 hospital services
- ☐ Level 2 hospital services
- ☐ Level 3 hospital services
- ☐ Specialized services
  - ☐ Radiotherapy
  - ☐ Hemodialysis/Peritoneal Dialysis
  - ☐ Others (please specify) ______________________
- ☐ ______________________ Benefit package and other services
  - ☐ Tuberculosis Directly Observed Treatment Shortcourse (TB DOTS)
  - ☐ Maternity Care Package
  - ☐ Newborn Care Package
  - ☐ Malaria Package
  - ☐ Primary Care Benefit Package
  - ☐ *Expanded Primary Care Benefit Package (EPCB)*
  - ☐ Outpatient HIV/AIDS Package
  - ☐ Animal Bite Package
- ☐ Z Benefit Package/s______________________

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Others (please specify)________________________________

____

b. For Health Systems/ HCI groups

That we shall deliver the following services for the duration of the validity of this commitment:

Name of Facility	Committed Services (choose from the enumerated services *above*)

16. That we shall provide and charge to the PhilHealth benefit of the client the necessary services including but not limited to drugs, medicines, supplies, devices, and diagnostic and treatment procedures for our PhilHealth clients.
17. That we, being an accredited government hospital or infirmary/*ASC*/*FDC*/MCP/TB DOTS/ Animal Bite package/ DRTC/PCB *and/or contracted provider for the Z benefit package provider, as applicable,* shall provide the necessary drugs, supplies and services with no out-of-pocket expenses on the part of the qualified PhilHealth member and their dependents admitted or who consulted in the HCI, as mandated by the PhilHealth "No Balance Billing (NBB) Policy"
18. *That we, being an accredited provider, shall abide by the rules set in the respective benefit package, including the prescribed disposition and allocation of the PhilHealth reimbursements, as stated in the current guidelines, which shall be used by the HCI to be able to provide the mandatory services and ensure better health outcomes.*
19. *That we, being an accredited EPCB/ contracted Z benefit provider/ s, as applicable, shall post the co-payment for the drugs/ diagnostics or other services, as applicable, in a conspicuous area within the HCI.*
20. *That we, being accredited EPCB provider commits to provide service to a maximum daily patient load of ____ and maximum annual family load of ____ that the HCI can cater to and that we shall not exceed this number.*
21. That we shall maintain a high level of service satisfaction among PhilHealth clients including all their qualified dependents/beneficiaries.
22. That we shall be guided by PhilHealth-approved clinical practice guidelines or if not available, other established and accepted standards of practice.
23. That we shall provide a PhilHealth Bulletin Board for the posting of updated information of the NHIP (circulars, memoranda, IEC materials, price reference index, etc.) in conspicuous places accessible to patients, members and dependents of the NHIP within our health facility.
24. That we shall always make available the necessary forms for PhilHealth member-patient's use.

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25. That we shall treat PhilHealth member-patient with utmost courtesy and respect, assist them in availing PhilHealth benefits and provide them with accurate information on PhilHealth policies and guidelines.
26. That we shall ensure that PhilHealth member-patient with needs beyond our service capability are referred to appropriate PhilHealth-accredited health facilities.

D.MANAGEMENT INFORMATION SYSTEM

27. That we shall maintain a registry of all our PhilHealth members-patients (including newborns) and a database of all claims filed containing actual charges (board, drugs, labs, auxiliary, services and professional fees), actual amount deducted by the facility as PhilHealth reimbursement and actual PhilHealth reimbursement, which shall be made available to PhilHealth or any of its authorized personnel.
28. That we shall maintain and submit to PhilHealth an electronic registry of physicians and dentists including their fields of practice, official e-mail and mobile phone numbers.
29. That we shall, if connected with e-claims, electronically encode the laboratory / diagnostic examinations done, drugs and supplies used in the care of the patient in our information system which shall be made available for PhilHealth use.
30. That we shall ensure that true and accurate data are encoded in all patients' records.
31. That we shall only file true and legitimate claims recognizing the period of filing the same after the patient's discharge as prescribed in PhilHealth circulars.
32. That we shall submit claims in the format required by PhilHealth for our facility.
33. That we shall regularly submit PhilHealth monitoring reports as required in PhilHealth circulars.
34. That we shall annually submit to PhilHealth a copy of our audited financial statement/report, to include the disposition of PhilHealth reimbursement.

E. REGULAR SURVEYS / ADMINISTRATIVE INVESTIGATIONS/DOMICILIARY VISITATIONS ON THE CONDUCT OF OPERATIONS IN THE EXERCISE OF THE PRIVILEGE OF ACCREDITATION

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35. That we shall extend full cooperation with duly recognized authorities of PhilHealth and any other authorized personnel and instrumentalities to provide access to patient records and submit to any orderly assessment conducted by PhilHealth relative to any findings, adverse reports, pattern of utilization and/or any other acts indicative of any illegal, irregular and/or unethical practices in our operations as an accredited HCI of the NHIP that may be prejudicial or tends to undermine the NHIP and make available all pertinent official records and documents including the provision of copies thereof; provided that our rights to private ownership and privacy are respected at all times.
36. That we shall ensure that our officers, employees and personnel extend full cooperation and due courtesy to all PhilHealth officers, employees and staff during the conduct of assessment/visitation/investigation/monitoring of our operations as an accredited HCI of the NHIP.
37. That at any time during the period of our participation in the NHIP, upon request of PhilHealth, we shall voluntarily sign and execute a new 'Performance Commitment' to

cover the remaining portion of our accreditation or to renew our participation with the NHIP as the case may be, as a sign of our good faith and continuous commitment to support the NHIP.

