Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

PHILHEALTH CIRCULAR
No. 2022 - 0007

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

SUBJECT : **Guidelines on the COVID-19 Community Isolation Benefit Package (CCIBP) (Revision 2)**

I. RATIONALE

In addressing the COVID-19 global pandemic, the President of the Philippines, through Republic Act 11469 (Bayanihan to Heal as One Act) and Presidential Proclamation No. 929 s.2020, declared a State of Public Health Emergency and subsequently imposed an Enhanced Community Quarantine (ECQ) throughout Luzon. In response, PhilHealth, through PhilHealth Board Resolution No. 2516 s. 2020, committed to develop benefit packages providing for health services, including community-based isolation, to all Filipinos affected by the COVID-19.

II. OBJECTIVES

This *PhilHealth* Circular aims to provide coverage for all Filipinos for health services in identified Community Isolation Units (CIUs) for COVID-19. It aims to operationalize the PhilHealth COVID-19 Community Isolation Benefit Package (CCIBP) and provide specific guidelines for *accreditation*, benefit availment and applicable payment mechanism, reporting rules and performance assessment.

III. SCOPE

This *PhilHealth* Circular shall apply to *accreditation and to* all claims for services provided by identified publicly or privately-run facilities temporarily serving as Community Isolation Units (CIUs) in response to the COVID-19 global pandemic.

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IV. DEFINITION OF TERMS

A. **Case Investigation Form (CIF)**[1] - electronic reporting form specific for COVID-19 data that allows standard reporting of information for epidemiologic study and monitoring.

B. **Community Isolation Units (CIUs)**[2]–*a* DOH certified publicly or privately owned non-

[1] *DOH- DILG* 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

hospital facilities set-up in coordination with or by the national government (NG) or local government units (LGUs) 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.

C. **Free Standing Facility** - a facility that does not share basic services with a hospital-based provider.

D. **Isolation**[3]- the separation of ill or infected persons from others to prevent the spread of infection or contamination.

E. **Local Isolation and General Treatment Areas for COVID-19 cases (LIGTAS COVID) center**[4]- a community-managed facility within a barangay, municipality, city or province, where contact, suspect, probable, and confirmed cases of COVID-19 with mild symptoms, whose home environment cannot support physical distancing (e.g. crowded living conditions) can be temporarily housed for quarantine or isolation, which is linked to a health care institution (HCI) for referral purposes. A LIGTAS COVID Center is one type of Community Isolation Unit (CIU).

F. **Mega LIGTAS COVID Center**[5]— larger scale versions of the LIGTAS COVID Center, managed by the national government and also referred to as Temporary Treatment and Monitoring Facilities (TTMF), operating at the provincial/regional level to supplement LIGTAS COVID Centers and properly refer patients to appropriate facilities in accordance with separate guidelines for the purpose to be issued by the DOH.

V. POLICY STATEMENTS

A. Accreditation of Community Isolation Units (CIUs) as Providers of the COVID-19 Community Isolation Benefit (CCIBP)

1. CIUs shall either be:
   a. Free standing facilities, including converted non-hospital facilities such as LIGTAS COVID and Mega LIGTAS COVID Centers, and level 1 (L1) hospitals, set up and managed by the local government unit (LGU) or national government (NG) linked to a PhilHealth accredited level 2 (L2) or level 3 (L3) referral hospital, or
   b. Facilities set-up and managed by a publicly or privately owned L2 or L3 hospital in coordination with a LGU or the NG, provided that (1) there is no LGU or NG managed CIU in or nearby the municipality and/or (2) the LGU and/or NG recognizes the need and provides explicit permission for the L2 or L3 hospital to set-up a CIU.
2. In order to be eligible to provide the CCIBP, CIUs must be certified by DOH and accredited by PhilHealth.
3. All CIUs seeking accreditation shall establish referral arrangements with a higher-level facility. CIUs shall be allowed to declare only Philhealth accredited L2 or L3 hospitals as referral facilities. Referral facilities shall provide technical support and shall service

[2] ibid
[3] ibid
[4] ibid
[5] ibid

patients needing endorsement to a higher-level facility as defined in applicable DOH guidelines.

4. All public and private facilities certified by the DOH as CIUs shall be deemed accredited by PhilHealth for the COVID-19 Community Isolation Benefit Package (CCIBP), provided they submit to PhilHealth the following:*
    a. Proof of DOH certification or inclusion in the list of DOH certified CIUs from Center for Health Development;
    b. Provider Data Record (see Annex A);
    c. Signed performance commitment (see Annex B);
    d. Supplemental Provider Data Record (see Annex C)**
    e. Authorization from PhilHealth accredited partner facilities with eClaim system such as MCP, TB-DOTS, hospitals, for electronic claims submission and reimbursement arrangements (see part II of Annex C).

    * *These documents shall be required for submission during application for initial, renewal and re-accreditation.*

    ** Supplemental PDR *shall* be submitted after *approval of initial* accreditation prior to the release of their reimbursements *and when there is/ are change/s in the auto credit payment system (ACPS).*

5. Different variations of ownership and management arrangements in setting up the CIU (see Annex D) shall be permitted provided that:
    a. the CIU facility and its designated manager is clearly identified;
    b. the CIU and its partners have an agreement to file and submit claims and receive claim payments electronically in a way that is consistent with existing PhilHealth guidelines and procedures, and;
    c. the CIU and its partners have an agreement for referral arrangements.

B. Benefit Package

1. The COVID-19 Community Isolation Benefit Package (CCIBP) shall include all identified services needed to effectively manage cases needing isolation, based on applicable guidelines adopted by DOH (*see Annex E),* whether suspect, probable, confirmed *or mild* (*see Annex F).*
2. Standards for these health services shall be in accordance with the applicable guidelines set forth by the DOH. The benefit package shall be updated as needed to reflect current protocols and standards in collaboration with relevant institutions, experts and stakeholders.
3. The package shall cover all inputs and activities within the entire episode of care at the CIU including payment for staff and professional fees, medicine, diagnostics, transport and other operational cost.
4. Testing and inpatient services for COVID-19 patients shall be covered by other applicable COVID-19 case rates.

C. Availment of the Benefit Package for Community Isolation

1. Criteria for availment of the package:
    a. *PhilHealth beneficiaries registered under the National Health Insurance Program (NHIP) who meet the clinical and/ or social criteria (see Annex G) as stated in the applicable DOH issuances for community isolation shall be eligible to avail of the package.*

b. *Filipinos who are not yet registered under the program shall automatically be covered, provided that they complete and submit an accomplished PhilHealth Member Registration Form (PMRF) for the issuance of the PIN or inclusion of the dependent upon availing of the benefit package. The patient, through the provider, shall submit the accomplished PMRF within the period of isolation in accordance with the rules on immediate eligibility defined in PhilHealth Circular No. 2019-0010.*

c. *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. Package Rate and Rules on Co-pay (see Annex *H*)

The package shall be paid as a case rate in the amount of Php 22,449.00. Any modifications in the package rate shall be released through a PhilHealth Advisory.

