**ANNEX A**

 (*of PC 2017-0020*)

HCI OFFICIAL LETTERHEAD

(Mailing Address, Email Address, Philhealth Accreditation Number)

**NOTICE OF AUTO-CREDIT PAYMENT SCHEME (ACPS) COMPLIANCE FOR PRIVATE HCIs**

**Date**

**(Name of the PhilHealth Regional Vice-President)**

**(PhilHealth Regional Office Address)**

**Sir/Madame:**

**In compliance with the PhilHealth Auto-Credit Payment Scheme (ACPS) Policy, we are hereby submitting 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** |  |

**Further, we certify that the foregoing information are true and correct.**

**Very truly yours,**

**(Signature over Printed Name of the Medical Director)**