38. That, unless proven to be a palpable mistake or excusable error, we shall take full responsibility for any inaccuracies and/or falsities entered into and/or reflected in our patients' records as well as in any omission, addition, inaccuracies and/or falsities entered into and/or reflected in claims submitted to PhilHealth by our institution.

39. That we shall comply with PhilHealth's summons, subpoena, subpoena 'duces tecum' and other legal or quality assurance processes and requirements.

40. That we shall recognize the authority of PhilHealth, its Officers and personnel and/or its duly authorized representatives to conduct regular surveys, domiciliary visits, and/or conduct administrative assessments at any reasonable time relative to the exercise of our privilege and conduct of our operations as an accredited HCI of the NHIP.

41. That we shall comply with PhilHealth corrective actions given after monitoring activities within the prescribed period.

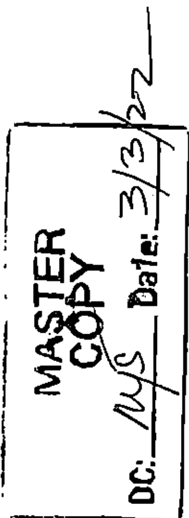
F. MISCELLANEOUS PROVISIONS

42. That we shall protect the NHIP against abuse, violation and/or over-utilization of its funds and we shall not allow our institution to be a party to any act, scheme, plan, or contract that may directly or indirectly be prejudicial or detrimental to the NHIP.

43. That we shall not directly or indirectly engage in any form of unethical or improper practices as an accredited health care provider such as but not limited to solicitation of patients for purposes of compensability under the NHIP, the purpose and/or the end consideration of which tends unnecessary financial gain rather than promotion of the NHIP.

44. That we shall immediately report to PhilHealth, its Officers and/or to any of its personnel, any act of illegal, improper and/or unethical practices of HCI of the NHIP that may have come to our knowledge directly or indirectly.

45. That we shall allow PhilHealth to deduct or charge to our future claims, all reimbursements paid to our institution under the following, but not limited to: (a) during the period of its non-accredited status as a result of a gap in validity of our DOH LTO, suspension of accreditation, etc; (2)downgrading of level, loss of license for certain services; (c)when NBB eligible PhilHealth members and their dependents were made to pay out-of-pocket for HCI and professional fees, if applicable; (d) validated claims of under deduction of PhilHealth benefits.



Furthermore, recognizing and respecting its indispensable role in the NHIP, we hereby acknowledge the power and authority of PhilHealth to do the following:

46. After due process and in accordance with the pertinent provisions of R.A. 7875 and its IRR, to suspend, shorten, pre-terminate and/or revoke our privilege of participating in the NHIP including the appurtenant benefits and opportunities at any time during the validity of the commitment for any violation of any provision of this Performance Commitment and of R.A. 7875 and its IRR.

47. After due process and in accordance with the pertinent provisions of R.A. 7875 and its IRR, to suspend, shorten, pre-terminate and/or revoke our accreditation including the

appurtenant benefits and opportunities incident thereto at any time during the term of the commitment due to verified adverse reports/findings of pattern or any other similar incidents which may be indicative of any illegal, irregular or improper and/or unethical conduct of our operations.

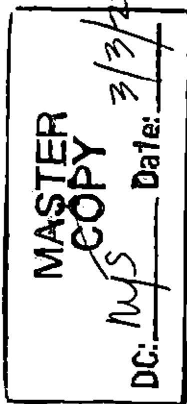
We commit to extend our full support in sharing PhilHealth's vision in achieving this noble objective of providing accessible quality health insurance coverage for all Filipinos.

Very truly yours,

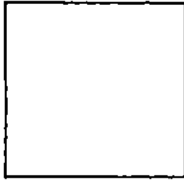
Head of Facility/Medical Director/
Chief of Hospital/ Medical Center Chief

With my express conformity,

Local Chief Executive (if LGU-owned)/Owner



Annex D: Certification of Service Delivery Agreement with a Referral Facility



Letterhead of the Referral Facility

CERTIFICATION OF SERVICE DELIVERY AGREEMENT
WITH A REFERRAL FACILITY

(Inpatient Care)

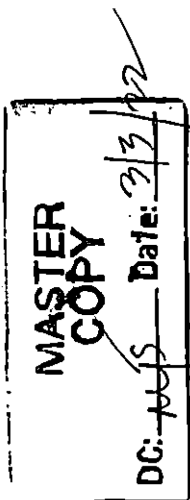
This is to certify that our facility is PhilHealth accredited and is the referral facility and/or service provider in behalf of (Name of referring facility) for the COVID-19 Home Isolation Benefit Package (CHIBP) from (period of engagement). As a service partner, we shall provide the following services:

Hospital

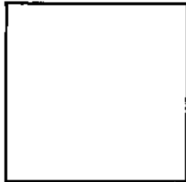
- ○ Management of patient needing inpatient care including laboratory and diagnosticservices (as needed)
- ○ Conduction of patient from home to hospital and vice versa, and as necessary

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: ____________



Annex E: Certification of Service Delivery Agreement with a Qualified Telemedicine Provider



Letterhead of the Referral Facility

CERTIFICATION OF SERVICE DELIVERY AGREEMENT WITH A QUALIFIED TELEMEDICINE PROVIDER

(Telemedicine)

This is to certify that we are a telemedicine service provider rendering teleconsultation services 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 any or all of the following services:

Teleconsultation service

- ☐ Videoconferencing
- ☐ Telephony
- ☐ Telereferral

Further, this facility shall while ensuring strict compliance to DOH guidelines on telemedicine practice, and data privacy laws 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:

Telemedicine provider

____
Manager
(Signature over printed name and designation)

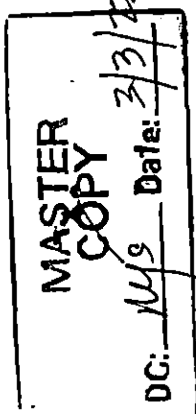
Date Signed:______________

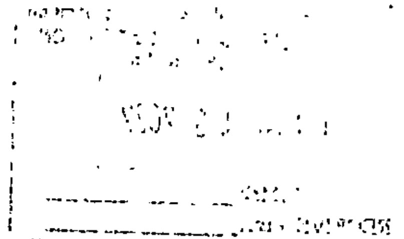
CONCURRED BY:

CHIBP provider

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

Date Signed: ______________





Annex F: Authorization Letter for the Use of eClaims System

Authorization for Use of eClaims System

This is to authorize (Name of the accredited PhilHealth facility) to use our eClaims system for the filing and submission of COVID-19 Home Isolation Benefit Package (CHIBP) claims using its own PhilHealth Accreditation Number (PAN) and cipher key. Further, all PhilHealth reimbursements for the CHIBP's filed claims shall be credited to the (name of partner facility) Auto-Credit Payment Scheme (ACPS) account and shall subsequently be disbursed to the said accredited facility based on agreed terms.

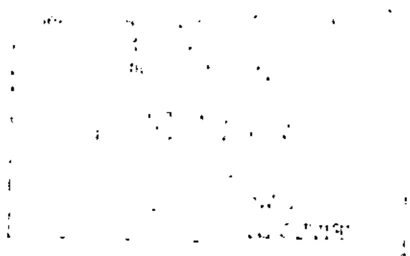
For this purpose, I hereby submit the following bank account information:

1. Bank Name ______________________________
2. Branch ______________________________
3. Bank Account Name ______________________________
4. Bank Account Number ______________________________
5. Official HCI Email Address ______________________________
6. Landline Number ______________________________
7. Mobile Number ______________________________

______(Partner Facility)______
Signature over printed name
Medical Director/Authorized Representative

____
Date signed

MASTER COPY
DC: ____ Date: 5/3/22



COVID-19 Home Isolation Benefit Package Services

Mandatory Service	Other Services
a. *Home isolation consultations based on DOH protocols, except in case of transfer due to deterioration or mortality and based on discharge criteria from applicable guidelines adopted by DOH.* • Physician consultation, at least twice for the duration of isolation; • *Consultations can be done face-to-face or through telemedicine. In case of teleconsultation, the patient shall be required to sign a Consent Form. The Consent Form (see Annex K) shall be submitted to PhilHealth as an additional claim requirement.* • *Teleconsultations may be done through any of the following: telephone call, cellphone or internet using Messenger, Viber, Zoom and other applications.* b. 24/7 daily monitoring of clinical and supportive care by a nurse *or a doctor which can either be conducted face-to-face or* through teleconsultations *for a minimum of five (5) days regardless of sample collection date, reported symptom onset, or isolation period.* c. *Monitoring shall be in accordance with the duration of isolation as prescribed by the DOH, as shown below in COVID-19 Isolation Matrix. The monitoring sheet (see Annex N) shall be accomplished by the Home Isolation Team and shall be submitted to PhilHealth.* d. Provision of home isolation kit which contains: 1L 70% alcohol, 5 pieces face mask, 1 digital thermometer (*with battery*), 1 pulse oximeter (*with battery*), drugs and medicines (18 pieces Paracetamol or pediatric preparation equivalent, 12 pieces Lagundi tablets or equivalent, 6 sachets oral rehydration salts, 10 pieces Ascorbic Acid *or pediatric preparation equivalent*, 10 pieces Vitamin D *or pediatric preparation equivalent* and *10* zinc *tablets or 2 bottles of zinc syrup*).	a. Patient Education • How to use pulse oximeter • Signs and symptoms to watch out for • Proper doses and when to use drugs and medicines • Waste disposal and infection control • Others as needed b. Patient referral to a higher level facility andpatient support while for transfer, if needed c. *The CHIBP provider shall secure the signed patient forms (see Annex K).*

MASTER COPY DC: MS Date: 3/3/22

COVID-19 Isolation Requirement Matrix

Asymptomatic (starting sample collection date)