3. Claims Filing and Reimbursement
   a. Whenever applicable, the CIU, through its partner facility, can file a claim using the e-Claim system for patients who were discharged after providing all mandatory services (see Annex E). Claims for testing for SARS-CoV-2 *shall be filed in* accordance to PhilHealth Circular on COVID-19 testing.
   b. All claim application shall include the following:
      b.1. Claim Form 2 (CF2)
      b.2. Case Investigation Form or CIF (see Annex I)
      b.3. Accomplished Claim Signature Form (CSF).
   c. Direct filing of claims by beneficiaries shall not be allowed.
   d. All claims submitted by the accredited CIU shall be processed by PhilHealth within sixty (60) calendar days from receipt of claim provided that all requirements are fulfilled.
   e. Claims shall be filed within 60 calendar days upon discharge of the patients. Existing rules on the late filing of claims shall apply.
   f. Claims with incomplete requirements/discrepancy/ies shall be returned to sender (RTS) for compliance within 60 calendar days from receipt of notice.
   g. The accredited CIU may apply for motion for reconsideration for all denied claims based on existing PhilHealth policies.
   h. In the event of the clinical deterioration of the patient, the CIU must follow the guidelines on patient transfer that have been set forth by the DOH. The accredited CIU may still file a claim for the services rendered to the patient.
   i. All claims filed for patients needing readmission to the CIU facility after discharge from an inpatient facility in accordance with DOH guidelines shall be filed as a new claim.
   j. In the event that the patient expires in the course of isolation, the accredited CIU may still file a claim for the CCIBP package.
   k. Converted non-hospital CIUs such as those identified as LIGTAS COVID and Mega LIGTAS COVID centers shall not be allowed to file for other case rates apart from CCIBP. Accredited hospitals and free standing facilities that are also DOH certified CIUs shall be allowed to continue to file claims for other case rates based on existing PhilHealth policies.
   l. Claims shall be paid to the CIU or through its partner facility if applicable.
   m. Payments for services rendered and applicable payment terms, whether for claims processing and/or diagnostics and commodities support, shall be negotiated and settled between the CIU and its partner facilities.
   n. PhilHealth shall not prescribe a provider-facility share nor recommend charging

rules for claims processing, for diagnostics and commodities support, and/or for any other shared costs between CIUs and their partner facilities.

D. MONITORING AND EVALUATION

The PhilHealth, through its Healthcare Provider Performance Assessment System (HCP-PAS) shall employ mechanisms to assure members of the guaranteed quality healthcare they deserve.

A monitoring and feedback system shall be implemented to assist providers to identify possible gaps in their practices or recommend mechanisms to ensure that they render the best possible service to their clients.

PhilHealth shall conduct a periodic review of this policy and specific provisions shall be revised as needed. *The review shall require the monthly submission of relevant documents including but not limited to, expenditure and utilization report (see Annex J) and the list of the admitted patients (see Annex K).*

CIUs shall ensure that the patient medical record or chart inclusive of admitting history, CIF, patient monitoring sheet, and administered medication, shall be made available upon the behest of PhilHealth.

E. ANNEXES (*to be posted in PhilHealth website)*

Annex A: Provider Data Record
Annex B: Performance Commitment
Annex C: Supplemental *Provider Data Record*
Annex D: Possible Scenarios in Terms of CIU Management and Ownership
Annex E: Mandatory and Other Health Services
Annex F: Definition of Eligible Cases for Isolation
Annex *G*: Clinical and/or Social Criteria
Annex *H*: Package Rate and Rules on Co-pay
Annex *I*: Case Investigation Form
Annex *J*: Expenditure and Utilization Report
Annex *K*: List of Admitted Patients

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.

VII. SEPARABILITY CLAUSE

If any of the provision of this PhilHealth Circular shall be declared invalid, unconstitutional, or unenforceable, the validity of the remaining provisions shall not in any way be affected and shall remain enforceable.

VIII. REPEALING CLAUSE

This policy *revises the following PhilHealth Circulars*:

A. Repeals PhilHealth Circular No. 2020-0012 "Guidelines On The COVID-19 Community Isolation Benefit Package (CCIBP)"

B. Repeals PhilHealth Circular No. 2020-0018 "Guidelines On The COVID-19 Community Isolation Benefit Package (CCIBP) – Revision 1"

C. Repeals PhilHealth Circular No. 2021-0024 "Modification On The Minimum Length Of Stay (LOS) In PhilHealth Accredited Community Isolations Units (CIU)"

IX. DATE OF EFFECTIVITY

The *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 (CEO)

Date signed: 13 April 2022

MASTER COPY
DC: Date: 4/19/22

PDR-March2014

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
City State Bldg., 709 Shaw Blvd., Pasig City
Health Line 441-7444; www.philhealth.gov.ph

PROVIDER DATA RECORD
HEALTH CARE INSTITUTION

THE PRESIDENT & CEO
Philippine Health Insurance Corporation
Pasig City, Philippines

Sir/Madam:

I, _____, of legal age, _____ with
(Position/Designation)
address at _____ and the duly authorized representative to act for and
in behalf of _____, hereby submits the following pertinent
(name of healthcare institution)
information and documentary requirements under Sec. 56 of the Implementing Rules and Regulations of RA 7875 as amended by RA 10606.

Name of Health Care Institution: (Please print legibly and provide appropriate spaces)

Accreditation Number/s		PhilHealth Employer Number	

Mailing/Billing Address:

No./St./Brgy.					
Municipality /City		Province:		ZIP Code	

Contact Information

Contact No	Fax No	Official Email Address: (mandatory)

Facility Head/ Medical Director/Chief of Hospital/Hospital Administrator	Accreditation No.

Contact Information of the Facility Head:

Contact Number	Email Address

A. Hospital:

☐ General ☐ Specialty **Hospital Level:** ☐ Level 1 ☐ Level 2 ☐ Level 3

DOH-LTO No Validity of DOH-LTO:

B. Other Health Facilities:

Primary Care Facilities

☐ With Inpatient Beds*
- ☐ Infirmary/Dispensary *
- ☐ Birthing Homes *

* DOH-LTO No._____
* Validity of DOH-LTO_____

☐ Without Beds:

Medical Outpatient Package Providers
- ☐ Anti TB/DOTS Package **
- ☐ Maternity Care Package (MCP)
- ☐ Primary Care Benefit (PCB)
  - ☐ Outpatient Malaria
- ☐ Animal Bite Package ** _____ _____

☐ MCP, DOTS** and PCB
☐ MCP and DOTS**
☐ MCP and PCB
☐ PCB and DOTS**

Specialized Outpatient Facility

☐ Ambulatory Surgical Clinic
* DOH-LTO No

☐ Freestanding Dialysis Clinic (FDC)*
* Validity of DOH-LTO:

Nature of Ownership

1. Government

☐ National - DOH retained
☐ DND / DOJ
☐ State Unitversities / College
☐ Others

☐ Local*
- ☐ Province
- ☐ Municipality
- ☐ City
- ☐ District

2. Private**

☐ Single Proprietor
☐ Partnership
☐ Corporation
☐ Others (Specify) _____

☐ Foundation
☐ Cooperative
☐ Civic organization

*Name of incumbent LC _____ **Name of owner/s _____

Type of Application: (Please check)

☐ **Initial Application**
☐ **Continuous Accreditation**
☐ **Re-accreditation***

* **Re-accreditation transactions**
- ☐ Transfer of location
- ☐ Change in facility classification
- ☐ Upgrading of hospital level
- ☐ Additional service
- ☐ Resumption of operation after closure/ cease operation

☐ Change of ownership
☐ Application after incurring a gap in accreditation regardless of length of gap
☐ Previous Continuous Accreditation was withdrawn

Profile Update
- ☐ Change in Facility Head/ Medical director/ COH
- ☐ Change in name
- ☐ change in contact Information

For PhilHealth Use Only

Remarks: _____

Date Received:	LHIO		By:	LHIO	
	PRO			PRO	
Date Evaluated:	LHIO		By:	LHIO	
	PRO			PRO	
Date Encoded:	LHIO/PRO (Receiving Module)		By:	LHIO	
	PRO (Data Entry)			PRO	

Control No.
OR No. _____
Date Paid: _____
Amount: _____

MASTER COPY Date: 4/19/22
DC: MJS

PC for CIUs
April 2020

(Letterhead of Healthcare Provider)

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

SUBJECT : Performance Commitment for Community Isolation Units

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 DOH 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 owned by _____
   and managed by _____
   and doing business under the name of _____
   with License/Certificate No. _____
3. 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:

3. That our officers, employees, and other personnel are members in good standing of the NHIP.
4. 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.
5. That we shall promptly inform PhilHealth prior to any change in the ownership and/or management of our institution.

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DC: MJS Date: 4/12/22

6. 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

7. 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.

