

PHILHEALTH CIRCULAR

No. 2026 - 0005

TO : ALL ACCREDITED HEALTH FACILITIES AND HEALTHCARE PROFESSIONALS, PHILHEALTH REGIONAL OFFICES AND ALL OTHERS CONCERNED

SUBJECT : Rationalization of Case Rates for Select Maternal and Gynecologic Services in the Hospital Setting

I. RATIONALE

PhilHealth aims to provide responsive benefits to meet the needs of its beneficiaries pursuant to Republic Act (R.A.) No. 7875, as amended by R.A. Nos. 9241 and 10606 (National Health Insurance Act of 2013), and financing reforms pursuant to Universal Health Care Act (R.A. No. 11223), towards implementing a closed-end, prospective payment system. Similarly, the benefits outlined are consistent with R.A. No. 10354 (Responsible Parenthood and Reproductive Health Act of 2012), which enables PhilHealth to develop benefits that support maternal and child health. Through this PhilHealth Circular, PhilHealth updates select case rates involving maternal and gynecologic services and implements select fee schedules in anticipation of the implementation of Diagnosis-Related Groups (DRG).

Thus, through PhilHealth Board Resolution No. 3089 series of 2026, the PhilHealth Board of Directors approved the Expansion of Maternal and Gynecologic Care Coverage in the Hospital Setting as part of PhilHealth's health financing reforms.

II. OBJECTIVES

- A. Rationalize case rates to be more responsive to current hospital costs;
- B. Reduce patient out-of-pocket spending; and
- C. Support cost containment for care provided in public and private hospitals.

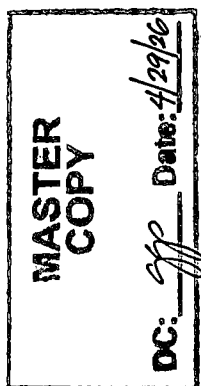
III. SCOPE

This PhilHealth Circular covers the inpatient management related to the expansion of maternal and gynecologic care coverage in the hospital setting. This shall apply to all accredited levels 1 to 3 Health Facilities, PhilHealth Regional Offices (PROs), and all other stakeholders involved in implementing the benefit packages for the expansion of maternal and gynecologic care coverage in the hospital setting.

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IV. DEFINITION OF TERMS

- A. **Balance Billing**¹ - an occurrence when a healthcare provider bills a patient in excess of insurance payment and any set cost share.
- B. **Basic or Ward Accommodation**² - the provision of regular meals, a bed in a shared room with 3 or more occupants, with at least fan ventilation, and shared toilet and bath. Also referred to as “non-private” accommodation in PhilHealth Claim Form 2, Part 2, No. 5.
- C. **Care Coordination** - the deliberate organization of patient care activities and sharing information among all the participants concerned with a patient's care to achieve safer and more effective care. The main goal of care coordination is to meet patients' needs and preferences in the delivery of high-quality, high-value health care. This means that the patient's needs and preferences are known and communicated at the right time to the right people, and that this information is used to guide the delivery of safe, appropriate, and effective care.
- D. **Care Coordinator** - a designated individual, who may be a physician, nurse, midwife, social worker, community health worker, or other qualified personnel, assigned by a healthcare provider of maternity care services to carry out the care coordination functions.
- E. **Cesarean Delivery**³ - the delivery of a fetus through surgical incisions made through the abdominal wall (laparotomy) and the uterine wall (hysterotomy).
- F. **Copayment Cap** - the maximum amount a facility can charge for a fixed period. The copayment cap for case rates is set per episode of care.
- G. **Cost Share** - a fixed amount or percentage of the cost set by PhilHealth to be paid by the beneficiary to the health facility. This can include fixed co-payments, co-insurance, and annualized deductibles.
- H. **Cross-subsidization** - when costs incurred by one party are subsidized by the other party. It can include using efficiency gains from PhilHealth payments made for a lower-cost case to cover costs in a higher-cost case.
- I. **Dilatation and Curettage**⁴ - a procedure to scrape and remove tissue from the inner lining of the uterus. The cervix is dilated (made larger), and a curette (spoon-shaped instrument) is inserted into the uterus to remove tissue. A tissue sample may then be checked under a microscope for signs of disease, such as infection or cancer. A dilatation and curettage may also be done after a miscarriage or to treat certain conditions, such as abnormal bleeding.



¹PC No. 2024-0001, Rules for Adjusting Case Rates

²DOH-AO 2021-0015, “Standards on Basic and Non-Basic Accommodation in All Hospitals.”

