

	ACCOUNT & CIPHER KEY REQUEST FORM	ACK REQUEST NO	
		ENGAGEMENT NO	
		DATE	

I. HEALTH CARE INSTITUTION (HCI) INFORMATION	
Accreditation No.	
Name of Facility	
Complete Address	
Email Address	
Contact No.	
II. ENGAGEMENT INFORMATION	
Name of Service Provider	
Software Certificate No.	
CIPHER KEY COMPLIANCE AGREEMENT	
<i>The UNDERSIGNED agrees/certifies to adhere to the following:</i> 1. To use my account and cipher key information conscientiously and not to share and allow anyone to use this information in compliance to the Data Privacy Act. 2. To report any possible security problems / breaches immediately to PhilHealth for replacement of the HCI cipher key. 3. The undersigned is authorized to receive the Cipher Key in behalf of the Health Care Institution and that the cipher key will be used only for its intended purpose such as to encrypt the electronic medical data prior to submission to PhilHealth. 4. I am aware that PhilHealth will not be held liable / accountable for the loss and misuse of the cipher key and any other information breaches that may arise from this incident. 5. All the above information is true and correct to the best of my knowledge and belief.	
Name and Signature of HCI Head or Authorized Representative	
Date signed	