8. That we shall abide with all the implementing rules and regulations, memorandum circulars, special orders, advisories and other administrative issuances by PhilHealth affecting us.

9. 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.

10. 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.

11. 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.

12. 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.

13. That being a government-owned (for public-owned facilities only) 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 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

14. That we are duly capable of delivering the CCIBP services for the duration of the validity of this commitment.

15. 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.

16. 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"

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17. That we, being an accredited provider, shall abide by the rules set in the CCIBP, including the prescribed disposition 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.

18. That we shall maintain a high level of service satisfaction among PhilHealth clients including all their qualified dependents/beneficiaries.

19. That we shall be guided by PhilHealth-approved clinical practice guidelines or if not available, other established and accepted standards of practice.

20. 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.

21. That we shall always make available the necessary forms for PhilHealth member-patient's use.

22. 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.

23. 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

24. 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.

25. 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.

26. 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.

27. That we shall ensure that true and accurate data are encoded in all patients' records.

28. 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.

29. That we shall submit claims in the format required by PhilHealth for our facility.

30. That we shall regularly submit PhilHealth monitoring reports as required in PhilHealth circulars.

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

31. 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.

32. 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.

33. 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.

34. 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.

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

36. 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.

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

F. MISCELLANEOUS PROVISIONS

38. 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.

39. 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.

40. 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.

41. 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:

42. 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, *as amended,* and its IRR.

43. 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

MASTER COPY Date: 6/19/12

Annex C: Supplemental Provider Record

Part I - General Information			
Name of Facility:			
Address			
Address line 1:			
Address line 2:			
City/Municipality:		Province:	
Region:		Postal Code:	
Mobile No.:		Landline No (Office):	
Email Address:			
CIU Manager			
Last Name:		Middle Initials:	
First Name:		Suffix:	
Institutional Affiliation:			
Position:			
Catchment			
No. of Municipalities catered:			
Names of Municipalities catered:			
Referral Hospital 1			
Name of Facility			
Address line 1:			
Address line 2:			
City/Municipality:		Province:	
Region:		Postal Code:	
Referral Hospital 2 (indicated N/A if no additional referral hospital)			
Name of Facility			
Address line 1:			
Address line 2:			
City/Municipality:		Province:	
Region:		Postal Code:	
Referral Hospital 3 (indicated N/A if no additional referral hospital)			
Name of Facility			
Address line 1:			
Address line 2:			
City/Municipality:		Province:	
Region:		Postal Code:	
In cases where there are more than 3 referral hospitals, please attach another form and fill out the "refer all hospital" section.			
Service Capacity			
Accommodations			
Ward type:			
No. of beds in ward type accommodations:			
No of bathrooms for patients in ward type accommodations:			
Total No of toilets for patients in ward type accommodations:			
Total No of showers for patients in ward type accommodations:			
With cohorting for patients in ward accommodations (Y/N):			
Single Room:			
No. of beds in single rooms w/o ensuite bathrooms:			
No. of beds in single rooms with ensuite bathrooms:			
Human Resource			
Total no. of employed physicians:			
No. of physicians on duty/day:			
Total no. of employed nurses:			
No. of nurses on duty/day:			
Total no. of other health workers employed:			
List other types of health workers employed:			
Total no. of other non-health workers employed:			
List other types of non-health workers employed:			

I certify that the information submitted in this application is true and correct to the best of my knowledge. I further understand that any false statements may result in denial or revocation of my accreditation.

For CIUS set up by Level 2 and Level 3 Hospitals

Further, in signing this document, I confirm that I have coordinated and secured explicit permission from LGUs of the municipality/municipalities identified above to serve as a CIU catering to their constituency.

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Part II - Authorization

This is to authorize (Name of the CIU facility) to use our eClaim system for the filing and submission of Covid-19 Community Isolation Benefit Package (CCIBP) claims using its own PhilHealth Accreditation Number (PAN) and cipher key. Further, all PhilHealth reimbursements for the CIU's filed claims shall be credited to the (name of partner institution) ACPS account and shall subsequently be disbursed to the said CIU 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

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Annex D: Possible Scenarios in Terms of CIU Management and Ownership

Scenario:	Partner Facilities:
Managed: LGU Owned: LGU/Private Type of CIU: L1 Hospital	For Referral: L2 or L3 referral Hospital
Managed: LGU Owned: LGU/Private Type of CIU: Converted non-hospital facility*	For Claims Filing: PhilHealth accredited facilities such as MCP, TB-DOTS, Animal Bite, Hospital For Commodities support: LGU-owned or Private L1 Hospital, or L2 or L3 referral For Referral: L2 or L3 referral Hospital
Managed: NG Owned: LGU/NG/Private Type of CIU: Converted non-hospital facility	For Claims Filing: PhilHealth accredited facilities such as MCP, TB-DOTS, Animal Bite, Hospital For Commodities support: LGU-owned or Private L1 Hospital, or L2 or L3 referral For Referral: L2 or L3 referral Hospital
Managed: Private Hospital or Institution** Owned: LGU/NG/Private Type of CIU: L1 Hospital	For Referral: L2 or L3 referral Hospital
Managed: Private Hospital or Institution Owned: LGU/NG/Private Type of CIU: Converted non-hospital facility	For Claims Filing: PhilHealth accredited facilities such as MCP, TB-DOTS, Animal Bite, Hospital For Commodities support: LGU-owned or Private L1 Hospital, or L2 or L3 referral For Referral: L2 or L3 referral Hospital

*if the CIU is a non-hospital facility and the partner facility is L1 and owned by a different LGU, it cannot be engaged for purposes outside diagnostic and commodities support which shall be allowed only in extraneous circumstances where, for whatever reason, the LGU cannot anymore provide the logistical requirements needed to run its own CIU.

**if a CIU is managed by a privately owned hospital or institution, the CIU shall be accredited to provide the benefit if (1) there is no LGU or NG managed CIU in the immediate vicinity and/or (2) the LGU and/or the NG recognizes the need to set up a CIU and provided explicit permission for the privately-owned hospital to set-up a CIU in its behalf.

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Annex E: Mandatory and Other Health Services

Mandatory Service	Other Service (as needed)
a. Minimum days *of* admission* (*see below Table 1 COVID- 19 Isolation Requirement Matrix) based on DOH applicable guidelines.* b. Boarding, food and individual hygiene kit c. Information and Education about respiratory etiquette and self- monitoring d. Monitoring by a Health Care Professional *Except in case of transfer due to deterioration or mortality based on discharge criteria from applicable guidelines adopted by DOH.	a. Drugs and Medicines, as specified in the applicable DOH policies. b. Diagnostic Tests and Imaging, as specified in the applicable DOH policies. c. Oxygen Support d. Referral and transportation to higher level facility

Table 1. COVID-19 Isolation Requirement Matrix

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

**Please indicate in the Case Investigation Form (CIF)*

Based on currently acceptable guidelines and other references including:

- *Department of Health Department Memorandum 2022-0013: Updated Guidelines on Quarantine, Isolation, and Testing for COVID-19 response and Case Management for the Omicron Variant*
- *Department of Health Department Circular 2022-0002: Advisory on Covid-19 Protocols for Quarantine and Isolation*
- *Department of Health Department Memorandum 2020-0512: Revised Omnibus Interim Guidelines on Prevention, Detection, Isolation, Treatment, and Reintegration Strategies for COVID-19*