³ <https://emedicine.medscape.com/article/263424-overview>

⁴ <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/dilatation-and-curettage>

- J. **High-risk Pregnancy**⁵ - a pregnancy state where potential complications are noted on medical examination that could affect the mother, the baby, or both. High-risk pregnancies require management by a specialist to help ensure the best outcome for the mother and baby.
- K. **Low-Risk Pregnancy**⁶ - the pregnancy state where, after thorough routine evaluation, no risk factors are identified on the woman and no signs and symptoms or pregnancy complications are noted.
- L. **Non-basic Accommodation**⁷ - the provision of minimum standards of care for patients, and includes fringe and/or additional amenities provided by the facility at the choice of the patient, in a room with two (2) or fewer occupants. Also referred to as “private” accommodation in PhilHealth Claim Form 2, Part 2, No. 5. Non-basic accommodation can be further subdivided as private accommodations with semi-private and private beds.
- M. **Non-basic Accommodations with Private Beds**⁸ - beds in a room with 1 occupant.
- N. **Non-basic Accommodations with Semi-private Beds**⁹ - beds in a room with at least 2 occupants.
- O. **Normal Spontaneous Delivery (NSD)**¹⁰ - a type of delivery that is spontaneous in onset, low-risk at the start of labor, and remains so throughout, and where the infant is born spontaneously in a vertex (head-down) position between 37 and 42 weeks of pregnancy. This means the labor starts on its own, the mother and baby are healthy throughout, and the baby is delivered without any interventions or complications.
- P. **Normal Spontaneous Delivery Benefit (NSD Benefit)**¹¹ - a PhilHealth benefit that covers only health services during the intrapartum and immediate post-partum period for normal delivery, regardless of the type of health care institution. The services shall include monitoring and management of labor, assisting in normal delivery and immediate post-partum care prior to discharge.

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⁵ DOH Department Circular No. 2021-0005 Adherence to the Definition of Low-Risk Pregnancy and High-Risk Pregnancy in the implementation of Administrative Order No. 2012-0012

⁶ Ibid

⁷PC No. 2020-0024 Governing Policies on No Co-payment / No Balance Billing for PhilHealth Benefits Packages. combining case-based payments and fee schedules, to reimburse HFs for the covered minimum standards

⁸Ibid

⁹PC No. 35, s-2013, ACR Policy No. 2 -Implementing Guidelines on Medical and Procedures Case Rates Annex 11 Guidelines on the proper accomplishment of PhilHealth Claim Form 2 (November 2013)

¹⁰<https://www.msmanuals.com/professional/gynecology-and-obstetrics/labor-and-delivery/management-of-normal-labor>

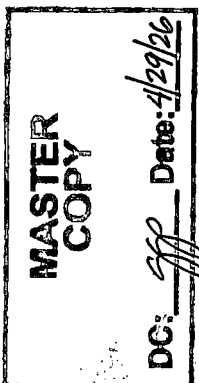
¹¹PhilHealth Circular No. 025,2015 Social Health Insurance Coverage and Benefits for Women About to Give Birth (Revision 1)

V. POLICY STATEMENTS

- A. All Filipinos are automatically entitled to avail of this benefits package. PhilHealth beneficiaries shall comply with the existing membership eligibility rules.
- B. Claims submission shall not require a printed copy of the member data record (MDR). All accredited HFs shall automatically deduct PhilHealth benefits any time or day of the week upon patient discharge.
- C. PhilHealth shall utilize a blended payment mechanism, using case-based payment and fee schedules, to reimburse HFs for the covered minimum standards for delivering services for managing maternal and gynecologic care cases.
- D. The minimum standards of care recommendations from clinical practice guidelines (CPG) disseminated by the World Health Organization (WHO), Department of Health (DOH), local medical societies, and other guideline sources, which are critically appraised and validated by current best practices in the local setting, shall serve as PhilHealth's basis for service coverage and costing analyses.

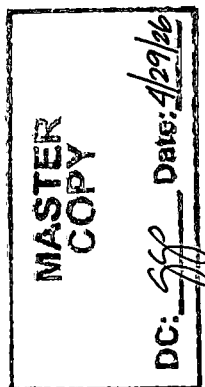
Accredited HFs shall follow CPGs to manage patients and ensure adherence by medical professionals who are appropriately credentialed and privileged to practice in the HFs and all hospital staff in charge of inpatient management for maternal and gynecologic care.

