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MSH MANAGEMENT SCIENCES FOR HEALTH, INC.
*Health Sector Reform Technical Assistance Project (HSRTAP)*

United States Agency for International Development USAID

# Operations Assessment and Business Process Design and Development of the Core Processes of the Philippine Health Insurance Corporation

I – Final Report
II – Operations Manual – Core Business Processes

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# Operations Assessment and Business Process Design and Development of the Core Processes of the Philippine Health Insurance Corporation

## Final Report

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# BUSINESS PROCESS REVIEW
# FINAL REPORT

## PROJECT BACKGROUND

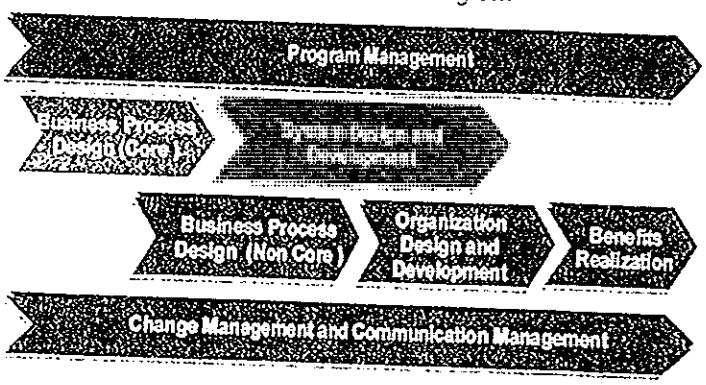
The Philippine Health Insurance Corporation (PhilHealth) undertook a Business Process Review (BPR) of its core business processes to build stronger, dynamic, and effective processes. The initiative was undertaken in support of the Health Sector Reform Agenda and the National Health Insurance Program as embodied in R.A. 7875, and to enhance the provision of health insurance services at the national and local levels. PhilHealth's core processes include:

- Manage membership and members relations
- Manage member contributions and collections
- Deliver and manage benefits
- Manage health care provider relations (Accreditation and Quality Assurance)

The project was undertaken with the assistance of the Management Sciences for Health (MSH) under its Health Sector Reform Technical Assistance Project (HSRTAP).

The Business Process Review was envisioned to be the first phase of the overall transformation project for PhilHealth.

Figure 1
PhilHealth Transformation Program




## PROJECT SCOPE

The study was divided into two (2) components:

- Operational Assessment
  - Validation, confirmation, and review of current business processes and the related policies and guidelines
  - Identification of key performance indicators



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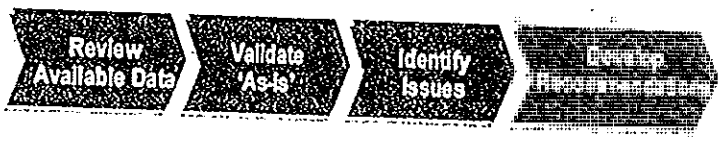
- Conduct of business process impact analysis and identification of process issues
- Identification of issues arising from process assessment that will be input to technology assessment

- "To Be" Process Design and Development
  - Redesign of the "ideal" processes, based on the approved recommendations
  - Development of the Operations Manual
  - Development of a Communications Plan

## PROJECT APPROACH AND METHODOLOGY

A participative approach was followed in the conduct of the project. Broad-based participation was obtained through interviews, focused group discussions (FGDs), process walkthroughs and brainstorming sessions. The following activities were undertaken to accomplish the project deliverables:

Figure 2
Project Methodology

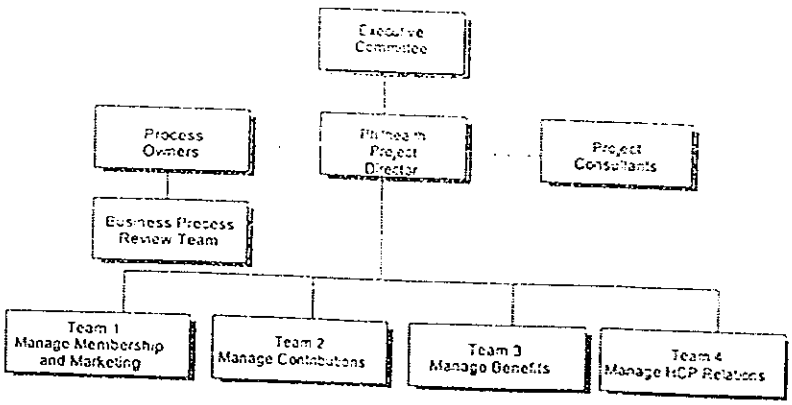



A total of 9 interviews were conducted with PhilHealth executives. A total of 123 employees representing 9 PROs and 8 CO units participated in the FGDs.

## PROJECT ORGANIZATION

In line with the participative approach, a project organization mainly composed of key PhilHealth executives and staff was created and mobilized to manage project scope, resources, schedule, issues, and risks. Detailed description of project organization is shown in *Appendix A*.

Figure 3
Project Organization



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## Business Process Review Guiding Principles

In reviewing the core processes and developing recommendations, key process excellence guiding principles were adopted:

Figure 4
Process Excellence Principles

- Value maximization and elimination of waste
- Design documentation
- Simple yet flexible design
- Time Compression
- Real-time feedback
- Clear links to other processes
- Customer-focused and user-friendly
  - Single consistent point of contact
  - Complete transactions in one event
  - Increase access and convenience
  - Simplify --- eliminate or reduce paperwork

Process Excellence

*A state in which an organization achieves superior business performance from superior processes within an enabling environment.*

- Actively owned and managed
- Measured
- Supported by technology
- Performed by people who are trained in the process

## Operations Assessment Results

PhiHealth can immediately benefit from the Business Process Review by implementing 'quick-wins' within the next 1 to 3 months. These quick-wins are in the areas of:

- Process streamlining and forms simplifications
- Control mechanism
- Policy clarifications
- Organizational roles delineation

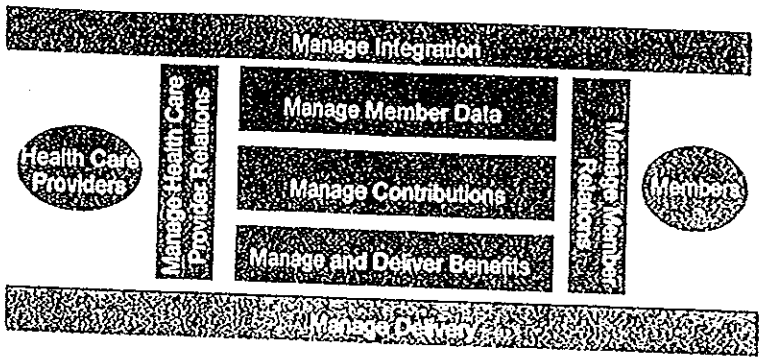
In the medium- and long-term, PhilHealth can implement innovative ideas in the way it approaches and conducts its business, which can have far-reaching impact in the long-term direction of the organization.

- *Redefine* organizational strategy
- *Refocus* policy and organizational roles
- *Realign* process, technology, and people to organizational strategy.

The detailed results are summarized in a matrix shown in *Appendices B to E*. The matrix shows the findings and recommendations, classified into quick-wins, medium-term and long-term. The matrix also shows the comments and feedback gathered from the process owners and business process review team on the findings and recommendations.

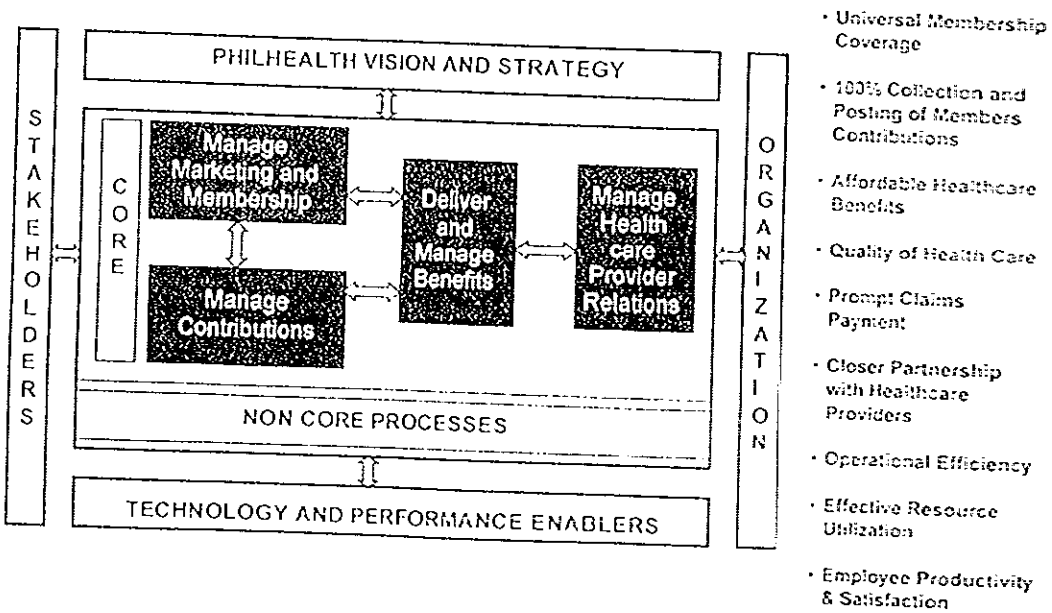
The proposed organization framework integrates the findings and recommendations into a cohesive model, which lays the foundation for strengthened customer relationship management coupled by process excellence in backroom operations to create tremendous opportunities for value optimization and customer satisfaction.