Annex F: Definition of Eligible Cases for Isolation

CASES	
Suspect Case	*Refers to:* ***1. Suspect Criteria A** - refers to a person who meets the clinical AND epidemiological criteria:* *a. Clinical criteria:* *i. Acute onset of fever AND cough; OR* *ii. Acute onset of ANY THREE OR MORE of the following signs or symptoms: fever, cough, general weakness/fatigue, headache, myalgia, sore throat, coryza, dyspnea, anorexia/ nausea/ vomiting, diarrhea, altered mental status AND* *b. Epidemiological Criteria:* *i. Residing or working in an area with a high risk of transmission of virus: closed residential settings, humanitarian settings such as camp and camp-like settings for displaced persons; anytime within the fourteen (14) days prior to symptom onset; or* *ii. Residing or travel to an area with community transmission anytime within the fourteen (14) days prior to symptom onset; or* *iii. Working in any health care setting, including within health facilities or within the community; any time within the fourteen (14) days prior to symptom onset.* ***2. Suspect Criteria B** - refers to a patient with Severe Acute Respiratory Illness (SARI): acute respiratory infection with history of fever or measured fever of > 38C°; and cough; with onset within the last ten (10) days; and requires hospitalization. A person who meets the clinical AND epidemiological criteria:* ***3. Suspect Criteria C** - refers to an asymptomatic person not meeting epidemiologic criteria with a POSITIVE SARS-CoV-2 Antigen-RDT*
Probable Case	*Refers to:* *1. A patient who meets clinical criteria AND is a contact of a probable or confirmed case or linked to a COVID-19 cluster; or* *2. A suspect case with chest imaging showing findings suggestive of COVID-19 disease;* *3. A person with recent onset of anosmia (loss of smell) or ageusia (loss of taste) in the absence of any other identified cause;* *4. Death, not otherwise explained, in an adult with respiratory distress preceding death; AND was a contact of a probable or confirmed case or linked to a COVID-19 cluster.*
Confirmed Case	*Refers to any individual, irrespective of presence or absence of clinical signs and symptoms, who was laboratory confirmed for COVID-19 in a test conducted at the national reference laboratory, a subnational reference laboratory, and/or DOH-licensed COVID-19 testing laboratory; OR* *any suspect or probable COVID-19 cases, who tested positive using antigen tests in areas with outbreaks and/or in remote settings where RT-PCR is not immediately available;*

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	provided that the antigen tests satisfy the recommended minimum regulatory, technical and operational specifications set by Health Technology Assessment Council

Mild COVID-19	• *No pneumonia or desaturation COVID-19*
	• *Acute onset of fever and cough or any three (3) 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*

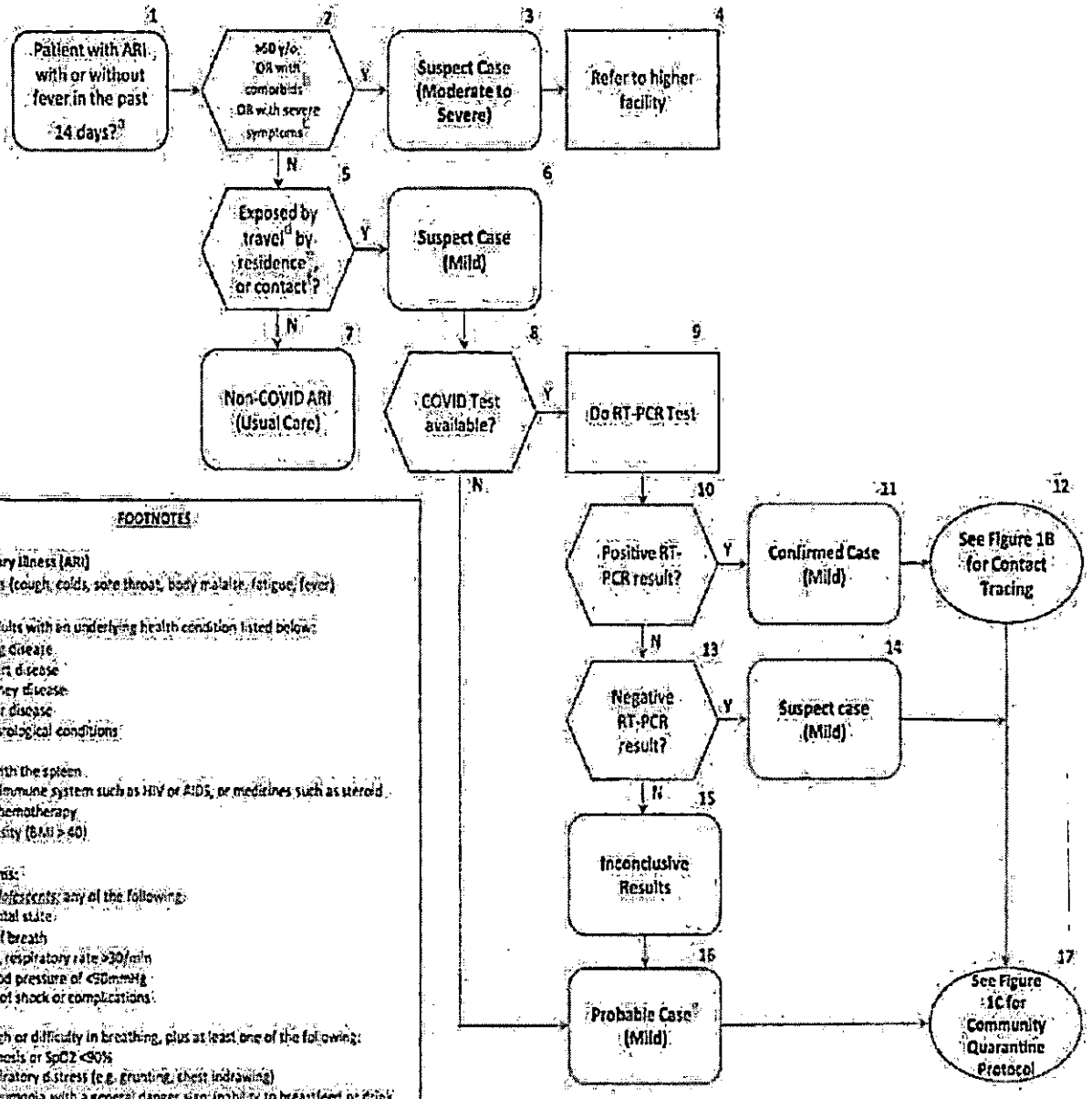
Source: Annex B of Department of Health Department Circular No. 2022-0002: Advisory on Protocols for Quarantine and Isolation, January 6, 2022

Clinical and Social Criteria based on Joint Administrative Order

ANNEX A. COVID-19 Patient Algorithm for Triage and Hospitalization (C-PATH).
Note: The DOH may henceforth release an updated version, which shall be used for this Order.

FIGURE 1A. CLASSIFICATION OF CASES

Version 06 April 2020 (original)



FOOTNOTES

[a] Acute Respiratory Illness (ARI)
Flu-like symptoms (cough, colds, sore throat, body malaise, fatigue, fever)

[b] Comorbids – adults with an underlying health condition listed below:
- Chronic lung disease
- Chronic heart disease
- Chronic kidney disease
- Chronic liver disease
- Chronic neurological conditions
- Diabetes
- Problems with the spleen
- Weakened immune system such as HIV or AIDS, or medicines such as steroid tablets or chemotherapy
- Morbid obesity (BMI > 40)

[c] Severe Symptoms:
For adults and adolescents: any of the following:
- altered mental state
- shortness of breath
- SpO2 <94%, respiratory rate >30/min
- systolic blood pressure of <90mmHg
- other signs of shock or complications

For children: cough or difficulty in breathing, plus at least one of the following:
- central cyanosis or SpO2 <90%
- severe respiratory distress (e.g. grunting, chest indrawing)
- signs of pneumonia with a general danger sign: inability to breastfeed or drink, lethargy/unconsciousness, or convulsions

Other signs of pneumonia may be present: fast breathing (in breaths/min): <2 months: ≥60; 2-11 months: ≥50; 1-5 years: ≥40

[d] Exposure by travel
Travel from a country/area where there is sustained community level transmission

[e] Exposure by residence
Lives in an LGU where there is sustained community level transmission

Exposure by contact
1. Providing direct care to suspect, probable, or confirmed COVID-19 patients without using proper PPE (i.e. healthcare workers);
2. Face-to-face contact with a probable or confirmed case within 1 meter and for more than 15 minutes;
3. Direct physical contact with a probable or confirmed case; OR
4. Other situations as indicated by local risk assessments

