|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Supplemental Provider Data Record** |  |  |  |  |
| ***Part I - General Information*** |
| *Name of Facility:* |  |
| ***Address*** |
| *Address line 1:* |  |
| *Address line 2:* |  |
| *City/Municipality:* |  | *Province:* |  |
| *Region:* |  | *Postal Code:* |  |
| *Mobile No.:* |  | *Landline No (Office):* |  |
| *Email Address:* |  |
| ***CIU Manager*** |
| *Last Name:* |  | *Middle Initials:* |  |
| *First Name:* |  | *Suffix:* |  |
| *Institutional Affiliation:* |  |
| *Position:* |  |
| ***Catchment*** |
| *No. of Municipalities catered:* |  |
| *Names of Municipalities catered:* |
|  |
| ***Referral Hospital 1*** |
| *Name of Facility* |  |
| *Address line 1:* |  |
| *Address line 2:* |  |
| *City/Municipality:* |  | *Province:* |  |
| *Region:* |  | *Postal Code:* |  |
| ***Referral Hospital 2*** *(indicated N/A if no additional referral hospital)* |
| *Name of Facility* |  |
| *Address line 1:* |  |
| *Address line 2:* |  |
| *City/Municipality:* |  | *Province:* |  |
| *Region:* |  | *Postal Code:* |  |
| ***Referral Hospital 3*** *(indicated N/A if no additional referral hospital)* |
| *Name of Facility* |  |
| *Address line 1:* |  |
| *Address line 2:* |  |
| *City/Municipality:* |  | *Province:* |  |
| *Region:* |  | *Postal Code:* |  |
| *In cases where there are more than 3 referral hospitals, please attach another form and fill out the "refer all hospital" section.* |
| ***Service Capacity*** |
| ***Accomodations*** |
| *Ward type:* |
| *No. of beds in ward type accomodations:* |  |
| *No of bathrooms for patients in ward type accomodations:* |  |
| *Total No of toilets for patients in ward type accomodations:* |  |
| *Total No of showers for patients in ward type accomodations:* |  |
| *With cohorting for patients in ward accomodations (Y/N):* |  |
| *Single Room:* |
| *No. of beds in single rooms w/o ensuite bathrooms:* |  |
| *No. of beds in single rooms with ensuite bathrooms:* |  |
| ***Human Resource*** |
| *Total no. of employed physicians:* |  |
| *No. of physicians on duty/day:* |  |
| *Total no. of employed nurses:* |  |
| *No. of nurses on duty/day:* |  |
| *Total no. of other health workers employed:* |  |
| *List other types of health workers employed:* |
|  |
| *Total no. of other non-health workers employed:* |  |
| *List other types of non-health workers employed:* |
| *I certify that the information submitted in this application is true and correct to the best of my knowledge.**I further understand that any false statements may result in denial or revocation of my accreditation.* |
|  |  |  |  |  |  |  |  |  |
| *XXX, CIU Manager* |  |  |  |  |  |  |
| ***Part II - Authorization*** |  |
| *This is to authorize (Name of the CIU facility) to use our eClaim system for the filing and submission of Covid-19 Community Isolation Benefit Package (CCIBP) claims using its own PhilHealth Accreditation Number (PAN) and cipher key. Further, all PhilHealth reimbursements for the CIU's filed claims shall be credited to the (name of partner institution) ACPS account and shall subsequently be disbursed to the said CIU based on agreed terms.For this purpose, I hereby submit 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* |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| *(Partner Facility)* |  |  |  |  |
| *Signature over printed Name* |  |  |  |  |
| *Medical Director/Authorized Representative*  |  |  |  |  |

Annex D Page 2 of 2