Patient

Vaccine Status		*Health Care Worker*	*Non-Health Care Worker*
	With Booster	*5 days*	*7 days*
	Full	*7 days*	*7 days*
	Partial/Unvaccinated	*10 days*	*10 days*

Symptomatic (starting reported symptom onset)

Patient

Vaccine Status		*Health Care Worker*	*Non-Health Care Worker*
	With Booster	*5 days*	*7 days*
	Full	*7 days*	*7 days*
	Partial/Unvaccinate d	*10 days*	*10 days*

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Based on the following DOH issuances:

- *Department of Health Department Memorandum No. 2020-0512: Revised Omnibus Interim Guidelines onPrevention, Detection, Isolation, Treatment, and Reintegration Strategies for COVID-19*
- *Department of Health Department Circular No. 2022-0002: Advisory on COVID-19 Protocols for Quarantine and Isolation*
- *Department of Health Department Memorandum No. 2022-0013: Updated Guidelines on Quarantine, Isolation, and Testing for COVID-19 Response and Case Management for the Omicron Variant*

Test Validity Period

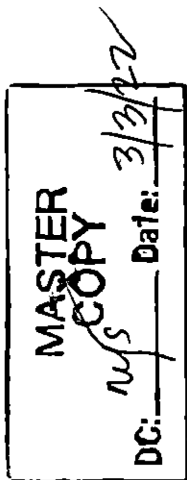
	RTPCR	*ANTIGEN*
VALID	*14 days or less*	*14 days or less*
INVALID	*>14 days*	*>14 days*

Notes:

1. *14 days is based on the incubation period of COVID-19*
2. *The period count to determine the validity of the test will start at the date of specimen sample/ date of sample collection.*

Important References and Links

- *List of Antigen Test Kits with FDA Special Certificate:* *https://bit.ly/3KskI7a*
- *DOH DC 2022-0002: Advisory on COVID-19 Protocols for Quarantine and Isolation* *https://doh.gov.ph/sites/default/files/health-update/dc2022-0002.pdf*
- *DOH DM 2022-0013: Updated Guidelines on Quarantine, Isolation, And Testing for COVID-19 Response and Case Management for the Omicron Variant* *https://www.officialgazette.gov.ph/2022/01/14/doh-department-memorandum-no-2022-0013/*



Annex H: CHIBP Package Rate and Rules on Co-pay

a. The applicable package code shall be encoded in the item 9 in CF2.

Package Code	Description
C19HI	COVID-19 Home Isolation Benefit Package

Table 1: Applicable Package Code

b. The ICD 10 Code in filing for COVID-19 claims shall be in accordance with World Health Organization (WHO) and DOH guidelines. Any further changes by the DOH in the applicable codes shall take precedence and shall be adopted accordingly by PhilHealth. The applicable ICD10 code shall be encoded in the item 7 in CF2.

ICD-10 Code	Description
"U07.1"	COVID-19 Confirmed
"Z29.0"	Isolation

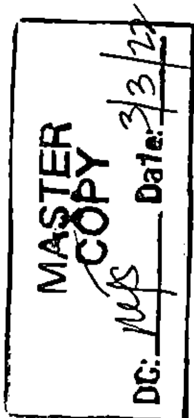
Table 2: Applicable ICD-10 codes per DOH DM No. 2020-0067

c. The corresponding reimbursement rate is **Php 5,917.00 per claim.**

d. The reimbursement for government health care facilities shall be utilized to cover all services and medicines provided for in this benefit package and other operating expenses to support delivery of care, including hiring of additional personnel, internet subscription, service provider subscription fee and IT hardware. Any remaining fund may be utilized for incentives, including hazard pay, for human resource involved in its operation, with sharing based on internal guidelines.

e. For private health care facilities, reimbursements shall be utilized at their discretion, provided that this shall also be used to cover for incentives, including hazard pay, for human resource involved in its operation, and other costs of delivering the services.

f. Patients shall shoulder payment for services and commodities provided by the accredited CHIBP provider not included in the package.



Certificate

(TESTING CENTER LETTERHEAD)

SAMPLE MEDICAL CERTIFICATE

Name: ________________

Birthdate: __________________

Age: ____________________

Date Performed: ______________

This is to certify that the abovementioned patient was tested for COVID-19 Rapid Antigen Test with the following details:

Test Method Used: Rapid Antigen Test

Specimen used (indicated if nasal, nasopharygeal and/or oropharyngeal): ___________

Rapid Antigen Test Kit Brand: _________________

Date Performed: ___________________________

Date of Result: __________________________

Result: _______________________

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

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Annex J: Assessment Checklist of Clinical Criteria for COVID-19 Home Isolation Benefit Package

ASSESSMENT CHECKLIST OF CLINICAL CRITERIA FOR ISOLATION

Name of Patient: ____

Birth date: ____________ Age: ____________ Test Result: ______________________

Type of confirmatory test: Testing Facility: ______________________

□ RTPCR □ RAT □ Other Test Result ____________ Date Done: __/__/____

Panuto: Lagyan ng tsek mark□ ang kahon sa tabi ng iyong obserbasyon at rekomendasyon ayon sa mga kasagutan ng pasyenteng ineevaluate. Siguraduhing lahat ng kahon ay napunan ng tama at ang mga rekomendasyon ay ayon sa mga panuntunan na nakasulat sa baba.