[g] Probable Case
Proceed to box 10 if repeat test becomes possible/available

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FIGURE 1B. CONTACT TRACING PROTOCOL

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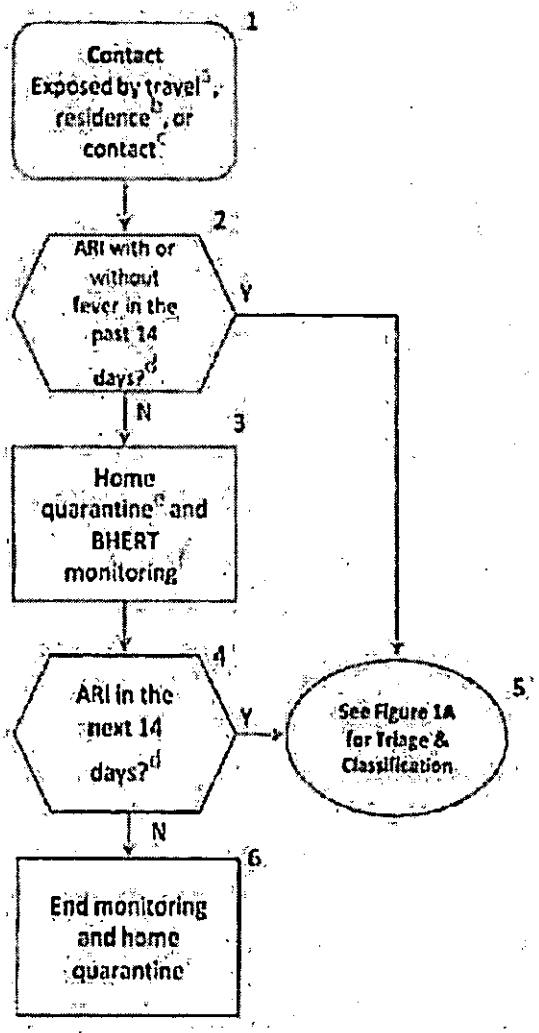

FOOTNOTES

[a] **Exposure by travel**
Travel from a country/area where there is sustained community level transmission

[b] **Exposure by residence**
Lives in an LGU where there is sustained community level transmission

[c] **Exposure by contact**
1. Providing direct care to suspect, probable, or confirmed COVID-19 patients without using proper PPE (i.e. healthcare workers);
2. Face-to-face contact with a probable or confirmed case within 1 meter and for more than 15 minutes;
3. Direct physical contact with a probable or confirmed case; OR
4. Other situations as indicated by local risk assessments

[d] **Acute Respiratory Illness (ARI)**
Flu-like symptoms (cough, colds, sore throat, body malaise; fatigue, fever)

[e] **Home Quarantine – All members of the household (including pets) must strictly stay at home**

[f] **BHERT Monitoring**
Barangay Health Emergency Response Team (BHERT)
- Accomplish a Case Identification Form (CIF)
- Ensure monitoring throughout the duration of isolation & quarantine
- Facilitate home care and basic needs
- A daily report shall be forwarded to the Municipality/City Epidemiology and Surveillance Units (MESU/CESU) which in turn are forwarded to the Provincial Epidemiology and Surveillance Units (PESU).

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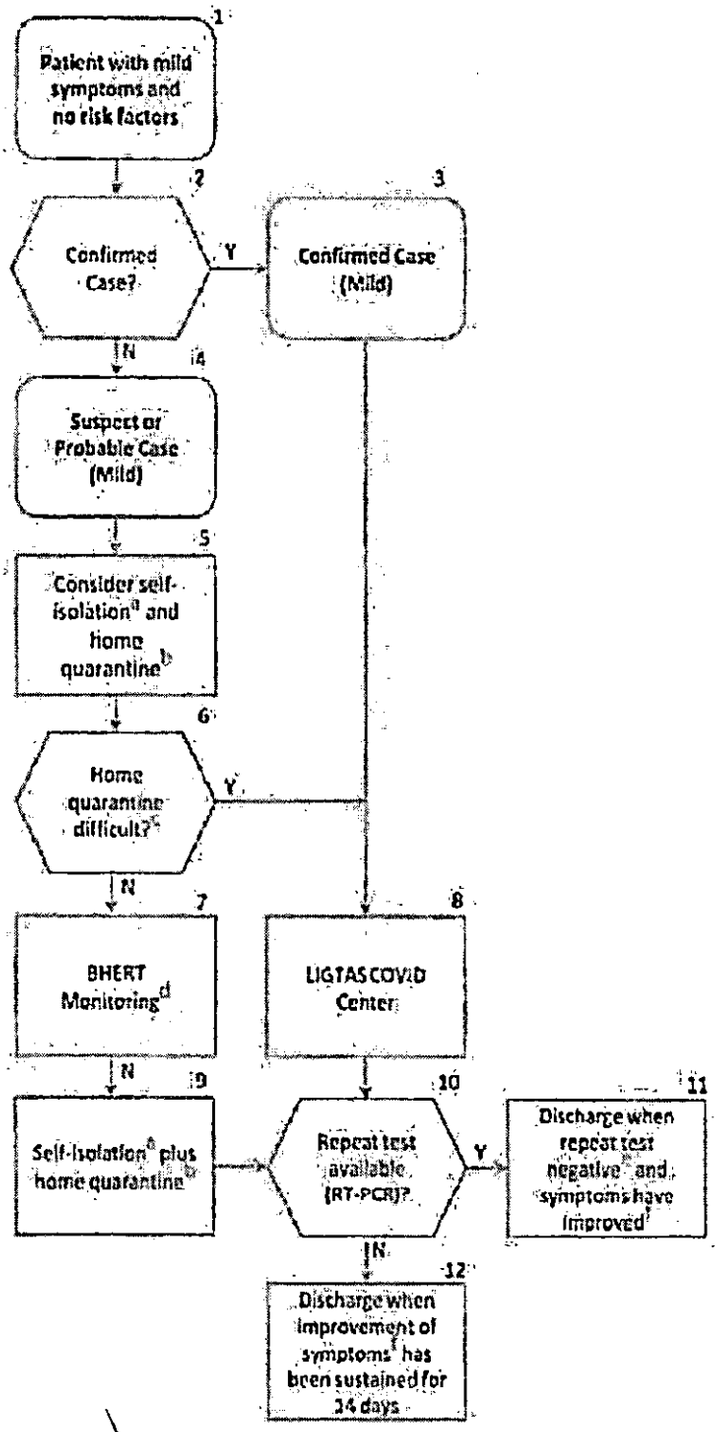
FIGURE 1C. COMMUNITY QUARANTINE PROTOCOL

Version 06 April 2020 (original)



FOOTNOTES

[a] **Self-isolation** – strict isolation of the patient in a separate room or area in the household

[b] **Home Quarantine** – All members of the household (including pets) must strictly stay at home

[c] **Situations where home quarantine is difficult**
1. Living with vulnerable person (with comorbids or >60y/o)
2. No separate bedroom or bed not >1m away
3. No separate bathroom for patient
4. Not well-ventilated
5. No separate utensils and personal things
6. No separate towels for handwashing

[d] **BHERT Monitoring**
Barangay Health Emergency Response Team (BHERT)
- Accomplish a **Case Identification Form (CIF)**
- Ensure monitoring throughout the duration of isolation & quarantine
- Facilitate home care and basic needs
- A daily report shall be forwarded to the Municipality/City Epidemiology and Surveillance Units (MESU/CESU) which in turn are forwarded to the Provincial Epidemiology and Surveillance Units (PESU).

[e] **Repeat Test Negative**
- Two consecutive negative tests 24 hours apart is preferred or at least one negative test prior to discharge

[f] **Improvement of symptoms:**
- Temp <37.8°C > 3 days
- Respiratory symptoms reduced significantly
- CXR shows significant improvement

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

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

Package Code	Description
C19CI	COVID-19 Community Isolation Package
C19CIS	Admissions that were referred to the CIU from higher level facilities for step-down care

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.

