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, _____, of legal age, _____ with address
Name of the Authorized Representative *Position/ Designation of the Authorized Representative*

at _____ and the duly authorized representative to act for and in behalf
Address of the Authorized Representative

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).

[1]**NAME OF HF:**	
[2]**MAILING/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)*
[3]**HF CONTACT INFORMATION:**	*Landline and/or Mobile Number* / *Official Email Address*
[4]**TIN:**	[5]**PHILHEALTH EMPLOYER NUMBER:**
[6]**DOH LTO NUMBER:**	**DOH FACILITY CODE:**
VALIDITY: *Start Date (MM/DD/YY)* – *End Date (MM/DD/YY)*	[7]**ACCREDITATION PERIOD APPLIED FOR:** ☐ 3 Years ☐ 2 Years ☐ 1 Year
[8]**NAME 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)*

[9]HF CATEGORY

☐ Hospital
Level ☐ 3 ☐ 2 ☐ 1
Authorized Bed Capacity (ABC): _____
With Hospital Extension Facility (HEF)? ☐ Y ☐ N
HEF address (if Y): _____
_____
_____
_____
☐ Infirmary
☐ Primary Care Facility
☐ Drug Abuse Treatment and Rehabilitation Center
☐ HIV-AIDS Treatment Hub

☐ Birthing Home
☐ Family Planning Clinic
☐ Ambulatory Surgical Clinic
☐ Animal Bite Treatment Clinic
☐ TB DOTS Clinic
☐ DepEd Clinic
☐ 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
☐ Dialysis Clinic
☐ Hemodialysis ☐ Peritoneal Dialysis
☐ Others
_____
_____
_____
_____
_____
_____

[10]PHILHEALTH 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 **CATCHMENT POPULATION:** _____
☐ Others
_____
_____
_____

Continue at the back.

[11]NATURE OF OWNERSHIP:

☐ Government		☐ Private	
☐ DOH-Retained	☐ State Universities and Colleges	☐ Single Proprietorship	☐ Others
☐ Provincial	☐ Government-owned and/or Controlled Corporation	☐ Partnership	_____
☐ City/ Municipal	☐ Others	☐ Cooperative	_____
☐ DND ☐ DOJ	_____	☐ Foundation	_____
☐ PNP	_____	☐ Corporation	

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 HF ☐ Change in HoF ☐ Decrease in ABC ☐ Downgrade of category or hospital level ☐ Change in HF contact information ☐ Others _____	_____	_____

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