Figure 5
Proposed Organization Framework




The Business Integration Framework encapsulates the required alignment of key components of PhilHealth business such as processes, people and technology with the organization strategy to achieve its goals and objectives

Figure 6
Business Integration Framework



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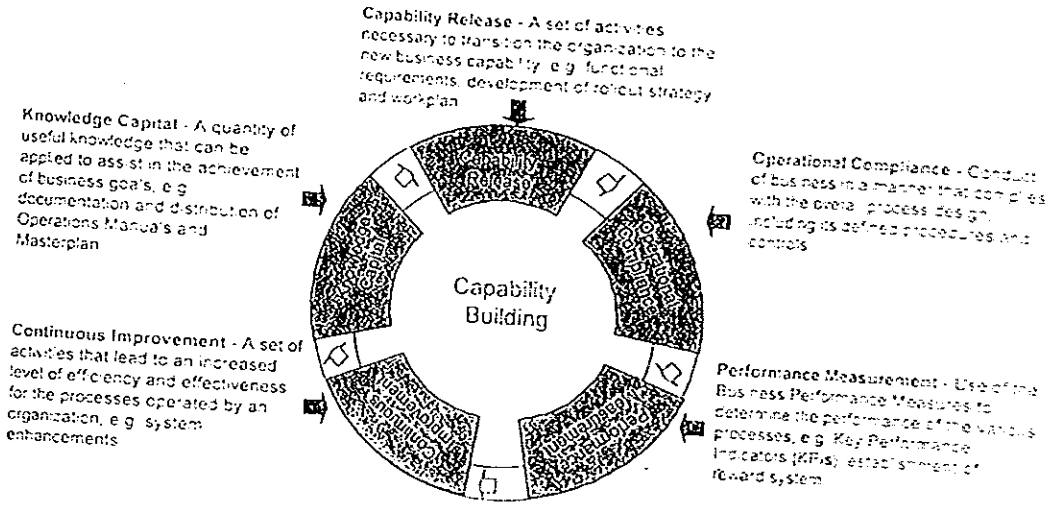
## IMPLEMENTATION GUIDELINES

The process owners should be responsible for implementing the recommendations. The model illustrates the various areas of process owner's accountabilities.

Figure 7
Process Owner Model

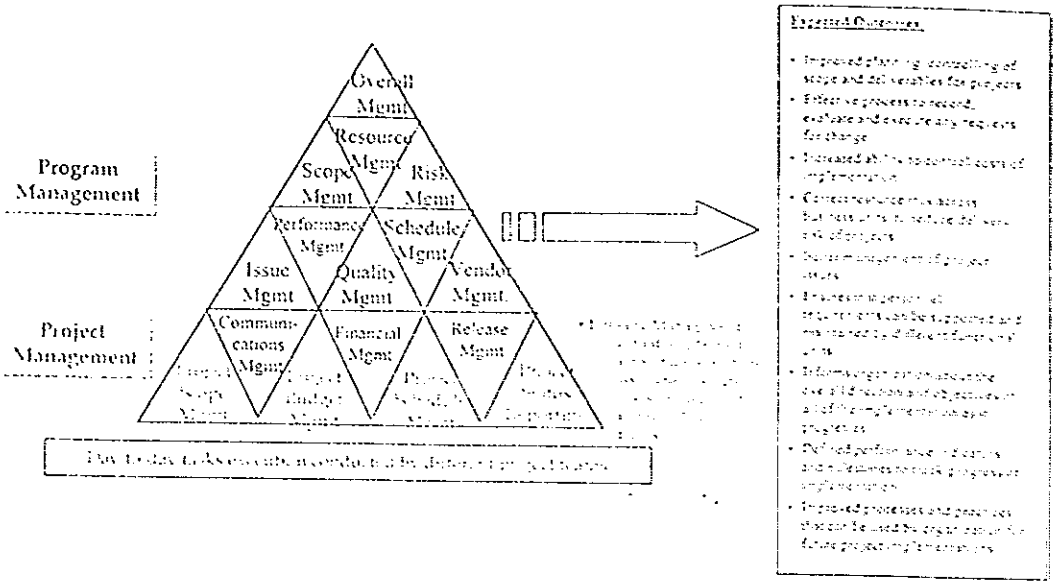



Effective sponsorship is very critical in ensuring successful implementation of the recommendations. An effective sponsor has the following characteristics:

- Power to legitimize the change
- Sufficient degree of pain with the status quo
- Clear definition of what change must occur
- Dedicate the resources to 'make it happen'
- Publicly demonstrates and support the change
- Privately convey strong personal support
- Communicate consistently and frequently
- Make sacrifices for the change implementation

If PhilHealth decides to pursue the larger transformation program, of which BPR is just the initial phase, an umbrella Program Management Office should be created to manage the entire program.

Figure 8
Program Management Office



# APPENDIX A

## BUSINESS PROCESS REVIEW

## *PROJECT ORGANIZATION*

# BUSINESS PROCESS REVIEW
# PROJECT ORGANIZATION

## EXECUTIVE COMMITTEE

| Members | Roles |
|---|---|
| Philhealth Executive Team | ▪ Provide overall project direction<br>▪ Decide on process, policy, and organizational issues that cannot be resolved at the project team level<br>▪ Approve project team recommendations and endorse the same to the Board |

## PROJECT DIRECTORS

| Project Directors | Roles |
|---|---|
| • Mr. Ruben John A. Basa<br>Manager, Corporate Planning<br><br>• Dr. Shirley B. Domingo<br>Manager, Human Resources | • Ensure that project objectives are clear to the entire project team<br>• Monitor project progress to ensure target schedules are met<br>• Ensure project outputs are in accordance with management expectations and quality standards; participate in validation meetings<br>• Resolve project issues that do not require PSC attention. |

## PROCESS OWNERS

| Process | Process Owners | Roles |
|---|---|---|
| Manage Marketing and Membership | • VP Rodolfo Balog<br>• VP Val S. Valilla | • Champions the process change, involves and supports the people to support the new capability |
| Manage Contributions | • VP Mr. Gregorio Rulloda | • Communicates changes in processes, responsibilities, and roles |
| Deliver and Manage Benefits | • DM Leticia Portugal,<br>• Dr. Narisa Sugay | • Establishes key performance indicators<br>• Resolves issues |
| Manage Healthcare Provider Relations | • VP Eduardo Banzon | |



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## BUSINESS PROCESS REVIEW TEAM (CONTENT EXPERTS)

| Process | Members | Roles |
|---|---|---|
| Manage Marketing and Membership | • Lolita Tullao<br>• Lemuel Untalan<br>• Delio Aseron<br>• Myrna Godelosao<br>• Edward Quilala | • Serve as subject matter resource involving their respective processes, areas of responsibility, or expertise<br>• Conduct first-line review of the project team's deliverables, in coordination with the Process Owners |
| Manage Contributions | • Rodolfo del Rosario, Jr.<br>• Ellen Herrera | |
| Deliver and Manage Benefits | • Dr. Narisa Sugay<br>• Dr. Nenita Balbuena<br>• Ms. Marilou Peredo | |
| Manage Healthcare Providers Relations | • VP Madeleine Valera<br>• Dr. Francisco Soria<br>• Dr. Nelia D. Tanio | |

## CONSULTANTS

| Consultants | Roles |
|---|---|
| Vlademer B. Ferreras<br>Project Manager | • In coordination with the Philhealth Project Co-Directors :<br>• Manage day-to-day activities, schedules, and resources of the project team<br>• Manage project issues, problems, and risks<br>• Ensure submission of complete and quality deliverables<br>• Act as liaison between the Project Team and the Project Steering Committee<br>• Participate in Project Steering Committee meetings |
| Susan C. Niles | • Assist the Project Manager in the conduct of the day-to-day project management requirements<br>• Assist the Project Teams in performing the project tasks and activities and preparing the deliverables |