ICD-10 Code	Description
"Z03.8" with additional code "Z20.8"	Patient observed without confirmation or with negative test
"U07.1"	COVID-19 Confirmed

Table 2: Applicable Z codes and ICD-10 codes per DOH DM 2020-0067

c. The corresponding reimbursement rate is Php 22,449.00 per claim.

d. The claims from government health care facilities shall be utilized to cover all services, medicines and diagnostics provided for in this Circular 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 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 the cost of delivering the services.

f. Patients shall not be charged out of pocket payment for the services received at the CIU.

g. CIUs shall AND submit the following reports to their concerned PROs on a monthly basis:
   i. Expenditure and Utilization Reports (see Annex *J*)
   ii. Electronic report (excel file) of admitted patients (see Annex *K*)

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Annex I: Case Investigation Form

Philippine Integrated Disease Surveillance and Response

Case Investigation Form
Coronavirus Disease (COVID-19)
Version 9

1) The Case Investigation Form (CIF) is meant to be administered as an interview by a health care worker or any personnel of the DRU. This is not a self-administered questionnaire.
2) Please be advised that DRUs are only allowed to obtain 1 copy of accomplished CIF from a patient.
3) Please fill out all blanks and put a check mark on the appropriate box. Never leave an item blank (write N/A). Items with * are required fields. All dates must be in MM/DD/YYYY format.

Disease Reporting Unit*	DRU Region and Province	PhilHealth No.*
Name of Interviewer	Contact Number of Interviewer	Date of Interview *(MM/DD/YYYY)**
Name of Informant *(if applicable)*	Relationship	Contact Number of Informant

If existing case *(check all that apply)**	☐ Not applicable (New case)	☐ Update case classification	☐ Update disposition
	☐ Not applicable (Unknown)	☐ Update vaccination	☐ Update exposure / travel history
	☐ Update symptoms	☐ Update lab result	☐ Others, specify:
	☐ Update health status / outcome	☐ Update chest imaging findings	
Type of Client*	☐ COVID-19 Case (Suspect, Probable, or Confirmed)	☐ Close Contact	☐ For RT-PCR Testing (Not a Case of Close Contact)
Testing Category/Subgroup* *(Check all that apply, refer to Appendix 2)*	☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G ☐ H ☐ I ☐ J		

Part 1. Patient Information

1.1. Patient Profile

Last Name*	First Name (and Suffix)*	Middle Name*
Birthday (MM/DD/YYYY)*	Age*	Sex* ☐ Male ☐ Female
Civil Status	Nationality*	
Occupation	Works in a closed setting? ☐ Yes ☐ No ☐ Unknown	

1.2. Current Address in the Philippines and Contact Information* *(Provide address of institution if patient lives in closed settings, see 1.5)*

House No./Lot/Bldg.*	Street/Purok/Sitio*	Barangay*	Municipality/City*
Province*	Home Phone No. (& Area Code)	Cellphone No.*	Email Address

1.3. Permanent Address and Contact Information *(if different from current address)*

House No./Lot/Bldg.	Street/Purok/Sitio	Barangay	Municipality/City
Province	Home Phone No. (& Area Code)	Cellphone No.	Email Address

1.4. Current Workplace Address and Contact Information

Lot/Bldg.	Street	Barangay	Municipality/City
Province	Name of Workplace	Phone No./Cellphone No.	Email Address

1.5. Special Population *(indicate further details on exposure and travel history in Part 3)*

Health Care Worker*	☐ Yes, name of health facility: _____ and location: _____	☐ No
Returning Overseas Filipino*	☐ Yes, country of origin: _____ and Passport number: _____ OFW: ☐ OFW ☐ Non-OFW	☐ No
Foreign National Traveler*	☐ Yes, country of origin: _____ and Passport number: _____	☐ No
Locally Stranded Individual / APOR / Local Traveler*	☐ Yes, City, Municipality, & Province of origin _____ ☐ Locally Stranded Individual ☐ Authorized Person Outside Residence / Local Traveler	☐ No
Lives in Closed Settings*	☐ Yes, institution type: _____ and name: _____ *(e.g. prisons, residential facilities, retirement communities, care homes, camps, etc.)*	☐ No

Part 2. Case Investigation Details

2.1. Consultation Information

Have previous COVID-19 related consultation?	☐ Yes, Date of First Consult *(MM/DD/YYYY)** _____	☐ No
Name of facility where first consult was done		

2.2. Disposition at Time of Report* (Provide name of hospital/isolation/quarantine facility)

☐ Admitted in hospital _____	Date and Time admitted in hospital _____
☐ Admitted in isolation/quarantine facility _____	Date and Time isolated/quarantined in facility _____
☐ In home isolation/quarantine	Date and Time isolated/quarantined at home _____
☐ Discharged to home	If discharged: Date of Discharge *(MM/DD/YYYY)** _____ ☐ Others: _____

2.3.	Health Status at Consult* *(Refer to Appendix 3)*	☐ Asymptomatic	☐ Mild	☐ Moderate	☐ Severe	☐ Critical
2.4.	Case Classification* *(Refer to Appendix 1)*	☐ Suspect	☐ Probable	☐ Confirmed	☐ Non-COVID-19 Case	

2.5. Vaccination Information*

Date of vaccination*	Name of Vaccine*	Dose number (e.g. 1st, 2nd)*	Vaccination center/facility	Region of health facility	Adverse event/s?
					☐ Yes ☐ No
					☐ Yes ☐ No

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2.6. Clinical Information

Date of Onset of Illness *(MM/DD/YYYY)** _____

Signs and Symptoms *(Check all that apply)*

☐ Asymptomatic	☐ Dyspnea
☐ Fever _____ °C	☐ Anorexia
☐ Cough	☐ Nausea
☐ General weakness	☐ Vomiting
☐ Fatigue	☐ Diarrhea
☐ Headache	☐ Altered Mental Status
☐ Myalgia	☐ Anosmia (loss of smell, w/o any identified cause)
☐ Sore throat	☐ Ageusia (loss of taste, w/o any identified cause)
☐ Coryza	☐ Others, specify_____

Comorbidities *(Check all that apply if present)*

☐ None	☐ Gastrointestinal
☐ Hypertension	☐ Genito-urinary
☐ Diabetes	☐ Neurological Disease
☐ Heart Disease	☐ Cancer
☐ Lung Disease	☐ Others _____

Pregnant? ☐ Yes, LMP *(MM/DD/YYYY)* _____ ☐ No

High-risk pregnancy? ☐ Yes ☐ No

Was diagnosed to have Severe Acute Respiratory Illness? ☐ Yes ☐ No

Chest imaging findings suggestive of COVID-19

Date done	Chest imaging done	Results
	☐ Chest radiography ☐ Chest CT ☐ Lung ultrasound ☐ None	☐ Normal ☐ Pending

☐ Chest radiography: Hazy opacities, often rounded in morphology, with peripheral and lower lung dist.
☐ Chest CT: Multiple bilateral ground glass opacities, often rounded in morphology, w/ peripheral & lower lung dist.
☐ Lung ultrasound: Thickened pleural lines, B lines, consolidative patterns with or without air bronchograms
☐ Other findings, specify _____

2.7. Laboratory Information

Have tested positive using RT-PCR before? * ☐ Yes, date of specimen Collection *(MM/DD/YYYY)** _____ ☐ No

Laboratory* _____ No. of previous RT-PCR swabs done ____

Date collected*	Date released	Laboratory*	Type of test*	Results*
			☐ RT-PCR (OPS) ☐ Antigen; reason_____ ☐ RT-PCR (NPS) brand of kit _____ ☐ RT-PCR (OPS and NPS) ☐ Antibody Test ☐ Others: _____	☐ Pending ☐ Negative ☐ Positive ☐ Equivocal ☐ Others:
			☐ RT-PCR (OPS) ☐ Antigen; reason_____ ☐ RT-PCR (NPS) brand of kit _____ ☐ RT-PCR (OPS and NPS) ☐ Antibody Test ☐ Others: _____	☐ Pending ☐ Negative ☐ Positive ☐ Equivocal ☐ Others:

2.8. Outcome/Condition at Time of Report*

☐ Active (currently admitted/isolation/quarantine) ☐ Recovered, date of recovery *(MM/DD/YYYY)** _____ ☐ Died, date of death *(MM/DD/YYYY)** _____

If died, cause of death*	Immediate Cause:	Antecedent Cause:
	Underlying Cause:	Contributory Conditions:

PART 3. Contact Tracing: Exposure and Travel History

History of exposure to known probable and/or confirmed COVID-19 case 14 days before the onset of signs and symptoms? OR If Asymptomatic, 14 days before swabbing or specimen collection? * ☐ Yes, date of last contact *(MM/DD/YYYY)** _____ ☐ No ☐ Unknown

Has the patient been in a place with a known COVID-19 transmission 14 days before the onset of signs and symptoms? OR If Asymptomatic, 14 days before swabbing or specimen collection? * ☐ Yes, International ☐ Yes, Local ☐ No ☐ Unknown exposure

If International Travel, country of origin		Inclusive travel dates:	From: To:
		With ongoing COVID-19 community transmission?	☐ Yes ☐ No

Airline/Sea vessel	Flight/Vessel Number	Date of departure *(MM/DD/YYYY)*	Date of arrival in PH *(MM/DD/YYYY)*

If Local Travel, specify travel places *(Check all that apply, provide name of facility, address, and inclusive travel dates in MM/DD/YYYY)*

Place Visited	Name of Place	Address *(Region, Province, Municipality/City)*	Inclusive Travel Dates From:	Inclusive Travel Dates To:	With ongoing COVID-19 Community Transmission?
☐ Health Facility					☐ Yes ☐ No
☐ Closed Settings					☐ Yes ☐ No
☐ School					☐ Yes ☐ No
☐ Workplace					☐ Yes ☐ No
☐ Market					☐ Yes ☐ No
☐ Social Gathering					☐ Yes ☐ No
☐ Others					☐ Yes ☐ No

☐ Transport Service, specify the following:

Airline / Sea vessel / Bus line / Train	Flight / Vessel / Bus No.	Place of Origin	Departure Date *(MM/DD/YYYY)*	Destination	Date of Arrival *(MM/DD/YYYY)*

- If symptomatic, provide names and contact numbers of persons who were with the patient two days prior to onset of illness until this date
- If asymptomatic, provide names and contact numbers of persons who were with the patient on the day specimen was submitted for testing until this date

Name *(Use the back page if needed)*	Contact Number

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Appendix 1. COVID-19 Case Definitions

SUSPECT	PROBABLE
A) A person who meets the **clinical AND epidemiological criteria** – **Clinical criteria:** 1) Acute onset of fever AND cough **OR** 2) Acute onset of **ANY THREE OR MORE** of the following signs or symptoms; fever, cough, general weakness/fatigue, headache, myalgia, sore throat, coryza, dyspnea, anorexia / nausea/ vomiting, diarrhea, altered mental status. **AND** – **Epidemiological criteria** 1) Residing/working in an area with high risk of transmission of the virus (e.g closed residential settings and humanitarian settings, such as camp and camp-like setting for displaced persons), any time w/in the 14 days prior to symptoms onset **OR** 2) Residing in or travel to an area with community transmission anytime w/in the 14 days prior to symptoms onset; **OR** 3) Working in health setting, including w/in the health facilities and w/in households, anytime w/in the 14 days prior to symptom onset; **OR** B) A patient with severe **acute respiratory illness** (SARI: acute respiratory infection with history of fever or measured fever of ≥ 38°C; cough with onset w/in the last 10 days; and who requires hospitalization)	A) **A patient** who meets the **clinical criteria** (on the left) **AND is contact of a probable or confirmed case, or epidemiologically linked to a cluster of cases** which had had at least one confirmed identified within that cluster B) **A suspect case** (on the left) with **chest imaging showing findings suggestive of COVID-19 disease.** Typical chest imaging findings include (Manna, 2020): – Chest radiography: hazy opacities, often rounded in morphology, with peripheral and lower lung distribution – Chest CT: multiple bilateral ground glass opacities, often rounded in morphology, with peripheral and lower lung distribution – Lung ultrasound: thickened pleural lines, B lines (multifocal, discrete, or confluent), consolidative patterns with or without air bronchograms C) A person with **recent onset of anosmia (loss of smell), ageusia (loss of taste) in the absence of any other identified cause** D) Death, not otherwise explained, in an **adult with respiratory distress preceding death AND who was a contact of a probable or confirmed case or epidemiologically linked to a cluster** which has had at least one confirmed case identified with that cluster
	CONFIRMED A person with **laboratory confirmation of COVID-19 infection,** irrespective of clinical signs and symptoms.

Appendix 2. Testing Category / Subgroup

A	Individuals with **severe/critical** symptoms and **relevant history** of travel/contact
B	Individuals with mild symptoms, **relevant history** of travel/contact, and considered **vulnerable;** vulnerable populations include those elderly and with preexisting medical conditions that predispose them to severe presentation and complications of COVID-19
C	Individuals with **mild** symptoms, and **relevant history** of travel and/or contact
D	Individuals with **no symptoms** but with **relevant history** of travel and/or contact or high risk of exposure. These include:
D1	**- Contact-traced individuals**
D2	**- Healthcare workers,** who shall be prioritized for regular testing in order to ensure the stability of our healthcare system
D3	**- Returning Overseas Filipino** (ROF) workers, who shall immediately be tested at port of entry
D4	- Filipino citizens in a specific locality within the Philippines who have expressed intention to return to their place of residence/home origin (**Locally Stranded Individuals**) may be tested subject to the existing protocols of the IATF
E	**Frontliners indirectly involved in health care provision** in the response against COVID-19 may be tested as follows:
E1	Those with **high or direct exposure to COVID-19 regardless of location** may be tested up to once a week. These include: **(1)** Personnel manning the Temporary Treatment and Quarantine Facilities (LGU and Nationally-managed); **(2)** Personnel serving at the COVID-19 swabbing center; **(3)** Contact tracing personnel; and **(4)** Any personnel conducting swabbing for COVID-19 testing
E2	Those who **do not have high or direct exposure to COVID-19** but who **live or work in Special Concern Areas** may be tested up to every two to four weeks. These include the following: **(1)** Personnel manning Quarantine Control Points, including those from Armed Forces of the Philippines, Bureau of Fire Protection; **(2)** National / Regional / Local Risk Reduction and Management Teams; **(3)** Officials from any local government / city / municipality health office (CEDSU, CESU, etc.); **(4)** Barangay Health Emergency Response Teams and barangay officials providing barangay border control and performing COVID-19-related tasks; **(5)** Personnel of Bureau of Corrections and Bureau of Jail Penology & Management; **(6)** Personnel manning the One-Stop-Shop in the Management of ROFs; **(7)** Border control or patrol officers, such as Immigration officers and the Philippine Coast Guard; and **(8)** Social workers providing amelioration and relief assistance to communities and performing COVID-19-related tasks
F	**Other vulnerable patients and those living in confined spaces.** These include but are not limited to: **(1)** Pregnant patients who shall be tested during the peripartum period; **(2)** Dialysis patients; **(3)** Patients who are immunocompromised, such as those who have HIV/AIDS, inherited diseases that affect the immune system; **(4)** Patients undergoing chemotherapy or radiotherapy; **(5)** Patients who will undergo elective surgical procedures with high risk for transmission; **(6)** Any person who have had organ transplants, or have had bone marrow or stem cell transplant in the past 6 months; **(7)** Any person who is about to be admitted in enclosed institutions such as jails, penitentiaries, and mental institutions.
G	**Residents, occupants or workers in a localized area with an active COVID-19 cluster,** as identified and declared by the local chief executive in accordance with existing DOH Guidelines and consistent with the National Task Force Memorandum Circular No. 02 s.2020 or the Operational Guidelines on the Application of the Zoning Containment Strategy in the Localization of the National Action Plan Against COVID-19 Response. The local chief executive shall conduct the necessary testing in order to protect the broader community and critical economic activities and to avoid a declaration of a wider community quarantine.
H	**Frontliners in Tourist Zones:**
H1	All workers and employees in the **hospitality and tourism sectors** in El Nido, Boracay, Coron, Panglao, Siargao and other tourist zones, as identified and declared by the Department of Tourism. These workers and employees may be tested once every four (4) weeks.
H2	All **travelers,** whether of domestic or foreign origin, may be tested at least once, at their own expense, prior to entry into any designated tourist zone, as identified and declared by the Department of Tourism.
I	All workers and employees of **manufacturing companies and public service providers registered in economic zones** located in Special Concern Areas may be tested regularly.
J	**Economy Workers**
J1	**Frontline and Economic Priority Workers,** defined as those 1) who work in high priority sectors, both public and private, 2) have high interaction with and exposure to the public, and 3) who live or work in Special Concerns Areas, may be tested every three (3) months. These include but not limited to: **- Transport and Logistics:** drivers of taxis, ride hailing services, buses, public transport vehicle, conductors, pilots, flight attendants, flight engineers, rail operators, mechanics, servicemen, delivery staff, water transport workers (ferries, inter-island shipping, ports) **- Food Retails:** waiters, waitress, bar attendants, baristas, chefs, cooks, restaurant managers **- Education:** teachers at all levels of education and other school frontliners such as guidance counselors, librarians, cashiers **- Financial Services:** bank tellers **- Non-Food Retails:** cashiers, stock clerks, retail salespersons **- Services:** hairdressers, barbers, manicurists, pedicurists, massage therapists, embalmers, morticians, undertakers, funeral directors, parking lot attendants, security guards, messengers **- Construction:** construction workers including carpenters, stonemasons, electricians, painters, foremen, supervisors, civil engineers, structural engineers, construction managers, crane/tower operators, elevator installers, repairmen **- Water Supply, Sewerage, Waster Management:** plumbers, recycling/ reclamation workers, garbage collectors, water/wastewater engineers, janitors, cleaners **- Public Sector:** judges, courtroom clerks, staff and security, all national and local government employees rendering frontline services in special concern areas **- Mass Media:** field reporters, photographers, cameramen
J2	**All employees not covered above are not required to undergo testing but are encouraged to be tested every quarter.** Private sector employers are highly encouraged to send their employees for regular testing at the employers' expense in order to avoid lockdowns that may do more damage to their companies.