- E. Each client shall have a designated Care Coordinator from their respective MCP provider. It is the responsibility of the Care Coordinator to conduct advance coordination and referral to birthing facilities and higher levels of care should they be considered a high-risk pregnancy and require additional services beyond the basic antenatal care package. The receiving facility shall provide all pertinent information to the Care Coordinator regarding the services and outcomes related to the patient for the Coordinator to fulfil their role in navigating the client to receive all their required services and documenting their complete care journey. The responsibilities of the Care Coordinator may be found in the PhilHealth Circular on the Expansion of Maternity Care Benefits for Non-Hospital and Outpatient Facilities.
- F. Costs in excess of payments made through the reimbursement rates for maternal and gynecologic care shall be subject to cross-subsidization, using either other fund sources, efficiency gains, as applicable, or out-of-pocket (OOP) spending, in accordance with PhilHealth rules and guidelines.
 - 1. HFs shall declare a differentiated count of beds in both basic and ward-type accommodations and in non-basic accommodations. The declaration for beds in non-basic accommodations shall distinguish between semi-private and private beds, as defined in the circular. The



declaration of available beds and bed types shall be submitted through an online survey administered by PhilHealth, issued through an advisory.

2. With the rate adjustment for maternal and gynecologic procedures and the increase in PhilHealth coverage, all PhilHealth beneficiaries shall be entitled to no co-payment when admitted to basic or ward accommodation, as defined in this policy, in both accredited public and private HFs, where HFs shall not balance bill patients in excess of the amount paid by PhilHealth for any medicines, procedures, supplies, professional fees, salaried labor, or other services that are already covered by PhilHealth.
3. Additionally, all PhilHealth beneficiaries shall be entitled to a co-payment cap when admitted in a semi-private accommodation in both public and private HFs, where HFs shall not balance bill patients in excess of the sum of PhilHealth payments and the fixed co-payment for any medicines, procedures, supplies, professional fees, salaried labor, or other services that are already covered by PhilHealth.
4. The reimbursement rate for maternal and gynecologic procedures is not a cap but reflects the average cost of treating an episode of care. It may differ from the actual hospitalization charges indicated in the statement of account (SOA). The actual cost of care per patient can be higher or lower than the published reimbursement rate. Therefore, PhilHealth retains the flexibility to adjust payment rates based on the services covered and on healthcare providers' efficiency in delivering quality care.
5. Services beyond PhilHealth coverage and the co-payment cap for the minimum standards of care in private accommodation and above of accredited HFs, which may include choice of physician, upgrade of services, or additional services unrelated to the maternal and gynecologic management, shall be subject to out-of-pocket payment by beneficiaries.
6. Patients are enjoined to report cases in which HFs fail to comply with the no-copayment and no balance-billing rules. In case of HF non-compliance, where patients in basic accommodations were required to pay, or in semi-private accommodations were required to pay in excess of the co-payment cap, patients may report the facility through the PhilHealth Corporate Action Center (CAC) via the hotline (02) 866-2588 or email actioncenter@philhealth.gov.ph



- G. All accredited HFs shall fully explain to the patient the contents/details and significance of PhilHealth's expansion of maternal and gynecologic procedures in a language the patient understands.
- H. As part of informed consent upon admission, HFs shall, through the attending physician/s, properly inform patients of the amount of

essential services covered by PhilHealth for the management of maternal and gynecologic procedures, their fixed co-payment, and what additional costs they have to incur in choosing to be admitted in private or suite accommodation.

- I. All accredited HF's should maintain minimum stock levels of essential and life-saving medicines, IV fluids, and supplies at all times to ensure good patient outcomes, the timely delivery of quality healthcare services, and to discourage unwarranted OOP from outside purchases and services.
- J. When patients are asked to purchase medicines, supplies, and any other inputs included in the package, they shall be entitled to a full refund from the provider, equivalent to the out-of-pocket cost paid by the patient. HF's shall inform PhilHealth of all cases when patients are asked to purchase medicines, supplies, and any other inputs included in the package using PhilHealth Claim Form 2.
- K. As stipulated in the UHC Act, Chapter IV, Sec. 18(b), there shall be no differentiation between facility and professional fees (PF). PhilHealth shall credit all payments to the accounts of accredited private and public HF's. In the case of government HF's, the sole responsibility of the HF is to distribute the professional fees (PF) to its health professionals in accordance with mutual agreement and internal guidelines.
- L. Accredited HF's that lack the service capability for managing maternal and gynecologic procedures, except HF's in geographically isolated and disadvantaged areas (GIDA), shall properly coordinate and facilitate the timely referral of patients after providing standard emergency and life-saving measures to higher-level HF's.
- M. Pregnant women shall endeavor to have a minimum of eight (8) prenatal visits for low-risk pregnancies within the course of pregnancy and keep a record of their prenatal check-ups in the form of a mother's book or hospital records (Annex A: Antenatal Care Record Form). This is to ensure the patient receives continuous, comprehensive, and coordinated care throughout pregnancy, delivery, and the postpartum period.
- N. Accredited HF's shall ensure delivery of the minimum standards of care for managing maternal and gynecologic procedures in accordance with CPG recommendations applicable in local practice, including the availability of drugs and medicines, functioning laboratory equipment, timely laboratory chemistry services, and appropriate human resources.
- O. As part of their Performance Commitment, all accredited public and private HF's shall ensure that emergency medical services, drugs and medicines, laboratory and diagnostic tests, supplies, equipment, and human resources are available at all times and, when needed by the patient, promptly provided. PhilHealth shall strictly monitor the compliance of accredited HF's with this policy provision.

