

REQUEST FOR QUOTATION

 Date: _____
 Quotation No. **0252-2025**

 Company Name: _____
 Address: _____

Please quote your lowest price on the item/s listed below, subject to the General Conditions on the last page, stating the shortest time of delivery and submit your **SEALED quotation** duly signed by your representative not later than _____ at **PhilHealth Regional Office VI/ Philhealth Capiz Local Health Insurance Office.**

DYAN D. LOYOLA
 Official Canvasser

NOTE ALL ENTRIES ARE ENCOURAGED TO BE TYPEWRITTEN/ WRITTEN LEGIBLY 1. APPROVED BUDGET FOR THE CONTRACT (ABC) IS PHP 124,370.50 2. PRICE VALIDITY PERIOD : 90 Days 3. DELIVERY PERIOD : Within 2 weeks upon receipt of the issuance of the Notice of Award/Proceed and completed until August 31, 2025 4. TERMS OF PAYMENT : Payment shall be made within 30 working days from receipt of the respective Billing Statement, Examination Results and other required documents 5. A. WARRANTY FOR SUPPLIES : N/A B. WARRANTY FOR EQUIPMENT : N/A 6. WE WITHHELD TAXES APPLICABLE TO ITEMS PURCHASED					
ITEM NO.	ITEM & DESCRIPTION	QTY.	UNIT	UNIT PRICE	TOTAL AMOUNT
	Procurement for Periodic Health Examination for CY 2025 For PhilHealth Regular & Casual Employees in LHIO Capiz (Including PCARES)	1	LOT		
1	Complete Physical Examination (PE) with Motor & Sensory Assessment (inclusive of laboratory examinations interpretations)	21	pax		
2	Complete Blood Count (CBC) with actual platelet count	21	pax		
3	Urinalysis	21	pax		
4	Chest X-ray (PA, filmless chest x-ray machine, preferably)	21	pax		
5	Chest X-ray (Lateral view, filmless chest x-ray machine, preferably)	1	pax		
6	Lipid Profile	21	pax		
7	ECG	21	pax		
8	FBS	21	pax		
9	Serum Creatinine	21	pax		
10	BUN	8	pax		
11	Uric Acid	10	pax		
12	Potassium	10	pax		
13	SGPT	21	pax		
14	SGOT	7	pax		
15	HBA1c	11	pax		
16	Total Prostate Serum Antigen	3	pax		
17	Fecalysis with Ocult Blood Test	3	pax		
18	Breast Ultra Sound	7	pax		
19	Digital Mammogram	6	pax		
20	Whole Abdominal Ultrasound	10	pax		
21	Pap Smear	2	pax		
	Refer to attached TOR				
	Purpose: For LHIO Capiz use				

After having carefully read all the provisions/ conditions provided above, I hereby comply, accept and quote you on the item at prices noted above.

NOTE: If with other conditions/ specifications other than provided above, please indicate below.

 Brand and Model: _____
 Delivery Period: _____
 Warranty: _____
 Price Validity: _____
 Terms of Payment: _____

Printed Name & Signature

Tel. No./ Cellphone No./ Email Address

PhilHealth Employer Number

Date