Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
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PhilHealthOfficial teamphilhealth

PHILHEALTH CIRCULAR
No. 2023 - 0023

TO : **ALL HEALTH CARE PROVIDERS AND ALL OTHERS CONCERNED**

SUBJECT : **Revised Provider Data Record for Health Facilities**

I. RATIONALE

Section 59 of the Revised Implementing Rules and Regulations of the National Health Insurance Act of 2013 states that the Corporation shall prescribe the requirements for accreditation of health facilities. One such requirement is the Provider Data Record (PDR) as prescribed by PhilHealth Circular (PC) No. 2023-0012 or the Omnibus Guidelines on the Accreditation of Health Facilities (HFs) to the National Health Insurance Program. This policy is issued to enhance the said PDR form.

II. OBJECTIVES

This policy aims to capture salient information necessary for the implementation of PhilHealth's Konsulta benefit package by amending the PDR for HFs.

III. SCOPE

This PhilHealth Circular shall apply to all health facilities applying for accreditation.

IV. POLICY STATEMENTS

The revised PDR [Annex A: Provider Data Record (PDR) for Health Facilities (HFs)] amends the entry next to the Konsulta item in Box 10 (bottom part of the form) from "Catchment Population" to "Maximum Patient Load."

V. REPEALING CLAUSE

This PhilHealth Circular amends Annex B of PC No.2023-0012.

VI. DATE OF EFFECTIVITY

This PhilHealth Circular shall take effect immediately after its publication in a newspaper of general circulation, a copy of which shall be deposited with the Office of the National Administrative Register, University of the Philippines Law Center.

EMMANUEL R. LEDESMA, JR.
President and Chief Executive Officer

Date signed: 11/08/2023

PhilHealth
Your Partner in Health

PROVIDER DATA RECORD (PDR) FOR HEALTH FACILITIES (HFs)

INSTRUCTIONS

1. All information should be written in UPPER CASE/ CAPITAL LETTERS.
2. All fields are mandatory unless indicated otherwise. If the information is not applicable, write "N/A."
3. For the Latitude and Longitude fields in Section No. 2 (Mailing/Billing Address), kindly provide the official geographic coordinates used in the DOH Health Facility Geographic Form.
4. For the name of the Head of Facility (HoF) in Section No. 8 (Name of Head of Facility), only check the appropriate box if the HoF has no middle name or has a single name (mononym).
5. If Change in HoF is selected under Section No. 12.B (Update/ Amendment), kindly indicate the contact information, designation, PAN and validity of PAN of the HoF (if applicable) in the "TO" column.
6. All transactions under Section No. 12.B (Update/ Amendment) requires **no** accreditation fee.

TYPE OF TRANSACTION:

☐ Initial
☐ Renewal
☐ Re-accreditation
☐ Update/ Amendment

HF PHILHEALTH ACCREDITATION NUMBER (PAN):

Not applicable for initial application.

THE PRESIDENT & CEO
Philippine Health Insurance Corporation
Pasig City, Philippines
Sir/Madam:

I, _____ (*Name of the Authorized Representative*), of legal age, _____ (*Position/ Designation of the Authorized Representative*) with address at _____ (*Address of the Authorized Representative*) and the duly authorized representative to act for and in behalf of the health facility, hereby submits the following pertinent information and documentary requirements under Section 56 of the Revised Implementing Rules and Regulations of the National Health Insurance Act of 2013 (R.A. No. 7875, as amended by R.A. No. 9241 and 10606).

1NAME OF HF:	
2MAILING/BILLING ADDRESS:	*Unit/Room Number/Floor, Building Name, Lot/Block/Phase/Number, Street Name, Subdivision, Barangay Name* / *City or Municipality*
Province and/or Region	*ZIP Code* / *Latitude (XX.XXXXX)* / *Longitude (XXX.XXXXX)*
3HF CONTACT INFORMATION:	*Landline and/or Mobile Number* / *Official Email Address*
4TIN:	5PHILHEALTH EMPLOYER NUMBER:
6DOH LTO NUMBER:	DOH FACILITY CODE:
VALIDITY: *Start Date (MM/DD/YY)* – *End Date (MM/DD/YY)*	7ACCREDITATION PERIOD APPLIED FOR: ☐ 3 Years ☐ 2 Years ☐ 1 Year
8NAME OF HEAD OF FACILITY (HoF): *Last Name* / *First Name* / *Extension* / *Middle Name* / ☐ *No Middle Name* / ☐ *Mononym*	
HoF CONTACT INFORMATION: *HoF Landline and/or Mobile Number* / *HoF Email Address*	DESIGNATION:
PAN OF HoF: ____-____-____-____	HoF PAN VALIDITY: *Start Date (MM/DD/YY)* – *End Date (MM/DD/YY)*