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P. Benefits Packages for Maternal and Gynecologic Care Coverage in the Hospital Settings

Procedure Code	Description	Package Rate (PHP)	Co-payment Cap		
			Basic/Ward Bed	Semi-Private Bed	Private Bed
NSD01	Vaginal Delivery (Normal Spontaneous Delivery Benefit) for L1 to L3 Hospitals	29,000	N/A	23,000	None
59513	Cesarean Section; Primary	58,000	N/A	None	None
59514	Cesarean Delivery	58,000	N/A	None	None
59620	Cesarean Delivery Only, Following Attempted Vaginal Delivery, After Previous Cesarean Delivery	62,000	N/A	None	None
58100	Endometrial Sampling (Biopsy)	31,500	N/A	None	None
58120	Dilation and Curettage	36,500	N/A	None	None
59812	Treatment of Incomplete Abortion, Any trimester, Completed surgically	24,000	N/A	None	None
59814	Manual Vacuum Aspiration for Spontaneous Abortion	21,450	N/A	None	None
ANCEH	Additional diagnostics for antenatal care (sum of fees)	Sum of diagnostic fees from "fee schedule."	N/A	None	None

Table 1: Benefit Package for NSD, CS, and D & C.

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Fee Code	Description	Facility	Rate (PHP)
0073	Blood Typing	Hospitals & Diagnostic Centers	576
0075	BUN	Hospitals & Diagnostic Centers	377
0076	CBC	Hospitals & Diagnostic Centers	310
0084	Creatinine	Hospitals & Diagnostic Centers	733
0101	FBS	Hospitals & Diagnostic Centers	156
0108	HbSAg	Hospitals & Diagnostic Centers	345
0118	LDH	Hospitals & Diagnostic Centers	137
0139	SGOT/AST	Hospitals & Diagnostic Centers	249
0140	SGPT/ALT	Hospitals & Diagnostic Centers	309
0154	Urinalysis	Hospitals & Diagnostic Centers	263
0345	Urine C/S	Hospitals & Diagnostic Centers	1,600
0346	OGTT	Hospitals & Diagnostic Centers	900
0347	HBA1C	Hospitals & Diagnostic Centers	870
0348	HIV testing	Hospitals & Diagnostic Centers	658
0349	RPR or VDRL	Hospitals & Diagnostic Centers	300
0350	Ultrasound (Pelvic or Transvaginal)	Hospitals & Diagnostic Centers	1,000

Table 2: Fee Schedule for Additional Diagnostic Services

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Q. Claims Filing

1. Accredited HFs shall strictly follow current PhilHealth policies on claims submission, including correct ICD-10 coding of the primary diagnosis and/or procedure coding, submission of properly accomplished PhilHealth Claims Forms (CF), statement of account (SOA), and other data and documentary requirements as stipulated in existing policies.
2. Medical management for patients' comorbidities (e.g., diabetes, high blood pressure, chronic lung disease, cardiac conditions, obesity)

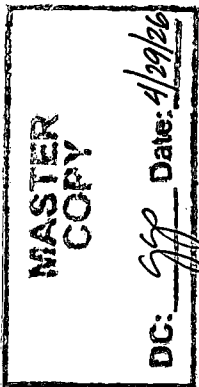
may be claimed separately and shall not be treated as overlapping claims.

3. Accredited HFs shall follow all relevant laws, such as R.A. No. 9994 or the Expanded Senior Citizens Act of 2010 and R.A. No. 10754 or An Act Expanding the Benefits and Privileges of Persons with Disability, including prospective laws providing mandatory discounts, guidelines of the Bureau of Internal Revenue (BIR), and the order of charging based on DOH-DSWD-PCSO-PHIC Joint Administrative Order No. 2020-0001 (Operational Guidelines for the Implementation of the Medical and Financial Assistance to Indigent and Financially-Incapacitated Patients Pursuant to Republic Act No. 11463 also known as "Malasakit Centers Act of 2019.")

