**ANNEX C**

(*of PC 2017-0020*)

LGU OFFICIAL LETTERHEAD

(Mailing Address, Email Address)

**NOTICE OF AUTO-CREDIT PAYMENT SCHEME (ACPS) COMPLIANCE FOR LGU OWNED 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 Details**  |
| **HCI Charges****Bank Account Name****Bank Account Number** |  |
| **Professional Fee Designated for Pooling****Bank Account Name****Bank Account Number** |  |
| **4.** | **Official HCI Email Address** |  |
| **5.** | **Landline Number** |  |
| **6.** | **Mobile Number** |  |

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

**Very truly yours,**

**(Signature over Printed Name of Local Chief Executive)**