Appendix 3. Severity of the Disease

MILD	CRITICAL
Symptomatic patients presenting with fever, cough, fatigue, anorexia, myalgias; other non-specific symptoms such as sore throat, nasal congestion, headache, diarrhea, nausea and vomiting; loss of smell (anosmia) or loss of taste (ageusia) preceding the onset of respiratory symptoms with **NO signs of pneumonia or hypoxia**	Patients manifesting with acute respiratory distress syndrome, sepsis and/or septic shock: 1. **Acute Respiratory Distress Syndrome (ARDS)** a. Patients with onset within 1 week of known clinical insult (pneumonia) or new or worsening respiratory symptoms, progressing infiltrates on chest X-ray or chest CT scan, with respiratory failure not fully explained by cardiac failure or fluid overload 2. Sepsis a. Adults with life-threatening organ dysfunction caused by a dysregulated host response to suspected or proven infection. Signs of organ dysfunction include altered mental status, difficult or fast breathing, low oxygen saturation, reduced urine output, fast heart rate, weak pulse, cold extremities or low blood pressure, skin mottling, or laboratory evidence of coagulopathy, thrombocytopenia, acidosis, high lactate or hyperbilirubinemia b. Children with suspected or proven infection and > 2 age-based systemic inflammatory response syndrome criteria (abnormal temperature [> 38.5 °C or < 36 °C); tachycardia for age or bradycardia for age if < 1year; tachypnea for age or need for mechanical ventilation; abnormal white blood cell count for age or > 10% bands), of which one must be abnormal temperature or white blood cell count. 3. Septic Shock a. Adults with persistent hypotension despite volume resuscitation, requiring vasopressors to maintain MAP > 65 mmHg and serum lactate level >2mmol/L b. Children with any hypotension (SBP < 5th centile or > 2 SD below normal for age) or two or three of the following: altered mental status; bradycardia or tachycardia (HR < 90 bpm or > 160 bpm in infants and heart rate < 70 bpm or > 150 bpm in children); prolonged capillary refill (> 2 sec) or weak pulse; fast breathing; mottled or cool skin or petechial or purpuric rash; high lactate; reduced urine output; hyperthermia or hypothermia.
MODERATE	
1. Adolescent or adult with **clinical signs of non-severe pneumonia** (e.g. fever, cough, dyspnea, respiratory rate **(RR) = 21-30 breaths/minute,** peripheral capillary oxygen saturation (SpO2) >92% on room air) 2. Child with clinical signs of non-severe pneumonia (cough or difficulty of breathing and fast breathing [< 2 months: > 60; 2-11 months: > 50; 1-5 years: > 40] and/or chest indrawing)	
SEVERE	
1. Adolescent or adult with **clinical signs of severe pneumonia or severe acute respiratory infection** as follows: fever, cough, dyspnea, **RR>30 breaths/minute,** severe respiratory distress or SpO2 < 92% on room air 2. Child with clinical signs of pneumonia (cough or difficulty in breathing) plus at least one of the following: a. Central cyanosis or SpO2 < 90%; severe **respiratory distress** (e.g. fast breathing, grunting, very severe chest indrawing); general danger sign: **inability to breastfeed or drink, lethargy or unconsciousness,** or convulsions. b. **Fast breathing (in breaths/min): < 2 months: > 60; 2-11 months: > 50; 1-5 years: > 40.**	

MASTER COPY Date: 4/19/20

Annex *J*: Expenditure and Utilization Report

Name of Facility: _____
Address: _____
Province: _____
Region: _____
Contact No. _____

Monthly Utilization

Bed Capacity	
Total Admissions	
Total Discharges	
Total Length of Stay	
Total Referrals to Hospital	
Average Length of Stay	
Total Number of Imaging Tests	
Total Number of Laboratory Tests	
Total Number of Prescriptions	

Monthly Expense Report

	Amount
Amount spent on personnel salaries and wages	
Amount spent on benefits for employees	
Allowances provided to employees at this facility	
Total amount spent on Personnel Services	
Amount spent on medicines (Revolving fund & National Government)	
Amount spent of medical supplies (i.e. consumables)	
Amount spent on laboratory and imaging tests	
Amount spent on utilities	
Amount spent on non-medical services (e.g. food supply, security, waste management, laundry, fuel)	
Total Amount spent on maintenance and other operating expense	
Amount spent on infrastructure (e.g. installation of ramps, tents, etc)	
Amount spent on equipment (e.g ECG, X-ray)	
Total Amount of Capital Outlay	
Total Expenditure	

CERTIFIED BY:
CIU

_____
CIU Manager
Signature over printed name and designation

Date Signed: _____

NOTE: Please email to your concerned PhilHealth Regional Office (PRO).

MASTER COPY Date: 4/9/20

Annex *K*: List of Admitted Patients

Name of Provider: _____
PhilHealth Accreditation Number (PAN): _____

Applicable Month : _____

PIN	Patient Name (Last, First and Middle Name)	Membership Category (Member or Dependent)	Date of Birth (mm/dd/yyyy)	Address	Date of Admission (mm/dd/yyyy)	Date of Discharge (mm/dd/yyyy)

Prepared by: _____
Approved by: _____

NOTE: Please email to your concerned PhilHealth Regional Office (PRO).