With this, PhilHealth benefits and all mandatory discounts provided by law, such as, but not limited to, senior citizen and PWD discounts, shall be deducted first from the patient's total hospital bill. Benefits from private health insurance (PHI), health maintenance organizations (HMO), or employee benefits shall be applied after PhilHealth deductions and complement the PhilHealth benefits packages.

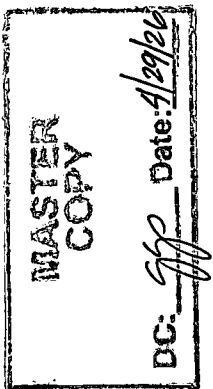
For beneficiaries admitted to basic and ward-type accommodations, where no co-payment applies, and no remaining OOP payments remain, mandatory discounts shall not apply.

4. Case rates for maternal and gynecologic procedures, apart from the additional diagnostics for antenatal care (package code ANCEH), shall not be claimed as a "second" case rate.
5. HFs shall be allowed to file repeat claims for additional diagnostics for antenatal care (package code ANCEH), provided that the additional diagnostics are essential in managing the pregnancy case in accordance with national Clinical Practice Guidelines (CPG), or prevailing CPGs from a PhilHealth-recognized and appropriate medical society, in the absence of a national CPG.
6. Accredited HFs shall properly indicate the amount of OOP and/or co-payment of the member/patient, including the amount of professional fees of the attending OB-Gyne and anesthesiologist, medicines purchased by patient within or outside the HF, in Part IIIA in PhilHealth Claim Form 2 (CF2), and in the electronic SOA following PC No. 2023-0026 [Electronic Data Submission of the Statement of Account (SOA) for All Case Rates (ACR) Claims and Identified PhilHealth Benefits (Revision 1)] and subsequent amendments.
7. The benefits package coverage for maternal and gynecologic cases includes surgical procedures, laboratory tests, medications and drugs listed in the current edition of the Philippine National Drug



Formulary (PNDF), and medical supplies. As such, all accredited private and government HFs shall not charge patients admitted to basic or ward accommodation.

8. Accredited HFs shall file all claims to PhilHealth within the prescribed filing period of sixty (60) calendar days. Direct filing by members/beneficiaries is not allowed. However, direct filing is permitted for claims arising from confinements abroad and emergency cases at non-accredited institutions.
9. Rules on late filing shall apply, except when the delay in filing claims is due to natural calamities or other fortuitous events, in which case the existing PhilHealth guidelines on the provision of special privileges to those affected by such events shall apply.
10. Accredited HFs may file a motion for reconsideration (MR) and appeal for claims denied by PhilHealth following existing policies.
11. PhilHealth shall process and pay claims for confinement abroad based on the remaining balance not covered by any additional insurance or incurred as OOP expenses, provided that such balance does not exceed the published reimbursement rates set out in the policy.
12. In filing for claims for Dilatation and Curettage (D&C), whether as treatment for incomplete abortion for any trimester or otherwise, shall require the submission of a detailed CF4 of the patient's clinical history, operative record, physical examination findings, and course in the ward, indicating whether the case for (D&C) involved pregnancy.
13. Accredited L1 to L3 HFs should provide the detailed patient's clinical history, physical examination findings, course in the ward, labor and delivery record, or operative record shall be indicated to PhilHealth Claim Form 4 (CF4) for NSD and CS.
14. For Cesarean Section (CS) claims, only obstetrically and medically indicated Cesarean procedures with correct ICD-10 coding for the indication, in accordance with national Clinical Practice Guidelines (CPG) or prevailing CPGs from a PhilHealth-recognized and appropriate medical society shall be covered by PhilHealth.
15. CS claims shall be subject to strict monitoring and compliance, with regular utilization reviews conducted.
16. CS Claims medically adjudicated as non-compliant to the rules outlined in the circular shall be subject to Return to Sender (RTS).
17. Antenatal & postpartum care provided in a hospital setting, shall be treated as outpatient services. Rules on accreditation, eligibility, benefit coverage, and claims filing shall be governed through the



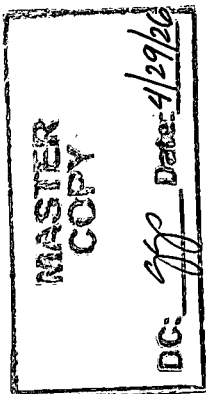
PhilHealth Circular on the Expansion of Maternity Care Benefits for Non-Hospital and Outpatient Facilities.