A. Clinical Evaluation

Part 1. Signs and symptoms

- Fever □ Yes □ No
- Cough □ Yes □ No
- Colds □ Yes □ No
- Muscle pain □ Yes □ No
- Body weakness □ Yes □ No
- Shortness of breath □ Yes □ No
- Chest pain □ Yes □ No
- Diarrhea □ Yes □ No
- Loss of taste/smell □ Yes □ No

Paalala sa BHERT: Kapag ang patient ay may shortness of breath, chest pain, iba pang sintomas ng malubhang COVID-19, i-rekomenda ang pasyente na magpakonsulta sa doctor.

Paalala sa Medical Professionals o sa Allied Health Professionals : Maaaring i- isolate ang mga pasyenteng may mild fever at ubo o may at least 3 sa mga nakalistang sintomas sa taas. Kapag base sa iyong assessment ay may pneumonia na ang pasyente, huwag irekomendang maghome isolate ang pasyente at i-refer agad sa ospital.

Tandaan:

(1) Ang mga asymptomatic, mild, and moderate COVID cases na walang pneumonia lamang ang maaring i-isolate sa bahay o sa mga CIU.

(2) Ang mga pasyenteng may positive COVID-19 test result lamang ang maaaring maka-avail ng benepisyo. Siguraduhing may positive test result ang pasyente upang malaman kung ito ay maaaring ipa-reimburse sa PhilHealth.

(3) Ang mga pasyenteng hindi kailangan i-admit sa ospital ay kinakailangang may sapat na kapasidad na ma-isolate sa bahay para maka-avail ng home isolation benefit ng PhilHealth. Siguraduhing may pirmadong social criteria checklist mula sa pasyente na siya ay maaaring i-isolate sa bahay. Kung walang pirmadong social criteria checklist, i-refer ang pasyente sa pinakamalapit na CIU.

Recommended for: □ **Home Isolation** □ **TTMF/CIU** □ **Ospital**

Assessed by: ______________________________

Name with signature and designation

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Form 1: Patient Attestation and Consent Form

Pagpapatunay at Pagbigay Pahintulot

Panuto:

Bago magpa-home isolate, importanteng siguruhin na ikaw ay nararapat na i-isolate sa bahay. Upang matukoy kung ikaw ay nmaaring magpa-home isolate, sagutin ang ilang mga katanungan na naka-lista sa baba. Lagyan lamang ng tsek mark and sagot ng ayon sa iyong kasalukuyang sitwasyon.

A. **Social criteria Evaluation**

1. Ako ay may sariling kwarto o ang higaan ko ay may sapat na distansya (1 metro) sa kama ng ibang mga kasamahan ko sa bahay	☐ Oo	☐ Hindi
2. Ako ay may magagamit na banyo/toilet	☐ Oo	☐ Hindi
3. Ang kwarto ko ay may sapat na airflow/ventilation	☐ Oo	☐ Hindi
4. Ako ay ay tagapangalaga o may sariling kakayanan na matugunan ang pang-araw-araw kong pangangailangan	☐ Oo	☐ Hindi
5. Ako ay may telepono o laptop o gadget na maaaring magamit para sa makausap ang healthcare workers o ang aking kapamilya	☐ Oo	☐ Hindi
6. Ako ay may access sa kuryente, tubig, at may paran para makaluto ng pagkain	☐ Oo	☐ Hindi
7. Ako ay may sariling basurahan	☐ Oo	☐ Hindi

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Tandaan: Kung ikaw ay may kahit isang sagot na "Hindi" sa social criteria evaluation sa itaas, ikaw ay hindi maaaring i-homeisolate.

Ikaw ba ay socially eligible para sa Home Isolation? ☐ **Oo** ☐ **Hindi**

I HEREBY CERTIFY that the information provided in this form is complete, true and correct to the best of my knowledge.

FURTHER, I HEREBY ACKNOWLEDGE that I give my consent to PhilHealth to collect, use and process my personal information. I understand that my consent does not preclude the existence of other criteria for lawful processing of personal data, and does not waive any of my rights under the Data Privacy Act of 2012 and other applicable laws.

Lastly, I give my consent to participate in telemedicine. I have read the attached document in this attestation on telemedicine outlining all the potential risks, consequences and benefits of telemedicine. I know I have the opportunity to ask questions about additional information on telemedicine to my physician of choice. I understand the written information provided to me.

Pinatototohanan ko na ang impormasyong ibinigay sa form na ito ay kumpleto, totoo at tama sa abot ng aking kaalaman.

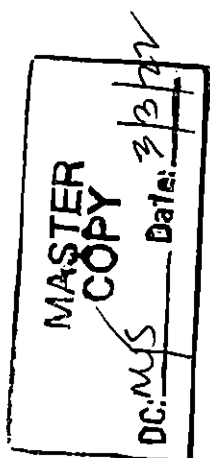
Bukod pa rito, pinahihintulutan ko ang PhilHealth na mangolekta, gamitin at iproseso ang aking personal na impormasyon. Nauunawaan ko na ang pahintulot ko ay hindi hadlang sa pagkakaroon ng iba pang mga pamantayan para sa pagproseso ng personal na data alinsunod sa batas at hindi inuurong ang alinman sa aking mga karapatan sa ilalim ng Data Privacy Act ng 2012 at iba pang angkop na mga batas.