## PROJECT TEAM

| Process | Members | Roles |
|---|---|---|
| Manage member relations | • Gilda Salvacion A. Diaz<br>• Josefina Q Dela Cuadra<br>• Helena Ruby Hernandez | • Perform the assigned project tasks and activities<br>• Prepare and submit the project outputs and deliverables, as scheduled |
| Manage membership | • Gilda Salvacion A. Diaz<br>• Josefina Q Dela Cuadra<br>• Helena Ruby Hernandez | |
| Manage member contributions and collections | • Bonifacio P. Hagoriles, Jr.<br>• Susan Rebecca B. Romero | |
| Deliver and manage benefits | • Jennifer F. Enriquez<br>• Fernando Antonio | |
| Manage healthcare provider relations | • Maila O. Pascua<br>• Nadine Navarro | |

# APPENDIX B

## SUMMARY OF FINDINGS AND RECOMMENDATIONS

## *MANAGE MEMBERSHIP*

Business Process Review
Summary of Findings and Recommendations

Manage Membership Process

| Findings | Recommendations | Comments |
|---|---|---|
| 1) Marketing strategies, processes, organization and role delineation are not clearly defined and/or communicated among key stakeholders of the marketing program. This results in potential confusion and uncoordinated, unsynchronized and redundant effort.<br>➢ Overlap of functions between Corcom and NCR marketing in terms of conducting orientation sessions for the employed sectors.<br>➢ Unclear delineation of functions between Indigent marketing and contribution collections with respect to LGU premium collections;<br>➢ Unclear working or reporting relationship between Membership Program Management Group and the PROs (including the NCR Group):<br>• Lack of uniform basic marketing strategies across PROs;<br>• Weak knowledge sharing and management; success stories not shared or replicated; and<br>• Lack of effective monitoring to assess marketing program effectiveness.<br>➢ Lack of training for marketing staff in the PRO.<br>➢ Insufficient marketing budget for some PROs, including the NCR,<br>➢ Marketing programs and strategies for self- | Medium-Term<br>• Establish and communicate clear marketing strategies, processes, organization and role delineation. Delineate functions between Program Management and PROs/NCR, Marketing and Corporate Communication, Marketing and Contribution Collections.<br>• The Membership and Marketing Program Management Group should be the 'think-tank' arm of Operations for indigent, self-employed and employed sectors. Its responsibilities should include the following:<br>➢ Develop and identify integrated and effective marketing strategies for all sectors based on best practices as well as successful practices experienced by PROs. Implement a process where success stories are shared and replicated with other offices. . *Please refer to Selected Marketing Practices – PROs (Exhibit 1).*<br>➢ Define the performance standards and benchmark.<br>➢ Develop the rollout plan including the timeframe of implementation and determine the resource requirements (e.g., manpower, equipment and materials). Facilitate budgeting of the resource requirements based on unique needs of the PRO<br>➢ Conduct pilot test for critical and massive rollout of initiatives; improve and refine the strategy based on results of the pilot test. | • As much as possible, marketing efforts in the regions should be synchronized. For example, a marketing effort with a unified or common message can be undertaken simultaneously across all PROs for a given quarter, under close monitoring by the Program Management Group<br>• Include during operational planning some discussions or brainstorming session on marketing practices that would be identified and undertaken per quarter for the succeeding year.<br>• Strengthen HRD which should provide technical expertise in:<br>➢ translating the module / content into an effective training program<br>➢ developing and certifying trainers who will be capable of transferring the technology<br>• Determine the advantage/ disadvantages of training budget under HRD.<br>• There is a need to have a written PhilHealth Communication Plan. |

| Findings | Recommendations | Comments |
|---|---|---|
| employed and indigent sectors are not integrated; Marketing programs and strategies for employed sector are not well established.<br>➢ Marketing initiatives are not subjected to a pilot test before actual rollout. | ➢ Provide performance support tools to PRO marketing staff, such as manual of procedures, job aids and guidelines. Coordinate training of staff with HRD.<br>➢ Coordinate with the Corporate Communications Department for nationwide tri-media campaign catering to general audience.<br>➢ Monitor implementation of marketing program and strategies; continuously gather feedback on program effectiveness; institute continuous program improvement.<br>• The PROs and the NCR Group, as program implementers, should translate broad marketing program guidelines and strategies into specific and actionable activities. Its responsibilities include:<br>➢ Conduct of tri-media/information and education campaign at the local level (covering all sectors);<br>➢ Share effective and practical marketing strategies with other PROs. | |
| 2) The self-employed and indigent programs are experiencing high 'drop-out 'rates due to the following reasons:<br>➢ Weak after sales service or follow-through:<br>• Marketing focuses on initial enrollment but very lax on renewals;<br>• Lack of manpower support; difficult to market or conduct follow through with self- | Medium-Term<br>• Implement 'account management' approach where equal attention shall be given to after sales service or follow-through. The account management team shall serve as the single point of contact with the members to address wide range of member needs and concerns.<br>➢ A competent full-time PhilHealth employee shall lead the account management team, which | • There is need to establish baseline data to generate statistics on drop out rates among self employed and indigent programs<br>• Legislating automatic appropriation of IRA for NHIP cannot be realistically achieved. |

Manage Membership Process

| Findings | Recommendations | Comments |
|---|---|---|
| employed sector due to unusual working hours;<br>• Lack of feedback mechanism.<br>➢ Some members experience problems in complying with payment: (refer to Manage Contributions):<br>• Payment centers not accessible;<br>• Preference to pay monthly rather than quarterly.<br>➢ Difficulty to sustain LGU continuing support for indigent program:<br>• Lack of sufficient funding for indigent;<br>• Low utilization rate of indigent;<br>• Existence of other LGU health programs;<br>• Lack of appreciation/ awareness/ knowledge of program's importance. | include qualified and trained external marketing agents as members (example: health volunteers for community campaign). Key responsibilities of the team shall include:<br>– Acquiring members (defining target market, profiling LGU, etc);<br>– Keeping and retaining members; addressing account problems and issues; conducting information and education campaign;<br>– Follow-up and close monitoring of accounts particularly problematic accounts (preparation of billing statements should be done by Contribution Collections);<br>– Growing membership base.<br>➢ Key performance indicators will include number of members/employer/LGU registered, percentage of accounts paying, issue resolution and account satisfaction.<br>➢ Effective incentive schemes for external agents may include payment of commission based on collections (contribution process should be designed to allow tracking of collections by agent)<br>• Work with legislatures to legislate automatic appropriation of IRA for NHIP to ensure continuing LGU participation in the indigent program.<br>• Continue upgrading benefit package within the bounds of actuarial feasibility. For example: | |

Manage Membership Process

| Findings | Recommendations | Comments |
|---|---|---|
| | ➢ Implement no or fixed co-payment schemes for indigent;<br>➢ Expand outpatient benefits. | |
| 3) The current process of identifying indigents through the means test is not entirely reliable.<br>➢ No mechanism to validate information provided by indigent family.<br>➢ Indigent program becomes a political tool by local government officials;<br>• Covering the poorest of the population may not be entirely achieved;<br>• Political accommodation increases probability that non-indigent members are included. | Medium-Term<br>• Strengthen and improve the means testing process aimed at identifying 'true' indigents.<br>➢ Include proxy indicators in the Family Data Survey Form (FDSF) such as type of house, access to safe drinking water/electricity, etc.;<br>➢ Implement control mechanisms to ensure compliance by the LGU to means testing guidelines and criteria.<br>– Randomly inspect using proven statistical techniques the indigents information (actual visit, check with available data) based on an audit plan;<br>– Tap marketing agents to conduct the spot/random checking;<br>– As much as possible, strictly enforce results of means test;<br>• Continue tapping religious/civic organizations/NGOs for sponsorship of indigents. | • Tap barangay volunteers to conduct the spot/random checking<br>• The PMG has on-going study on validation of proxy indicators, which will be presented to Execom for approval before the pilot testing. |
| 4) Lack of proactive and integrated effort to strengthen linkages with other government agencies (such as SSS, SEC, DTI) to establish reliable, consistent, adequate data on target membership base and | Quick-Win<br>• Pursue top level inter-agency collaboration to share information/data among the following agencies: | • Can also utilize LGU data on employers securing business permit<br>• Cross matching the data from SSS, SEC, DTI, LGU is already being done; however, |



