PDR-March2014

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
City State Bldg., 709 Shaw Blvd., Pasig City
Health Line 441-7444; www.philhealth.gov.ph

PROVIDER DATA RECORD
HEALTH CARE INSTITUTION

THE PRESIDENT & CEO
Philippine Health Insurance Corporation
Pasig City, Philippines

Sir/Madam:

I, _____, of legal age, _____ with
(Position/Designation)
address at _____ and the duly authorized representative to act for and
in behalf of _____, hereby submits the following pertinent
(name of healthcare institution)
information and documentary requirements under Sec. 56 of the Implementing Rules and Regulations of RA 7875 as amended by RA 10606.

Name of Health Care Institution: (Please print legibly and provide appropriate spaces)

Accreditation Number/s		PhilHealth Employer Number	

Mailing/Billing Address:

No./St./Brgy.					
Municipality /City		Province:		ZIP Code	

Contact Information

Contact No.	Fax No.	Official Email Address: (mandatory)

Facility Head/ Medical Director/Chief of Hospital/Hospital Administrator	Accreditation No.

Contact Information of the Facility Head:

Contact Number	Email Address

A. Hospital:

☐ **General** ☐ **Specialty**

Hospital Level: ☐ Level 1 ☐ Level 2 ☐ Level 3

DOH-LTO No _____ Validity of DOH-LTO: _____

B. Other Health Facilities:

Primary Care Facilities

☐ With Inpatient Beds*
- ☐ Infirmary/Dispensary *
- ☐ Birthing Homes *

* DOH-LTO No. _____
* Validity of DOH-LTO _____

☐ Without Beds:

Medical Outpatient Package Providers
- ☐ Anti TB/DOTS Package **
- ☐ Maternity Care Package (MCP)
- ☐ Primary Care Benefit (PCB)
  - ☐ Outpatient Malaria
- ☐ Animal Bite Package ** _____ _____
- ☐ MCP, DOTS** and PCB
- ☐ MCP and DOTS**
- ☐ MCP and PCB
- ☐ PCB and DOTS**

Specialized Outpatient Facility

☐ Ambulatory Surgical Clinic ☐ Freestanding Dialysis Clinic (FDC)*

* DOH-LTO No _____ * Validity of DOH-LTO: _____

Nature of Ownership

1. Government

- ☐ National - DOH retained
- ☐ DND / DOJ
- ☐ State Unitversities / College
- ☐ Others
- ☐ Local*
  - ☐ Province
  - ☐ Municipality
  - ☐ City
  - ☐ District

2. Private**

- ☐ Single Proprietor
- ☐ Partnership
- ☐ Corporation
- ☐ Others (Specify) _____
- ☐ Foundation
- ☐ Cooperative
- ☐ Civic organization

*Name of incumbent LCE _____ **Name of owner/s _____

Type of Application: (Please check)

- ☐ **Initial Application**
- ☐ **Continuous Accreditation**
- ☐ **Re-accreditation***

*** Re-accreditation transactions**
- ☐ Transfer of location
- ☐ Change in facility classification
- ☐ Upgrading of hospital level
- ☐ Additional service
- ☐ Resumption of operation after closure/ cease operation
- ☐ Change of ownership
- ☐ Application after incurring a gap in accreditation regardless of length of gap
- ☐ Previous Continuous Accreditation was withdrawn

Profile Update
- ☐ Change in Facility Head/ Medical director/ COH
- ☐ Change in name
- ☐ change in contact Information

For PhilHealth Use Only

Remarks: _____

Date Received:	LHIO	By:	LHIO		
	PRO		PRO		
Date Evaluated:	LHIO	By:	LHIO		
	PRO		PRO		
Date Encoded:	LHIO/PRO (Receiving Module)	By:	LHIO	OR No.	
	PRO (Data Entry)		PRO	Date Paid:	
				Amount:	

Control No. _____