Sa huli, binibigay ko ang aking pahintulot na makibahagi sa telemedicine. Nabasa ko na ang nakalakip na dokumento sa pagpapatunay na ito ukol sa telemedicine na nagbabalangkas ng lahat ng potensyal na panganib, kahihinatnan at benepisyo ng telemedicine. Alam ko na may pagkakataon akong magtanong sa aking mangagamot ng mga karagdagang impormasyon tungkol sa telemedicine. Nauunawaan ko ang nakasulat na impormasyong ibinigay sa akin.

Signature

____
Patient (or person authorized to give consent)

Date:_______



TELEMEDICINE CONSULTATION

Purpose and Benefits. The purpose of this service is to use telemedicine to enable patients to still receive health services even while staying at home during the enhanced community quarantine, except for serious conditions, emergencies, or to avail of COVID-19- related health services as per standing protocols.

Layunin at mga Benepisyo. Ang layunin ng serbisyong ito ay gamitin ang telemedicine upang makatanggap pa rin ang mga pasyente ng mga serbisyong pangkalusugan habang nananatili sa bahay sa panahon ng quarantine, maliban na lang kung may malubhang kondisyon, emergency, o upang makuha ang mga serbisyong pangkalusugan ayon sa mga umiiral na protocol.

Nature of Telemedicine Consultation: During the telemedicine consultation:

MASTER COPY Date: 3/

a) Details of you and/or the patient's medical history, examinations, x-rays, and tests will be collected and discussed with other health professionals through the use of interactive video, audio and telecommunications technology if needed.

b) Physical examination of you or the patient may take place.

c) Nonmedical technical personnel may be present in the telemedicine studio to aid in video transmission, if needed.

d) Video, audio, and/or digital photo may be recorded during the telemedicine consultation visit.

Medical Information and Records. All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Additionally, dissemination of any patient identifiable images or information from this telemedicine interaction to researchers or other entities shall not occur without your consent, unless authorized by existing law, policies and guidelines on privacy and data protection.

Confidentiality. Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation. Organizational, physical and technical security measures are in place to ensure that all information processed during the consultation will remain confidential and only authorized personnel will have access to such information on a need-to-know basis. All existing laws, policies and guidelines on privacy and data protection apply to information disclosed during this telemedicine consultation.

Potential Risks and Consequences. The telemedicine consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a physician at a distance. At first you may find it difficult or uncomfortable to communicate using video images. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to physician contact. As any medical procedure, there may be potential risks associated with the use of this technology. These risks may include, but may not be limited to:

a. Information transmitted may not be sufficient to allow for a conclusive consultation by specialist. Following the telemedicine consultation, your physician may recommend a visit to a health facility for further evaluation.
b. Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment. Security protocols could fail, causing a breach of privacy of my confidential medical information.
c. A lack of access to complete medical records may result in errors in medical judgement.
d. There is no guarantee that this tele-consultation will eliminate the need for me to see a specialist in person.

Rights. You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right of future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. You have the optionto consult with the physician in person if you travel to his or her location.

Financial Agreement. You and/or your insurance company will not be billed for this visit.

Form 2: Confirmation of Receipt of Kits

Aking natanggap and COVID-19 Homecare kit na naglalaman ng:

1. 1L 70% Alcohol
2. 5 pieces Face Mask
3. 1-unit Pulse Oximeter
4. 1-unit Digital Thermometer
5. Authorization and Consent to Participate in Teleconsultation
6. Drugs and Medication
   a. 18 pieces Paracetamol tablet (500 mg) or pediatric preparation equivalent
   b. 12 pieces Lagundi Tablets or equivalent
   c. 6 sachets ORS
   d. 10 pieces Ascorbic Acid or pediatric preparation equivalent
   e. 10 pieces Vitamin D or pediatric preparation equivalent
   f. Zinc (10pcs tablets or 2 bottles syrup)

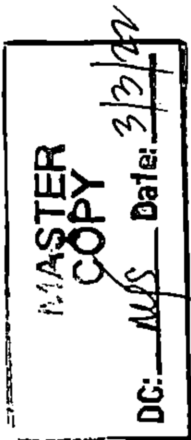
Mula kay: ______________________________
Signature over Printed Name