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| Findings | Recommendations | Comments |
|---|---|---|
| identify unregistered employers<br>➢ Large chunk of private sector not yet accounted for;<br>➢ Lack of appreciation of the value of data from other government agencies;<br>➢ Without clear definition of the target market base, difficult to measure success of coverage effort and gauge potential gaps. | ➢ SSS – Employers, members and dependents data<br>➢ SEC – Employers data<br>➢ DTI – Employers data<br>➢ BIR – Employers, members; and salary data (annual alpha list)<br>➢ NSO – Potential IPM and IPP data<br>➢ GSIS – Gov't. agencies, members and dependents data<br>• Based on the data, develop a master list of unregistered employers. Actively use the list to help prioritize, plan, and manage the marketing effort *Please refer to Unregistered Employers Monitoring Worksheet (Exhibit 2).* | problem arises when employers change business address/contact numbers.<br>• Mapping is important in marketing. Later on, critical is the Geographic Information System (GIS) that can be applied to all sectors |
| 5) Incomplete and stand-alone membership databases in the Central Office and PROs result in processing inefficiencies and member inconvenience:<br>➢ Most of the contributing employed members are not yet in the membership database. Thus, ID cards have not yet been issued.<br>➢ Member database cannot be entirely relied upon to establish member and dependents' eligibility because its not yet complete. Members need to repeatedly present supporting documents (such as birth certificate for dependents) each time claim is filed.<br>➢ Retirees need to resubmit supporting | Quick Win<br>• To accelerate data capture and build up of employed member database, implement a well planned and managed effort to capture employed member data through the employers using the improved ER2. *Please refer to Revised ER2 Form (Exhibit 3):*<br>➢ If possible, the form should be pre-filled out – available information known to PhilHealth should be supplied in the form. Thus, employers shall only provide missing information (such as date of birth, address, and name of dependents). Employees who already have PNC need not be included in the form | • If the proposed revised ER2 is implemented, the following should be taken into consideration:<br>➢ marketing approach with big companies / employers – how to sell the idea to them.<br>➢ physical appearance of the form. There is also a need to ensure that the member-employee is certifying all the information reflected therein.<br>➢ best approach on how to process the form.<br>➢ need to include employee's address, religion, nationality.<br>➢ how about the supporting |



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Manage Membership Process

| Findings | Recommendations | Comments |
|---|---|---|
| documents to register as a non-paying member.<br>➢ There is a real possibility that a member can be issued with more than one PIN (within and across sectors);<br>• Difficult to track and monitor payment;<br>• Waste of resources;<br>• Availment of benefits more than once, specially for the dependents, can be possible<br>➢ Legitimacy of the registering private firms and validity of the authorized signatory cannot be established. Validity of the premium payment certification in the Claims Form cannot be ascertained. | ➢ The ER2 should be sent with a letter from the CEO explaining the rationale for the initiative and implications for non-compliance. Frequently Asked Questions (FAQs) should be included as well as telephone hotline in case of questions. The employer shall have the option to submit the softcopy.<br>➢ If the strategy proves to be effective, continue the practice on a regular basis for new/additional employees.<br>• The Member Data Record (MDR) containing complete information about the member (including data on dependents) should be issued to members, instead of the membership card.<br>➢ The members applying for claims shall be required to show the MDR, instead of birth certificates, to the health care provider to check dependent's eligibility.<br>➢ MDR should be printed using a hard or security paper, if possible.<br>Medium-Term<br>• A member should retain the original PhilHealth number despite change in membership category (indigent, self-employed, employed and retirees). Common membership database should be able to tag membership categories.<br>• A central clearing module should be in place to determine and weed out double registrations | documents?<br>➢ Technical assistance from MIS is necessary for the transfer of soft copy or template to employers.<br>• If a dependent is not reflected in the MDR, the dependent should present a proof of dependency. The document should be used to update the member records.<br>• If possible, the signature of the employer should be reflected in the MDR. Require a new one if there is a change in employer |



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Manage Membership Process

| Findings | Recommendations | Comments |
|---|---|---|
| | • Require new employer registrants to attach specimen signature of authorized official in the employer data form (ER1) and other requirements such as the SEC Article of Incorporation/partnership. Use the specimen signature for validating authenticity of Payment Certification in Claims Form.<br><br>Note: The practice of requiring employer payment certification for claims should be discontinued once a reliable, complete and accurate collection database is in place for eligibility checking.<br><br>Long-Term<br><br>• Implement on-line registration; invest in Wide Area Network. | |
| 6) Long and slow turnaround time for processing and issuance of membership cards for employed members (2 to 3 months);<br><br>a) Centralized processing causes long and multiple hand-offs; redundant screening of documents<br><br>➢ Cards are sometime lost in transit or forwarded to wrong destination. | Quick-Win<br><br>• Strengthen screening at the source (SO and PRO) to eliminate the need for screening in the Central Office<br><br>➢ Re-orient staff at the Service Office and PROs on proper screening procedures.<br><br>➢ Explore possibility of incorporating errors committed in employee performance appraisal.<br><br>• Decentralize printing and issuance of MDR while maintaining centralized database build-up. MIS shall install the File Transfer Protocol (FTP) in the PROs.<br><br>Medium-Term<br><br>• Decentralize database buildup of employed sector Retain contralized build-up for centrally reporting employers. Provide copy of the database to the PRO | • Decentralization of database build-up of employed sector can be done through clustering by PROs. |



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Business Process Review
Summary of Findings and Recommendations

Manage Membership Process

| Findings | Recommendations | Comments |
|---|---|---|
| | where employees are located | |
| 7) Issuance of ID to indigents takes time due to long processing time in premium payment by the LGU. | Quick-Win<br>• Contribution should issue the Bill Statement to the LGU immediately after commitment has been obtained and budget has been allocated, as evidenced by a Certificate of Funds Availability.<br>➢ Payment processing by the LGU will run parallel with processing of indigents applicants (finalization of the list of indigents, accomplishing of forms, and verification of forms and documents)<br>➢ The lag time between collection of payment and membership database build up will be minimized. | • This is already being done in NCR. |
| 8) Premium payments of potential individually paying members are not accepted due to lack of PIN. | Quick-Win<br>• Allow the use of the M1b as payment form for initial payments.<br>➢ Speed up processing of membership to ensure issuance of PIN before the next payment.<br>➢ Use the regular payment form for succeeding payments.<br>➢ Update dependents' records upon submission of birth certificate to membership or through claims processing. | • This can only be done for over-the-counter payments. |
| 9) Unclear policy on documentary requirements for registration of indigenous/cultural/ ethnic groups | Quick-Win<br>• In the absence of a birth certificate, enforce and communicate the policy of allowing an affidavit of two (2) disinterested persons as per revised IRR. | |

Business Process Review
Summary of Findings and Recommendations

Manage Membership Process

| Findings | Recommendations | Comments |
|---|---|---|
| 10) Others | | • Need to reevaluate the current policy on eligibility requirements (minimum 3 months contribution within 6 months to avail of benefits) particularly for IPMs. There is a need to establish longer residency (like 1 year) for IPMs before they could avail of the benefits.<br>• For example, there should be stricter eligibility criteria for pregnant women/IPMs, especially those who will undergo caesarian operation. Under the current rule, they are already entitled to benefits a month after paying the previous quarter premium. Afterwards, there is no compelling reason to continue paying until the time they see the need to resume payment (refer to Manager Benefits). |



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# APPENDIX C

## SUMMARY OF FINDINGS AND RECOMMENDATIONS

## *MANAGE CONTRIBUTIONS*

Business Process Review
Summary of Findings and Recommendation

## Manage Contributions

| Findings | Recommendations | Comments |
|---|---|---|
| 1) The optimal operational goal of the Membership and Contributions Management Department at the Central Office and the Contributions Section at the Philhealth Regional Offices (PROs) is 100% collection of premium contributions from all enrolled Philhealth members in the employed, individually-paying (IPM), and indigent (IPG) sectors nationwide.<br><br>To achieve this target, assigned personnel from these offices, in addition to sending reminder notices and doing phone follow-ups, personally visit employers, local government units (LGU), and organized groups (e.g. market vendor associations) to encourage them to remit their premium contributions.<br><br>Considering that a significant percentage of Contribution tasks are backroom in nature, the issue raised involves the propriety and effectiveness of lodging in Contributions the collection follow-up responsibility, particularly that which requires direct interaction with the members. | Quick Win<br><br>• Reassign the collection follow-up task to Marketing, specifically, that which would require direct personal interaction with the concerned employers, LGUs, and other member groups. Under this set-up, the proposed work distribution would be, as follows :<br><br>➢ For all the sectors (employed, IPM, and IPG), Contribution will :<br><br>o Generate the reminder notices for late payments<br><br>o Release the reminder notices to the concerned parties through the Records Section<br><br>o Provide Marketing with a list of employers, LGUs , and other member groups with late remittances, together with their contact information, to serve as basis for their follow-up task<br><br>➢ For collection follow-ups within the employed sector, Contributions will perform the initial follow-up during the 30-day grace period. Marketing will handle the subsequent follow-ups as well as problematic and delinquent accounts.<br><br>➢ For the IPG and IPM sectors, Marketing will call up and visit the LGUs and member groups with unpaid premiums beyond their respective due dates. | • Additional procedural details to be included are, as follows :<br><br>➢ Marketing will handcarry and deliver late payment reminder notices to delinquent members whom they will personally visit.<br><br>➢ For those who will not be site visited by Marketing, reminder notices will be released through the Records Section.<br><br>➢ Marketing will document the outcome of the site visit to serve as input for drafting the complaint affidavit.<br><br>➢ Contribution will draft, issue, and send the complaint affidavit to the concerned member through registered mail.<br><br>• Under the current set up, the Collection Enforcement unit under CAMD does the personal follow-up of delinquent members. This set-up currently works.<br><br>➢ The proposed reassignment of this responsibility to Marketing is intended to further enhance the |