18. Hospitals may file for additional diagnostic services as enumerated in Table 2 (Fee Schedule for Diagnostic Services) beyond the mandatory diagnostic services included in the basic antenatal care package for pregnancies (Refer to the PhilHealth Circular on the Expansion of Maternity Care Benefits for Non-Hospital and Outpatient Facilities, Table 2. Mandatory Services for Clinic Antenatal Care). Additional laboratory tests claimed under the package code ANCEH shall be filed separately and must be specified in the additional diagnostic services for antenatal care form (Annex B: Additional Diagnostic Services for Antenatal Care Form) to be attached to the claim along with the necessary claim forms.

Claims for package code ANCEH shall be paid based on the accumulated corresponding fees, in accordance with the applicable fee schedule.

19. PhilHealth members shall be allowed to directly file claims to PhilHealth for maternal and gynecologic services provided by outpatient clinics and diagnostic centers in and outside hospital settings not currently accredited by PhilHealth. Current rules and procedures for direct claims filing shall apply.¹²
20. In recognition of the continuum of maternal care, beneficiaries who initially availed of antenatal care services in non-hospital settings (e.g., primary care facilities, birthing homes, or outpatient facilities) and are subsequently referred to or managed in hospital settings due to a change in pregnancy risk classification shall remain eligible to claim benefits for services rendered in both settings.

- a. Antenatal care services provided in the non-hospital setting prior to referral shall be considered valid and reimbursable, provided that these were delivered in accordance with existing PhilHealth policies, properly documented, and duly filed by the originating facility.
- b. Hospitals and non-hospital providers may file claims independently and simultaneously for services rendered within their respective levels of care, subject to applicable benefit packages, claims requirements, and non-duplication of claims for the same service. Such claims shall not be considered overlapping, as these correspond to distinct episodes of care delivered across different levels of the service delivery network.



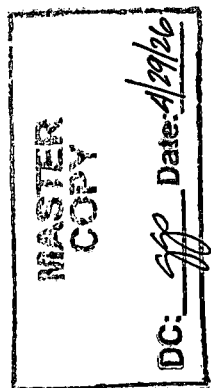
¹² PhilHealth Circular No. 20, s-2014- ACR Policy No. 4 - Directly Filed Claims for All Case Rates and Return to Sender

R. Claims Evaluation and Payment

1. PhilHealth shall reimburse accredited HFs with service capability for maternal and gynecologic procedures that can deliver quality services in accordance with the minimum standards of care in basic or ward accommodation. These services include the procedure, medications, drugs, supplies, professional fees, and salaried labor covered under this policy. Any amount declared in the SOA that is below or above the published case rates shall not be interpreted as over- or underpayment.
2. PhilHealth reserves the right to subject any or all claims to medical review before and/or after payment or reimbursement to its accredited HFs, in accordance with existing guidelines.
3. PhilHealth shall return to the health facility any claim documents with incomplete requirements, discrepancies in supporting documents or attachments, or incompletely filled-out claim forms, to ensure compliance within the prescribed period.
4. Existing rules on All Case Rates (PC No. 35, s. 2013, "ACR Policy No. 2 – Implementing Guidelines on Medical and Procedure Case Rates") on the percentage allocation of health facility and professional fees shall apply to claims for these benefit packages.
5. Claims for maternal and gynecologic procedures of accredited levels 1 to 3 HFs with a patient disposition of "Home Against Medical Advice (HAMA)" or "absconded" indicated in CF2 shall be paid by PhilHealth the amount stated on the SOA, but not to exceed the rates established in this benefit package for the maternal and gynecological procedures. PhilHealth shall closely monitor accredited HFs submitting claims with a patient disposition of HAMA or absconded.
6. Rules on the evaluation & payment of claims for antenatal & postpartum care provided in hospitals shall be defined through the PhilHealth Circular on the Expansion of Maternity Care Benefits for Non-Hospital and Outpatient Facilities.
7. PhilHealth shall pay the corresponding rate for diagnostic services indicated in Table 2 without reference to the amount indicated in the SOA.

S. Monitoring

1. PhilHealth shall enforce its current policies and guidelines for monitoring the performance of accredited HFs in implementing the Rationalization of Case Rates for Select Maternal and Gynecologic Services in the Hospital Setting and establish strict control mechanisms to ensure quality healthcare delivery and financial risk



protection, as well as to prevent adverse provider behaviors and non-compliance with existing rules.