9HF CATEGORY

☐ Hospital
Level ☐ 3 ☐ 2 ☐ 1
Authorized Bed Capacity (ABC): _____
With Hospital Extension Facility (HEF)? ☐ Y ☐ N
HEF address (if Y): _____

☐ Infirmary
☐ Ambulatory Surgical Clinic
☐ Dialysis Clinic
☐ Hemodialysis ☐ Peritoneal Dialysis

MASTER COPY Date: 11/13/23 DC: [illegible]

☐ Primary Care Facility
☐ Birthing Home
☐ TB DOTS Clinic
☐ Animal Bite Treatment Clinic
☐ Family Planning Clinic
☐ HIV-AIDS Treatment Hub
☐ Rural Health Unit/ Health Center
☐ City/ Municipal Health Office
☐ Provincial Health Office
☐ Barangay Health Station
☐ Community Isolation Unit

☐ COVID-19 Testing Laboratory
☐ RT-PCR ☐ Cartridge-based
☐ Drug Abuse Treatment & Rehabilitation Center
☐ DepEd Clinic
☐ Others _____

10PHILHEALTH BENEFIT PACKAGE/S OFFERED:

☐ Outpatient HIV-AIDS Treatment
☐ Outpatient Malaria Treatment
☐ Animal Bite Treatment
☐ Maternity Care
☐ TB-DOTS
☐ COVID-19 Home Isolation Benefit
☐ Family Planning
☐ Subdermal Contraceptive Implant
☐ Non-Scalpel Vasectomy
☐ IUD Insertion
☐ Konsulta MAXIMUM PATIENT LOAD: _____
☐ Others _____

Continue at the back.

11 NATURE OF OWNERSHIP:

☐ Government
- ☐ DOH-Retained
- ☐ Provincial
- ☐ City/ Municipal
- ☐ DND ☐ DOJ
- ☐ PNP
- ☐ State Universities and Colleges
- ☐ Government-owned and/or Controlled Corporation
- ☐ Others _____

☐ Private
- ☐ Single Proprietorship
- ☐ Partnership
- ☐ Cooperative
- ☐ Foundation
- ☐ Corporation
- ☐ Others _____

Name/s of the Local Chief Executive/s (if Government): Continue on separate sheet if necessary.

Name/s of the Owner/s (if Private): Continue on separate sheet if necessary.

12 DETAILS OF THE RE-ACCREDITATION OR UPDATE/AMENDMENT TRANSACTION

A RE-ACCREDITATION Validity: _____	FROM	TO
☐ Transfer of location ☐ Upgrading of facility level or category ☐ Change in classification ☐ Change in ownership		
☐ Acquisition of additional service capability that would require change in license/ certificate as applicable		

☐ Previous accreditation has lapsed/ Subsequent application was denied ☐ Failure to submit the requirements for continuous accreditation within the prescribed period ☐ Resumption of operation after closure/ cessation of operation

B UPDATE/ AMENDMENT Validity: _____	FROM	TO
☐ Change in name of health facility ☐ Change in head of facility ☐ Decrease in beds ☐ Downgrade of category or hospital level ☐ Change in HF contact information ☐ Others	MASTER COPY Date: 11/19/24	

Under penalty of law, I hereby attest that the information provided, including the documents I have attached to this form, are true and accurate to the best of my knowledge. I agree and authorize PhilHealth for the subsequent validation, verification and for other data sharing purposes only under the following circumstances:

- As necessary for the proper execution of processes related to the legitimate and declared purpose;
- The use or disclosure is reasonably necessary, required or authorized by or under the law, and;
- Adequate security measures are employed to protect my information.

_____ _____

Authorized Representative's Signature over Printed Name | Date

FOR PHILHEALTH USE ONLY **CONTROL NO:**

Date Received	LHIO	By	LHIO
	PRO		PRO

Date Evaluated	LHIO	By	LHIO
	PRO		PRO

Date Encoded	LHIO/PRO Receiving	By	LHIO/PRO
	PRO Data Entry		PRO