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Business Process Review
Summary of Findings and Recommendation

## Manage Contributions

| Findings | Recommendations | Comments |
|---|---|---|
| | Medium Term<br>➢ The Account Management Team concept proposed for "Manage Marketing and Membership" will support and reenforce this recommended reassignment of responsibility. Account Management Teams will be assigned specific clusters of potential and existing groups (e.g. by specific groups, geographic area) within which to capture, expand, and sustain membership in Philhealth. | collection effort by making the Marketing people responsible for ensuring initial premium payments as well as sustaining existing membership contributions through personal calls and follow-up visits<br>➢ This approach will utilize and further sharpen the marketing and interpersonal skills of the Marketing personnel.<br>➢ This procedure is an application of the Account Management Team concept introduced in the process for "Manage Marketing and Membership". |
| 2) Corollary to the above, there is also a need to reexamine the following related issues :<br>➢ When is a member considered enrolled - upon member registration or upon initial payment of premiums due ?<br>➢ Where does the Marketing process end - upon member registration or upon collection of the initial premiums due ?<br>➢ Who is, therefore, responsible for ensuring that the initial payment has been made - Marketing or Contributions? | Quick Win<br>• Assign to Marketing the responsibility for ensuring that the first premium payment from a new member has been made. Include initial premium payment as part of their performance metrics.<br>➢ Since the Marketing staff are the first contact points of potential members, they are in the best position to solicit the initial premium payments from them.<br>However, while the Marketing staff should ensure initial payment of premiums due from potential members, they will not be authorized. | • With proper internal controls in place, the Marketing personnel should be authorized to accept payments from members. |



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## Manage Contributions

| Findings | Recommendations | Comments |
|---|---|---|
| | as a control measure, to directly accept cash payments from members. | |
| 3) The document handoff between Marketing and Contributions (specifically, the Indigent Program Group) involving the preparation of the initial Billing Advice (estimates) to LGUs can be eliminated. The existing process is outlined below :<br>➢ Marketing provides the Indigent Program Group (IPG) at the Central Office with the estimated number of households to be covered by the Memorandum of Agreement between Philhealth and the participating LGUs.<br>➢ IPG prepares the initial Biling Advice (or billing estimates) to LGUs, based on data from Marketing<br>➢ Marketing receives the initial Billing Advice from Contributions<br>➢ Marketing goes to the concerned LGUs to submit the Billing Advice. | Quick Win<br>• Authorize the Marketing staff assigned to the LGU to prepare the initial Billing Advice (estimates), if required by the LGU for fund allocation.<br>• Train the Marketing staff to be assigned to LGUs on the mechanics of Billing Advice preparation. | |
| 4) Philhealth experiences a high "drop-out" rate in self employed attributable, among others, to the following collection-related issues :<br>➢ Inaccessible payment centers<br>➢ Quarterly payment contributions not affordable to some individually-paying | Medium-Term<br>• Identify additional community-based collecting agents (e.g. municipal treasurer, barangay treasurer, cooperatives, associations, Bayad Centers, etc) who are closer to IPMs<br>• Expand the use of rural banks' services to support | • The Service Offices and Marketing personnel will also serve as collecting agents to address the issue on inaccessible payment centers |



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Business Process Review
Summary of Findings and Recommendation

## Manage Contributions

| Findings | Recommendations | Comments |
|---|---|---|
| members | Philhealth's collection requirements, in areas where rural banks have not been accredited as collecting agents<br>➢ Reassess the accreditation criteria for rural banks to ensure that only financially stable, effectively managed banks are accredited as payment centers.<br>➢ Constantly monitor the financial health of accredited rural banks to ensure that Philhealth deposits with these banks are safeguarded from possible bank closures.<br>➢ Implement in rural banks the same set of policies and guidelines used for accredited commercial banks (ACBs) and accredited government depository banks (AGDBs), with respect to collection remittances and supporting documentation.<br>• Pursue the use of collection services of the Philippine Postal Corporation (Philpost) and the Philippine Postal Savings Bank.<br>• Explore the possibility of allowing monthly premium payments for IPMs, through identified community-based collecting agents, as earlier mentioned. | • Decentralization of collections to the PROs will be implemented within the short term<br>• Philhealth will directly accredit local and rural banks through the PROs, instead of through Land Bank. |
| 5) There is a need to institute control procedures and related mechanisms to detect and prevent the occurrence of the following problems: | Long-Term<br>• Simplify the contribution structure:<br>➢ For the employed sector, modify and simplify the premium contribution structure geared | • A single, fixed contribution rate for the employed sector violates the 50%-50% premium contribution |



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Business Process Review
Summary of Findings and Recommendation

## Manage Contributions

| Findings | Recommendations | Comments |
|---|---|---|
| For Employers<br>➢ Underreporting / underremitting employers<br>o Employee contributions and employer's share not remitted or reported to Philhealth (deducted but not remitted)<br>o Employee contributions and employer's share not accurately reported and remitted (misdeclared salary brackets)<br>o Employee not deducted at all for Philhealth premium contributions (employee not deducted for premium contributions)<br>➢ Nonreporting / nonremitting employers (employers with no remittance record for the past 6 months / employers with no remittance since 1999 for the private sector and 1998 for the public sector)<br>Under the existing procedure, employers submit a copy of their RF1s and ME5s quarterly to Philhealth.<br>➢ However, some employers submit their RF1s and ME5s late, submit incomplete documents, or do not submit their documents at all. | towards a single, fixed rate, regardless of salary bracket<br>➢ For the IPM sector, differentiate between the professionals and non-professionals, to stress the socialized contributions structure.<br>For example :<br>Professionals - P 200 / month<br>Non-professionals - P100 / month<br>Medium-Term<br>• If the contribution structure continues to be multi-level, use the Annual Alphalists submitted by employers to the BIR as basis for validating completeness of employees reported to Philhealth. The Alphalist contains information on the gross taxable income of all company employees for a tax year.<br>➢ Undertake a MOA with the Bureau of Internal Revenue (BIR) granting Philhealth access to the Alphalist for a specific purpose<br>➢ Subject to resource constraints, select the employers to be reviewed, based on established criteria, such as, recurring reporting deficiencies, company size, etc | sharing ratio between the employer and the employee, as stipulated in RA 7875. Implementation of a fixed rate will require a legislative amendment and a thorough actuarial study.<br>• Government agencies should optimize and share information and resources across each other.<br>• Cross-validation against the Annual Alphalists should be done on selective basis only, because of the large effort to be spent in undertaking this practice. |

Business Process Review
Summary of Findings and Recommendation

## Manage Contributions

| Findings | Recommendations | Comments |
|---|---|---|
| ➢ Contributions spends additional time to validate and adjust contributions data as well as follow-up and send compliance requests letters to the concerned employers about these deficiencies<br><br>➢ Deficient reports cannot be posted immediately to the Employers database, pending compliance by the employers of their respective deficiencies.<br><br>➢ To issue reminder notices for late payments, Contributions has to reference RF2s and ME5s submitted by accredited banks to Treasury to confirm nonpayment of premiums by an employer. | • Continue procedure of following-up underremitting / nonremitting employers identified by Claims in the process of undertaking eligibility checking; coordinate with Marketing in dealing with problematic accounts | |
| For Accredited Banks :<br><br>➢ Underreporting / underremitting banks<br><br>Under the current procedure, accredited banks submit twice a month the following documents : RF2A, RF2, and ME5, together with their check remittances to Philhealth. The RF2s are used as basis in updating the Treasury Database for bank remittances.<br><br>➢ The RF2s and ME5s are not accountable forms. Based on these documents, there | Medium-Term<br><br>• Use pre-numbered Philhealth Official Receipts (PORs) as proof of payment.<br><br>➢ Require all ACBs, AGDBs, and other collecting agents to issue accountable PORs<br><br>➢ Develop clear implementation guidelines to enforce procedures and strict controls over :<br><br>o Safekeeping and issuance of PORs by banks and other collecting agents | |



