Health Facility Logo
Health Facility Name
Health Facility Address

Letter of Undertaking as Provider of the Expanded Maternity Care Benefits

Date: _____

NAME OF RVP
Address of PhilHealth Regional Office

Dear RVP_____:

We, the _____(Name of Facility)_____, with address at _____
Would like to signify our intent to be a PhilHealth Accredited Provider of the Expanded Maternity Care Benefits:

1. We would like to signify our intent to provide the following services available in our facility: (Please check item/s as applicable)

   ☐ Antenatal Care (Clinical)
   ☐ Postpartum Care Services (Clinical)
   ☐ Intrapartum Services (NSD)
   ☐ Diagnostic Antenatal Care (DANC) Services

      ☐ Laboratory Services (Pregnancy Test, Blood Typing, CBC, Urinalysis, OGTT, Hepa B, HIV, and Syphilis Screening)
      ☐ Ultrasound Services (Pelvic and Transvaginal)

2. We commit that the facility is capable to provide the said services, with valid license/s or proof/s of training, as applicable, is/are available.
3. We acknowledge that PhilHealth shall pay for the services through benefit rate payment as stipulated in the applicable issuances.
4. We agree with the set rates and shall apply the co-payment scheme as applicable in accordance with the respective issuances.
5. We will comply with PhilHealth implementing guidelines for this issuance.

Very truly yours,

NAME OF HEAD OF FACILITY
Name of Facility

_____

SUBSCRIBED AND SWORN TO before me this ____ day of _____20_____ in_____ _____ and affiant exhibiting to me his/her _____ issued on _____ at _____.

NOTARY PUBLIC

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Series of 20 _____