Recipient

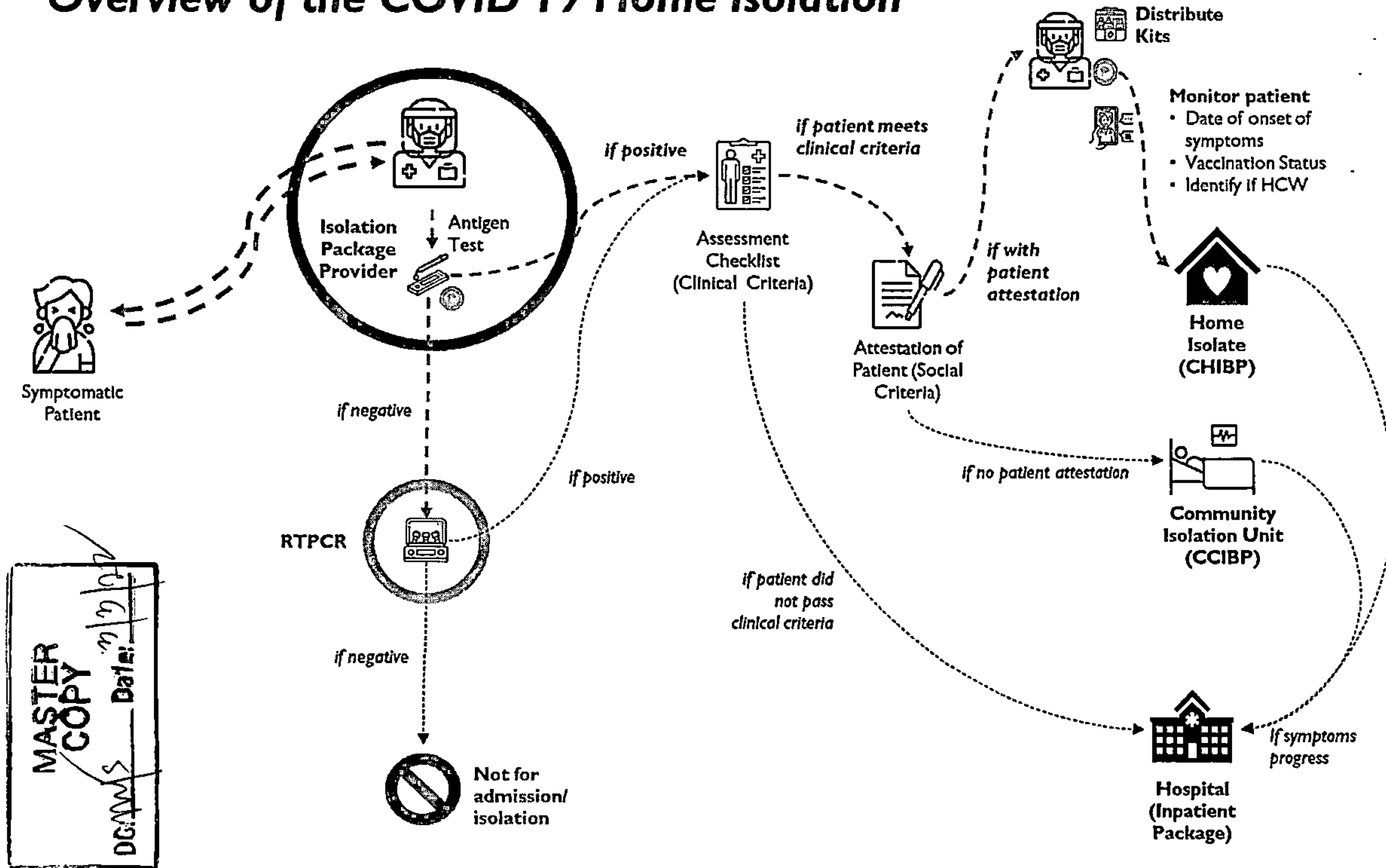
Signature:

____
Patient (or person authorized to give consent)

Date:_______



Overview of the COVID 19 Home Isolation



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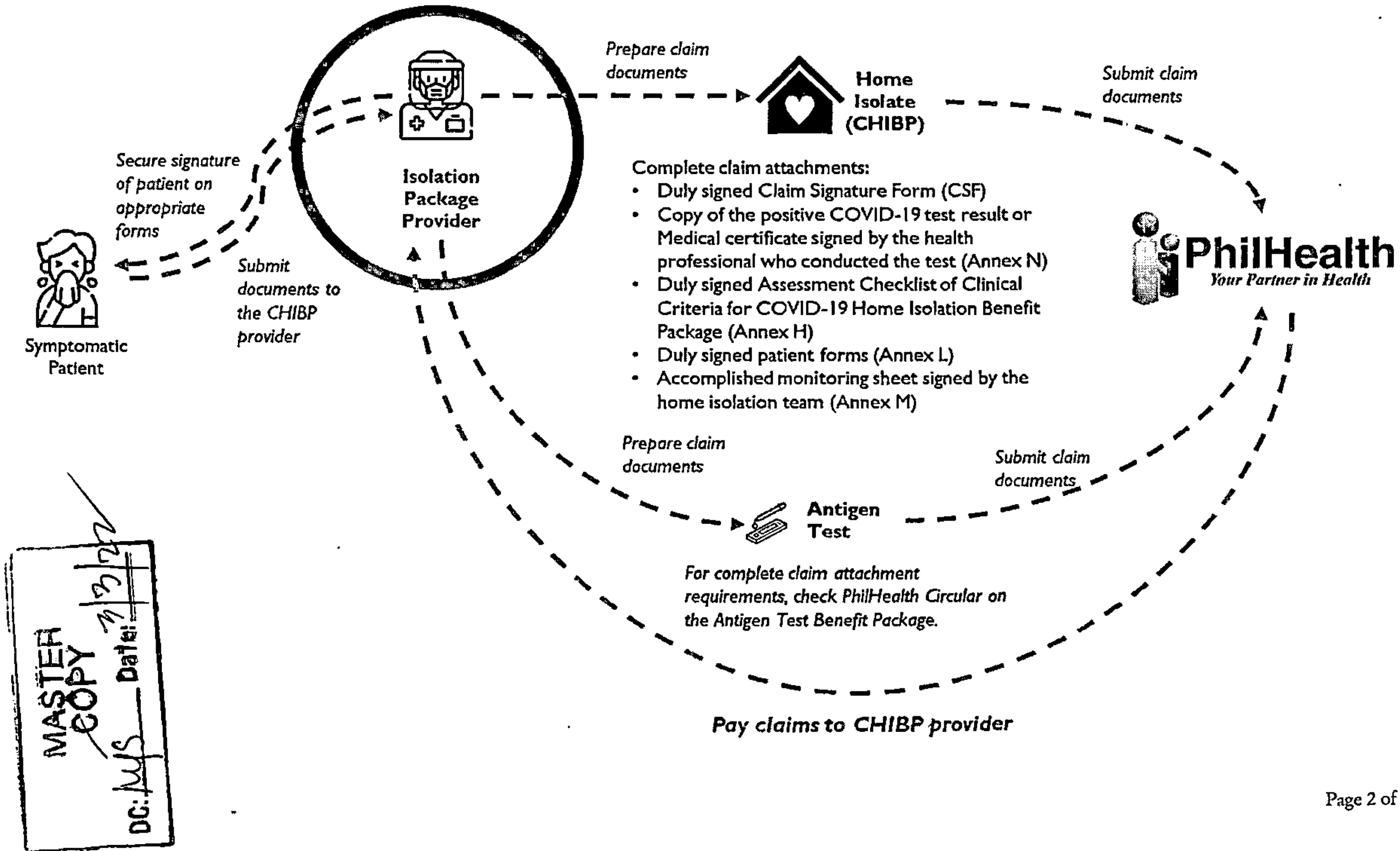
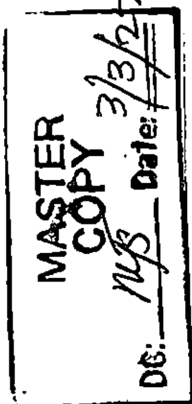
Benefit Availment Process



Claims Requirement

a. Duly signed Claim Signature Form (CSF);
b. Copy of the positive *COVID-19 test result or Medical certificate signed by the health professional who conducted the test (Annex I);*
c. Duly signed Assessment Checklist of Clinical Criteria for COVID-19 Home Isolation Benefit Package (Annex *J*);
d. Duly signed attestation form confirming compliance to the social criteria for home isolation (Annex K)
e. Duly Signed Certification of COVID-19 Home Isolation Kit Issuance (Annex *K*) or a duly signed acknowledgement receipt;
f. Signed Authorization and Consent to Participate in Teleconsultation (Annex *K*)
g. Accomplished monitoring sheet signed by the home isolation team (Annex *N*)



Annex N: Home Isolation Patient Monitoring Sheet

Home Isolation Patient Monitoring Sheet

Confirmed Case ID:______________________ Start Date of Clinical Support:_____/_____/_____ Min Isolation Period*: ____ Region:______________
Patient Name: ______________________ Date of Symptom Onset: _____/_____/_____ End of Isolation Period Date:_____/_____/_____
Vaccine Status: ______________ Vaccine Brand: ______________ Date of 1st dose: ___/___/_____ Date of 2nd dose: ___/___/_____ Date of Booster: ___/___/_____
Healthcare Worker or employee from an authorized sector (Yes/No): ______________

Instructions: Monitoring should be done twice a day; once in the morning and once in the afternoon/evening. Indicate the date and go through each item. Put a check if a patient has the symptom upon monitoring in the correct column (AM/PM) and indicate temperature taken (ie. 38C).

		Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14
Date:															
Temp	AM														
	PM														
Oxygen	AM														
	PM														
Cough (ubo)															
Chills (panginginig)															
Fatigue/Tiredness (pagkapagod)															
Body pain (Sakit ng Katawan)															
Headache (Sakit ng Ulo)															
Loss of Taste and Smell (Pagkawala o bawas ngpanlasa o pangamoy)															
Sore Throat (masakit ang lalamunan)															
Congestion or runny nose (Sipon na bakabara o tumutulo)															
Diarrhea (Basa o labis ang pagdudumi)															
Nausea/Vomiting (Naduduwal onagsusuka)															
Red flags (magreport agad kung maranasan ang sumusunod na sintomas)															
Shortness of Breath or Difficulty in breathing (Hirap sa paghinga)															
Persistent Pain or Pressure in the Chest (sakit o bigat sa dibdib na di nawawala)															
Confusion (Biglang pagkalito)															
Difficulty in waking up or sleeping (hirap matulog o magising)															
Pale, gray, or bluish lips or nailbeds (pagbabago ng kulay ng balat, labi, o kuko)															
Others (Ibang sintomas): 1. 2.															

MASTER COPY
Date: 3/3/22
DC:

Assessed and monitored by:

____
Doctor/Nurse of the Home Isolation Team Printed Name and Signature

Designation

**Based on prevailing Clinical Practice Guidelines as adopted by the Department of Health (DOH)*