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## Manage Contributions

| Findings | Recommendations | Comments |
|---|---|---|
| is no assurance that the bank remittance is complete.<br>➢ Therefore, an added procedure to reconcile bank-submitted documents with employer-submitted documents is done to detect :<br>o Underremittances / underreporting by banks<br>o Nonpayment of premiums by employers<br>➢ In addition, the banks have no basis to determine the amount that the employers should remit to Philhealth. | o Distribution of PORs from Philhealth to all collecting agents<br>o Monitoring of inventory of PORs at Philhealth and collecting agents<br>• If use of POR is implemented, adopt the proposed procedures, considering nonexistent connectivity between the computerized Treasury System and Member Accounts Information System (MAIS) :<br>➢ Require the employers to submit 2 copies of their RF1s to the collecting agent, to serve as basis for payment<br>➢ Require the collecting agent to stamp the RF1 and retain one copy<br>➢ Upon collection remittance to Philhealth, the collecting agent should submit the following documents to Philhealth Treasury :<br>o RF2<br>o Bank-stamped RF1<br>o 2 copies of the POR<br>➢ After receipt and review of the documents, Treasury shall furnish Contributions with the RF2, RF1, and one copy of the OR. | • The proposed procedures will eliminate the following activities:<br>➢ Separate submission of the RF1 by employers to Philhealth<br>➢ Collecting RF1s from dropboxes<br>➢ Generating and sending acknowledgment letters to employers for RF1s received through dropboxes and mail.<br>• While the benefits of the proposed procedures are recognized, the banks will not accept the additional burden of receiving and temporarily safekeeping RF1s for subsequent transmittal to Philhealth.<br>• The procedure will shift the responsibility over receipt and review of the RF1s from CAMD to Treasury. |

## Manage Contributions

| Findings | Recommendations | Comments |
|---|---|---|
| | ➢ Contributions can, then, process and post the RF1 to the Employers' Contributions DB.<br><br>Long-Term :<br>• Enhance PMAIS to electronically generate Billing Statements to employers at least two (2) weeks prior to the due date of the premium contributions<br>• Adopt the following procedures, assuming system capability to generate Billing Statements, availability of current data on employees contributions, and an interface, at a minimum, between the Treasury System and PMAIS :<br>➢ Send Billing Statements to employers<br>➢ Require employers to present and submit the Billing Statement and Employee Contributions Amendment Form to the collecting agents, upon payment of their premium contributions<br>➢ Twice monthly, the collecting agents will submit to Philhealth Treasury a copy of the RF2, 2 copies of the Official Receipt, and the Employee Contributions Amendment Form, together with their check remittance<br>➢ After receipt and review of the documents, Treasury shall furnish.Contributions with the RF2, Employee Contributions Amendment Form, and one copy of the OR<br>➢ Contributions can, then, process and update the Employers and Employees Contributions | • Billing Statement generation and issuance would be a costly solution for Philhealth. Alternatively, 'internal billing statement' can be implemented.<br>• A recent office instruction states that Treasury will not capture the PENs / PINs of members into its database.<br>• The Process Owner, however, indicated that :<br>➢ For the employed sector, the POR should contain the paying member's name, at the minimum<br>➢ For IPMs, the PIN should be captured by Treasury.<br>• The Consultant's position is to require Treasury to capture the PIN / PEN, as part of the collection information.<br>➢ The PIN / PEN will serve as the |

## Manage Contributions

| Findings | Recommendations | Comments |
|---|---|---|
| | Databases. | link between the Treasury database and PMAIS, if Billing Statements are not generated.<br>➢ If Billing Statements are generated, the Bill No. can serve as the link between Treasury and Contributions<br>➢ Collection data captured by Treasury will be passed on to PMAIS for posting to the employers' and employees' contribution database<br>• Partial payments by employers will not affect employees' contributions.<br>➢ Even with partial remittances from employers, employees' contributions are considered fully paid.<br>➢ Hence, there may be points in time when total employer contributions would not equal total employee contributions. |
| 6) There is currently a large number of past years' employee contributions data to be encoded by a service bureau. Questions that arise are : | Medium-Term<br>• Focus available resources initially on updating | • Past years' data on employee contributions will be needed to : |

## Manage Contributions

| Findings | Recommendations | Comments |
|---|---|---|
| ➢ Is there any significant information value to be derived from encoding past years' employee data - apart from accumulating the 120 monthly contributions that would qualify a member as nonpaying upon retirement ?<br><br>➢ What is the expected additional amount to be collected, if underremittances / nonremittances are established vs. the cost of encoding past years' data ? | employers' and employees' contributions database, based on current years' data (meaning the past 12 months) ; then, process backlogs, as necessary.<br><br>• If Billing Statement generation can be immediately incorporated in PMAIS and an interface with the Treasury System can be developed, pilot test the process described in No. 7 above involving Billing Statement generation and Employee Contribution posting to the database. | ➢ Establish the 120 monthly contributions required to qualify a member as nonpaying upon reaching the age of retirement.<br><br>➢ Determine pastdue collectibles from employers due to nonremittance or underremittance<br><br>• If backlog data on employee contributions are not encoded and captured into the system, the member's service records with his employers can be used as alternative documentation to support application for nonpaying membership upon reaching the legal age of retirement.<br><br>• The issue on whether to encode backlog contribution data from 1999 to 2000, however, has become academic. The contract with the service bureau to encode past years' member contributions has been approved by the PBAC. Data from Year 2000 onwards will be encoded. |
| 7) The PROs do not have complete information on employer premium payments (or potentially, IPMs) to banks.<br><br>➢ PROs do not have any record of centrally remitting employers These records are | Quick Win<br><br>• For non-centrally remitting employers, request the banks to provide the PROs with copies of their bank abstracts. | • Information on centrally remitted premium contributions are needed by PROs for budgeting purposes only. |



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## Manage Contributions

| Findings | Recommendations | Comments |
|---|---|---|
| centralized at the Central Office.<br>➢ Not all banks provide the PROs with their bank abstracts or the equivalent of the RF2s<br>➢ The value of inadequate data on employers' premium contributions is diminished for eligibility checking and follow-ups. | • For centrally remitting, Central Office should provide the PROs with a copy of bank remittances for their respective regions. | |
| 8) The process flow at CAMD can be further streamlined and standardized.<br>➢ Work efficiency can be enhanced if similar work activities are done once within the assigned group or unit.<br>o For example, there is screening at Central Records and another screening at Member Accounts Division (Private Sector) and Public Sector Data Management Division<br>➢ The offices use different computerized modules to serve their own purposes :<br>o Transmittal List System (TLS) to generate the acknowledgment letters<br>o Batch Control Module (BCS) of MAIS | Quick Win<br>• Implement a standard process flow (team approach) for both private and public sectors - from Receiving to Posting of Contributions.<br>➢ Receive documents from Central Records<br>➢ Screen documents for completeness of documentary requirements and correctness of reported documents<br>➢ Adjust the report for underpayment / overpayment<br>➢ Encode contributions data<br>➢ Review encoded data<br><br>Medium Term<br>• Include a quick enhancement to PMAIS to enable the | • The current CAMD organizational structure is the workable set up, given the existing resources and skills vs. the volume and nature of work being done.<br>• Public Sector has a different collection pattern from the Private Sector. Remittances of the share of public sector employers in the premium contributions are dependent on budgetary releases from the Department of Budget and Management.<br>• In anticipation of the implementation of PMAIS, CAMD has developed a simplified collection process. A more cohesive organization set up, margining the Public Sector, Private Sector, and Data Management |

## Manage Contributions

| Findings | Recommendations | Comments |
|---|---|---|
| to encode employers data and generate the Batch Control Slips and Transmittal Lists for documents to be forwarded to the Service Bureau<br>o Premium Compliance System (PCS) to monitor employers' reporting deficiencies | following :<br>➢ Generation of acknowledgment letters for reports submitted through mail or drop boxes or an interface with an email system -- to eliminate the Transmittal List System.<br>(Note, however, that if employers will no longer be required to submit documents directly to Philhealth, as earlier suggested, generation of acknowledgment letters may not even be necessary)<br>➢ Monitoring of deficient reports and generation of deficiency letters - to eliminate the Premium Compliance System<br>• Consider merging divisions involved in the process from Receiving to Review of encoded data | Groups into one is also being considered |
| 9) There is a need to enhance and integrate the computerized application and build up an up-to-date employers / employees contributions database.<br>➢ Employers' and employees' contributions data are not yet current<br>➢ Contributions data cannot be relied upon for eligibility checking<br>➢ Contributions have to be integrated with Membership and Claims. | Long-Term<br>• Develop a computerized Contributions Account Management System that has the following features and capabilities :<br>➢ Integrate with Membership to obtain information on new members and updates to existing members' data<br>➢ Integrate with Treasury to access payments data<br>➢ Post premium payments received from all sectors (employed, IPM, IPG) to the database<br>➢ Track and calculate changes in premium | • The project team should look into potential issues related to over-the-counter (OTC) transactions.<br>• Collection of premium contributions should be properly booked and recorded in FMIS.<br>• There should be a master plan for implementing the approved quick wins, medium-term, and long-term recommendations The project team will draw up a high-level implementation plan. |