2. PhilHealth also encourages external researchers to review and conduct appropriate studies on healthcare providers' actual practices during the implementation of the Rationalization of Case Rates for Select Maternal and Gynecologic Services in the Hospital Setting, including documenting adverse provider behaviors that result in inefficiencies in health service delivery and a reduction in the quality of care provided.
3. Utilization of maternity and gynecologic benefits shall be subject to regular claims review, where discrepancies indicating potential upcoding and other forms of non-compliance in claims filing can be subject to fact-finding and further legal investigation.
4. PhilHealth beneficiaries are strongly encouraged to provide feedback or report concerns about the implementation of the selected gynecologic procedures policy or their experience with benefit availment to the Corporate Action Center (CAC) via the hotline (02) 866-2588 or email actioncenter@philhealth.gov.ph

T. Marketing and Promotion

PhilHealth shall conduct communication and social marketing activities in collaboration with experts and stakeholders to educate healthcare providers and the public on the benefits of the packages for selected obstetrical procedures, in accordance with the current Social Marketing and Communication Plan (SMCP).

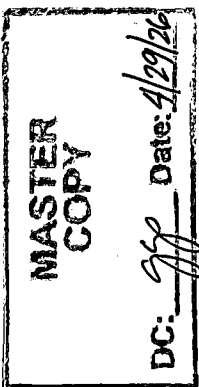
PhilHealth shall endeavor to inform HFs of what maternal and gynecologic services are reimbursable in their facilities. PhilHealth shall develop marketing & promotion materials and activities to ensure that HFs are well informed about the package.

U. Policy Review

PhilHealth retains the flexibility to adjust payment rates based on the services covered and on healthcare providers' efficiency in delivering quality care.

PhilHealth shall conduct a policy review of the Rationalization of Case Rates for Select Maternal and Gynecologic Services in the Hospital Setting in parallel with the development and transition to the DRG provider payment mechanism, in collaboration with and in consultation with key stakeholders, experts, and implementers.

This PhilHealth Circular shall be enhanced as necessary based on the results of the policy review.



VI. PENALTY CLAUSE

Any violation of this PhilHealth Circular shall be dealt with and penalized in accordance with pertinent provisions of R.A. No. 7875, as amended by R.A. Nos. 9241 and 10606 (National Health Insurance Act of 2013), R.A. No. 11223 (Universal Health Care Act), and their respective Implementing Rules and Regulations, including the PhilHealth Rules on Administrative Cases (PROAC).

VII. TRANSITORY CLAUSE

Claims for ANC and ANCEH shall be attached to claims application in PDF format pending availability of the system

Moreover, pending issuance of guidelines on Care Coordination Performance Payment, all accredited providers shall comply with Care Coordinator designation and reporting requirements upon effectivity of this Circular.

VIII. SEPARABILITY CLAUSE

In the event that any part or provision of this PhilHealth Circular is declared unauthorized or invalid by any Court of Law or competent authority, those provisions not affected by such declaration shall remain valid and effective.

IX. REPEALING CLAUSE

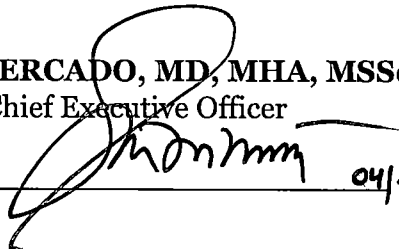
Pertinent provisions of PhilHealth Circular No. 025 s. 2015, PhilHealth Circular No.2024-0037, regarding maternal and gynecologic care services and other issuances, rules, and regulations or parts thereof that are contrary to and inconsistent with this PhilHealth Circular are hereby repealed, amended, or modified accordingly.

X. DATE OF EFFECTIVITY


This PhilHealth Circular shall take effect immediately after publication in the Official Gazette or in any newspaper of general circulation. Three (3) certified true copies shall be filed with the Office of the National Administrative Register (ONAR) of the University of the Philippines Law Center.

Correspondingly, this policy shall apply to all admission/availment upon effectivity of this PhilHealth Circular.

EDWIN M. MERCADO, MD, MHA, MSSc
President and Chief Executive Officer

Date signed:  04/28/2024

Rationalization of Case Rates for Select Maternal and Gynecologic Services in the Hospital Setting

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Annex A: Antenatal Care Record Form