Business Process Review
Summary of Findings and Recommendation

## Manage Contributions

| Findings | Recommendations | Comments |
|---|---|---|
| | remittances of employers – due to personnel updates (e.g. resignations, new hires, etc)<br>➢ Establish underpayments and / or overpayments; apply underpayments or overpayments, based on Philhealth's policy on application of payments<br>➢ Generate Billing Statements<br>➢ Generate Reminder Notices of Pastdue Accounts<br>➢ Accumulate members' premium contributions (120 premium contributions to qualify as non-paying members)<br>➢ Generate certification of members' contributions<br>➢ Integrate with Claims to enable electronic eligibility check<br>➢ Enable web-based premium payments (EPRS)<br>• Implement standard computerized systems at the PROs<br>• Implement Value-Added Network (VAN) | • The existing MAIS interfaces with Membership and Treasury. |



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# APPENDIX D

## SUMMARY OF FINDINGS AND RECOMMENDATIONS

## *MANAGE HEALTH CARE PROVIDERS RELATIONS*

Business Process Review
Summary of Findings and Recommendations

## Manage Healthcare Provider Relations

| Findings | Recommendations | Comments |
|---|---|---|
| 1) Philhealth relationship with healthcare providers stands improvement -- anchored on trust and cooperation and working together towards raising the quality of affordable healthcare to all Filipinos. | Medium- to Long-Term<br>• Institutionalize a paradigm shift in health care provider relationship from policing to partnership, adversarial to collaborative/consultative. In line with this direction, transform the accreditation team to a relationship management team to serve as the single-point of contact, capable of addressing wide range of health care provider issues and concerns. Among others, its responsibilities could include:<br>➢ Monitor sustained compliance with quality health care standards (for accreditation or renewal). Recommend required quality interventions to achieve quality service.<br>➢ Act as 'quality advisors or consultants' to hospitals in relation to the implementation of benchbook.<br>➢ Conduct periodic consultative meetings with the providers involving new circulars, policies, guidelines, problems with claims applications (RTH), suggestions for improvement on benefits payments, policies, etc.<br>➢ Facilitate provision of training and performance support tools to medical staff of healthcare providers on new procedures or policies such as ICD-10 coding. | • To carry out its new role as 'quality consultant', the Accreditation Staff need to undergo formal training and education on health care quality improvement. |

## Manage Healthcare Provider Relations

| Findings | Recommendations | Comments |
|---|---|---|
| | ➢ Implement a well-designed incentive mechanism for outstanding health care providers.<br><br>Notes:<br>• Team composition: team lead and 2-3 assistants. Team assignments will be per cluster of healthcare providers, subject to rotation.<br>• Performance and decision support tools should be available to the team, which include a 'dash board' of hospitals' key performance indicators. | |
| 2) There are opportunities to improve the accreditation processes:<br>➢ Compliance with accreditation requirements by the healthcare providers<br>➢ Accreditation process at the PROs<br>➢ Accreditation approval process at the Central Office.<br>➢ Dissemination of information on approved / disapproved applications for accreditation to the Philhealth Regional Offices (PROs) | PhilHealth Regional Office (PRO)<br><br>Quick Win<br>• Continue constant follow up of health care providers on compliance with requirements for accreditation or re-accreditation to ensure completion and submission of mandatory requirements to the Central Office, at least 1 month prior to accreditation expiry.<br>• Promptly resolve issues that could deter approval of the accreditation by the Accreditation Committee Set a reasonable turnaround response time for the Central Office to address the PRO queries.<br>• If necessary, immediately refer questions to the Central Office for quick resolution through the fastest available mode of communications (e.g mobile phone, landline, fax, email, PDAs | • Currently, there is plan to acquire PDAs. |

## Manage Healthcare Provider Relations

| Findings | Recommendations | Comments |
|---|---|---|
| | • For initial accreditation, as soon as the accreditation requirements have been complied with by the healthcare provider, inform the Central Office immediately – so that hospital inspection can be scheduled right away even without a copy of the application form. | • There is a need to receive the application prior to scheduling so that initial review can be done. |
| | Medium Term<br>• Assign the Healthcare Provider Relationship Management Team to monitor and ensure compliance with the accreditation requirements and help respond to / resolve healthcare provider issues and questions promptly (refer to previous recommendation). | |
| | Central Office (CO) | |
| | Quick Win<br>• Delegate the authority to approve accreditation of fully compliant health care providers (without issues) to Head of Accreditation, upon the recommendation of the Accreditation Team. Alternatively, process approval of accreditation of fully compliant health care providers by Accreditation Committee through a referendum. | • This can be implemented for accreditation renewals only. The Accreditation Committee should approve all applications for initial accreditation. |
| | • Given the above scenario, determine if there are cases, which the PROs can directly recommend for approval. | |

## Manage Healthcare Provider Relations

| Findings | Recommendations | Comments |
|---|---|---|
| | • Document and compile all accreditation issues and their resolutions into case digests or knowledge database. Facilitate sharing of case digests or knowledge exchange among PROs. | |
| | • Accelerate the development of new accreditation survey tools and evaluation rules for health 'outcomes' without replicating the DOH licensing procedures and requirements. Implement the Consolidated Licensing and Accreditation Survey Process (CLASP) with the DOH. | • In the long-term, accreditation will be capability-based. Hospitals can be mapped according to their capabilities. |
| | • Other process improvement opportunities: | |
| | ➢ For initial accreditation, the Central Office should schedule hospital inspection immediately after being informed of full compliance by the hospital to accreditation requirements – without the need to wait for copies of documentation from the PRO. | • Central Office Accreditation personnel need to receive the application forms prior to hospital visit so that they can prepare. Certain rules can be interpreted differently by the PRO. |
| | ➢ Eliminate the preparation of narrative verification reports, which summarize information that can already be obtained from the hospital inspection and verification reports. | |
| | ➢ Respond immediately and clearly to questions posed by PROs as well as by the healthcare providers (within the set response time frame) based on documented case digests or knowledge database. | |
| | ➢ Upon receipt of documentation from the PROs, | |

Business Process Review
Summary of Findings and Recommendations

## Manage Healthcare Provider Relations

| Findings | Recommendations | Comments |
|---|---|---|
| | include the application in the agenda for the Accreditation meeting immediately.<br>• Require only one (1) countersignature on the on the 2nd copy of the certificate of accreditation.<br>• Transmit electronic data to the PROs immediately – so that the accreditation data in UCPS can be updated right away.<br>➢ Create a separate file of a few relevant accreditation data (e.g. name of hospital, hospital category, accreditation number, accredited beds, validity period) for immediate data transmission to the PROs and printing of the certificate of accreditation<br>➢ Or, if paper-based information is more readily available, transmit the information to the PRO right away and allow an authorized PRO officer to update the Accreditation database - but impose strict user access control to the system<br>Long-Term<br>• Enhance the Accreditation System to allow centralized and decentralized capture of information and update of healthcare providers database. The system should be properly interfaced with the Claims Processing System. | • This will not be a problem if health care providers will submit application within reasonable time prior to expiration of accreditation.<br>• Lack of enough manpower to handle accreditation at the PROs can be a reason for delayed processing. To address this, create a pool of accreditation personnel to handle clusters of PROs. Accordingly, schedule inspections of the cluster to maximize use of the pool.<br>• Implement the document tracking system where selected information can be captured by PROs.<br>In the long-term, outsource the accreditation function to third-party organizations (example: PCAHO, JCAHO). Initially, PhilHealth will control and define the standards. This in line with transforming the PhilHealth Accreditation personnel into relationship managers. |

Business Process Review
Summary of Findings and Recommendations

## Manage Healthcare Provider Relations

| Findings | Recommendations | Comments |
|---|---|---|
| 3) The accreditation forms can be redesigned to simplify format and eliminate redundant information.<br>➢ Separate forms are used for primary, secondary, and tertiary hospitals – which can be simplified and merged into one form.<br>➢ Separate forms are used for application, inspection, verification and evaluation. | Quick Win<br>• Combine the separate applications for accreditation and the hospital inspection and verification forms into a single Accreditation form.<br>➢ Only one form will be used for primary, secondary, and tertiary hospitals.<br>➢ The information to be filled up and requirements to be complied with should be enumerated in a clearer, more organized format.<br>➢ Columns on the right hand side of the forms will be provided where the PROs and Central Office Accreditation staff can indicate the status of compliance, together with any additional comments.<br>The sample format is presented as Attachment A. | • Combine secondary and tertiary hospital accreditation forms. Maintain separate accreditation form for secondary hospitals. |
| 4) Indications of fraudulent claims have been noted.<br>➢ Higher amount of claims filed by the hospital vs. compensable claims deducted from patients' bills<br>➢ Examples of noticeable repeating cases of suspicious claims (e.g. non-existent patients) | Quick Win<br>• Enforce suspension / revocation of accreditation, based on proven fraud cases as a result of thorough data analysis and hospital visits.<br>• Fast track conduct of training for Accreditation team on the required and legally acceptable documentary evidence necessary to file a legal case against the hospitals<br>• Accelerate the development of clear policies and | • Accreditation can deny application for renewal based on proven fraud cases as a result of data analysis and hospital visits. |