Facility Logo Facility Name Facility Address						
ANTENATAL CARE RECORD						
PART I: PATIENT (MOTHER) INFORMATION						
PhilHealth Accreditation Number (PAN) - Institutional Health Care Provider: <input type="text"/>						
1. Health Facility Name: _____						
2. Name of Patient: _____			3. PhilHealth Identification Number (PIN): <input type="text"/>			
Last Name		First Name		Middle Name		
4. Address: _____						
House number/Street		Subdivision/Barangay		City/Municipality		Province
5. G. P. _____		Last Menstrual Period (LMP): _____		Expected Date of Confinement (EDC): _____		
6. Brief History of Present Illness/DB History: _____						
PART II: PHYSICAL EXAMINATION						
7. GENERAL SURVEY (PERTINENT FINDINGS PER SYSTEM)						
ANTENATAL CARE NO.	1 st	2 nd	3 rd	4 th	5 th	6 th
Date of visit (mm/dd/yyyy)	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
ACG (in weeks)						
Fundal Height (cm)						
VITAL SIGNS:						
BP:						
Temperature:						
Weight:						
8. SERVICES PROVIDED						
Tetanus Immunization:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MMB:	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____
Iron:	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____
Folic Acid:	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____
Calcium:	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____
Deworming:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza Vaccine:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. LABORATORIES REQUESTED						
Blood Typing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CBC:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinalysis:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Syphilis:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CGTT:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SUN:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Creatinine:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FB S:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LDF:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SGOT/AST:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SGPT/ALT:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HBsAg:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine CrB:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vibacount:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. REFERRED	<input type="checkbox"/> Reason	<input type="checkbox"/> Reason	<input type="checkbox"/> Reason	<input type="checkbox"/> Reason	<input type="checkbox"/> Reason	<input type="checkbox"/> Reason
11. Certification of Attending Physician/Midwife:						
I certify that the above information given in this form are true and correct.						
SIGNATURE:						
PRINTED NAME:						
12. PATIENT'S CONFORME						
SIGNATURE:						
PRINTED NAME:						
DATE SIGNED:						

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PART II: PHYSICAL EXAMINATION CONTINUATION

7. GENERAL SURVEY (PERTINENT FINDINGS PER SYSTEM)

ANTENATAL CARE NO.	7 th	8 th	9 th	10 th	11 th	12 th
Date of visit: (month/day/year)	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
AOG (in weeks)						
Fundus Height (cm)						

VITAL SIGNS:

BP:						
Temperature:						
Weight:						

8. SERVICES PROVIDED:

Tetanus Immunization:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM2:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iron:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Folate Acid:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calcium:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
De-worming:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza Vaccine:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. LABORATORIES REQUESTED

Blood Typing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CBC:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinalysis:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Syphilis:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OGTT:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SUN:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cresinine:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FB2:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LDH:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SGOT/ALT:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SGPT/ALT:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HBA1C:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine Clb:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wtbs count:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. REFERRED:	<input type="checkbox"/> Reason	<input type="checkbox"/> Reason	<input type="checkbox"/> Reason	<input type="checkbox"/> Reason	<input type="checkbox"/> Reason	<input type="checkbox"/> Reason

14. Certification of Attending Physician/Midwife:
 I certify that the above information given in this form are true and correct.

SIGNATURE:						
PRINTED NAME:						

15. PATIENT'S CONFORME:

SIGNATURE:						
PRINTED NAME:						
DATE SIGNED:						

- Reminders:**
- Write legibly in BLOCK LETTERS using black or blue ink only.
 - Ensure that all required fields are completely filled out; write "N/A" if not applicable.
 - Provide accurate and updated personal and medical information at all times.
 - Indicate the correct dates (e.g., LMP, EDC, visit dates) using the prescribed format.
 - Avoid erasures; if correction is needed, draw a single line over the error, write the correct entry, and affix your initials.
 - Record all findings and measurements (e.g., BP, weight, temperature) accurately and in the proper units.
 - Check or mark only the appropriate boxes for services provided and laboratory tests requested.
 - Specify details when "Others" is selected in any section.
 - Ensure that the attending physician or midwife signs the form with the date accomplished.
 - Review all entries carefully before submission to ensure completeness and accuracy.






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Fixed Fee List for Additional Diagnostic Services

Item No.	Price Category	Price Item	Fixed Fee
73	Laboratory	Blood Typing	576
75	Laboratory	BUN	377
76	Laboratory	CBC	310
84	Laboratory	Creatinine	733
101	Laboratory	FBS	156
108	Laboratory	HbSAg	345
118	Laboratory	LDH	137
139	Laboratory	SGOT/AST	249
140	Laboratory	SGPT/ALT	309
154	Laboratory	Urinalysis	263
345	Laboratory	Urine C/S	1600
346	Laboratory	OGTT	900
347	Laboratory	HBA1C	870
348	Laboratory	HIV testing	658
349	Laboratory	RPR or VDRL	300
350	Imaging	Ultrasound (Pelvic or Transvaginal)	1000

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 DC: *JJ* Date: *4/29/26*