## Manage Healthcare Provider Relations

| Findings | Recommendations | Comments |
|---|---|---|
| ➢ Non-prosecution of healthcare providers with repeating cases of fraudulent claims | guidelines on the handling of fraudulent claims.<br>• Require the healthcare providers to attach a copy of the Summary Statement of Accounts paid for and signed by the member to the Claims documents<br>• Continue to conduct an awareness campaign among members (through the Account Management Team of Marketing) regarding claims benefits<br>• Continue the practice of conducting onsite inspections of patient admissions and other relevant records for problematic hospitals. | |
| 5) One reason cited for long claims processing is the need to perform itemized checking of drugs, as per benefit design.<br>➢ Associate drugs against diagnosis<br>➢ Check the quantity of dosage vs. illness<br>➢ Validate drugs dispensed vs. the PNDF<br>➢ Check the cost of drugs charged to the patient | Long-Term<br>• Continue reviewing the benefits package for drugs and medicines and explore the possibility of defining compensable drugs by case payment - to eliminate tedious checking of drugs and medicines | • Itemized encoding of drugs is required to help PhilHealth play its implicit role in drug price regulation in the country.<br>• In line with this, case payments can be implemented, except for drugs.<br>• Coding is required to simplify claims processing. ICD 10 implementation can be modified (down to 4 characters only) |
| 6) The policy of 45-day maximum confinement cannot be enforced due to technical difficulty to track confinement periods.<br>➢ Inability to compile and consolidate all | Quick Win<br>➢ Include information on previous confinements in the Philhealth Claims form.<br>Long-Term | • Eliminate 45-day policy, instead, use number of availments as a control mechanism (subject to actuarial study). |

Business Process Review
Summary of Findings and Recommendations

## Manage Healthcare Provider Relations

| Findings | Recommendations | Comments |
|---|---|---|
| benefits utilized by a member;<br>• Disabled UPS functionality to check confinement periods;<br>• UPS in PROs not interconnected (in view of portability);<br>• Hospital not connected to philhealth.<br>➢ Delayed claims information due to the 60-day grace period to file the claim and the additional 30 to 60 days to process a claim. | ➢ Develop and implement a computerized Claims Processing System that :<br>• Integrates with Membership and Member Accounts Information System<br>• Integrates properly with the Accreditation System<br>• Keeps a history of past illnesses (ICD-10s) and compensable benefits utilized by members and members' dependents<br>• Enables claims data sharing across Philhealth offices nationwide<br>• Decentralize the implementation of the system to the PROs<br>• Enable healthcare providers (through Hospital Operations Management Information System or HOMIS) to connect to the Philhealth System | • There is a plan to implement electronic log-book system for hospitals. |
| 7) Relevant data and information which are needed to establish quality of care standards and monitor health care providers are not readily available. | Quick Win<br>• Identify other research modes that can be adopted to obtain data to be used for outcomes assessment and benefits package design.<br>• As a stopgap measure, utilize existing historical claims data (e.g. 6 – 24 months back) to establish claims patterns of healthcare providers and, on that basis, identify those which need closer monitoring.<br>Long-Term<br>• Implement an updated, integrated Claims | • Several sources of information are:<br>o Claims<br>o MMHR<br>o Survey<br>o Logbook<br>o Member feedback (complaints, etc)<br>• There is a need for a separate Utilization Review unit for this function. |

## Manage Healthcare Provider Relations

| Findings | Recommendations | Comments |
|---|---|---|
| | Processing System, as mentioned above, that will cater to the information needs of various key stakeholders (e.g. Claims, Accreditation and Quality Assurance, Corplan, Executive Committee members, etc). | |
| 8) Accreditation (Central Office) has no operational control over the PROs which makes it difficult to obtain buy-in from the operating groups and get the new policies, guidelines, procedures, etc. implemented. | Quick Win<br>• Continue holding consultative meetings with the operations groups to discuss and address issues with existing benefits, circulars, and policy guidelines as well as and /or discuss and anticipate potential issues and operational impact of policies, circulars, benefits, etc. being developed.<br><br>Medium-Term<br>• Review the organizational setup and reporting lines between the Central Office Accreditation Group and the PRO Accreditation units. Explore a matrix organization where Accreditation Central Office has functional supervision over PROs accreditation personnel. The PRO would have administrative supervision of the PRO Head. | |
| 9) Coordination and communication lines between the Central Office and the PROs with regard to the issuance of new circulars and guidelines can be further enhanced.<br><br>➢ Variations in the interpretation of Philhealth circulars; | Quick Win<br>• Manage the timing of the issuance of circulars Avoid issuing circulars anytime, anyday. For example, a quarterly issuance can be arranged<br>• Post new circulars or amendments to existing ones to the Philhealth website. Assign a staff responsible for posting circulars to the Philhealth website as | • Quarterly issuance can be implemented when situation has already stabilized (within a year's time)<br>• Posting to website is the responsibility of Corcom |

## Manage Healthcare Provider Relations

| Findings | Recommendations | Comments |
|---|---|---|
| ➢ Delay in the transmittal of circulars to PROs -- in some cases, healthcare providers have received copies of the circulars, but PROs have not been provided with their copies of the circulars;<br><br>➢ Inability of healthcare professionals to receive their copies of Philhealth circulars. | soon as the circular is approved.<br>• Send follow-up emails to the PROs to inform them that new circulars have been released, with an electronic copy of the circular.<br>• Update the mailing / emailing list of healthcare providers. Group email the circulars.<br>• Publish the circulars in newspapers of general circulars and newsletters of medical associations; include an advisory to visit the Philhealth website to obtain copies of new circulars, guidelines, and updates to existing ones.<br>• Require the hospitals to post Philhealth circulars in areas frequently visited by their medical staff.<br>• Continue consulting the affected departments, divisions, or PROs on the viability and clarity of the circulars and guidelines prior to release or implementation<br>• For greater clarity of the circulars:<br>➢ Anticipate and illustrate potential scenarios that could result from the implementation of the circular<br>➢ Present calculations to illustrate a point, for complex cases.<br>➢ Compile "Frequently Asked Questions" (FAQs) and official responses to these queries. Post to the Philhealth website to make it accessible to all | • Publication of circulars quite expensive but a must for those with penalty clause or legal impact. Also need to inform UP Law Center.<br>• Tap pharmaceutical representatives, academic institution, PHA, medical associations to help in information dissemination.<br>• Guidelines should be set on the level of consultations needed. Too much consultation can be paralyzing. Currently, consultation is done at the execom level. Execom participants should be responsible for cascading the consultation process in their respective units/departments. |

## Manage Healthcare Provider Relations

| Findings | Recommendations | Comments |
|---|---|---|
| | authorized personnel.<br>• Simulate the implementation of the circular over a designated area, as necessary.<br>• Revisit the procedures of Central Records for releasing circulars to PROs and healthcare providers<br>• Ensure that performance support systems to implement the circulars or guidelines are ready and operational. | |

# APPENDIX E

## SUMMARY OF FINDINGS AND RECOMMENDATIONS

## *MANAGE AND DELIVER BENEFITS*

Business Process Review
Summary of Findings and Recommendations

## Deliver and Manage Benefits

| Findings | Recommendations | Comments |
|---|---|---|
| 1) Claims processing is time-consuming. Philhealth's challenge is to reduce the processing turnaround time from 60 days to 30 days or even shorter. The issues that hamper processing are, as follows :<br>➢ Numerous documentary requirements to support a claim (e.g. operative records); difficulty experienced by healthcare providers in complying with the requirements which results to incomplete submission of documentary requirements to Philhealth | Medium Term<br>• Deploy claims staff temporarily to selected healthcare providers (hospitals) to validate completeness of supporting documentary requirements before submitting the claims form to Philhealth. | • The objective of the recommendation is to minimize the vicious cycle of handling and reprocessing of "return to hospital" claim applications.<br>• As proposed, claims personnel will be deployed only to healthcare providers with frequently noted documentary deficiencies.<br>• It was indicated, however, that the problem with documentary requirements is "internal" to the healthcare providers and cannot be resolved by assigning claims personnel to check completeness at source.<br>• Extending the claims filing period from 60 days to 120 days would be a more responsive solution. |
| ➢ Absence of and / or erroneous encoding of ICD-10 by healthcare providers<br>o Insufficient training of hospital medical clerk on the use of ICD –10<br>o Assigned medical clerks are not paramedics and, therefore, not qualified to identify the correct ICD-10 to use<br>o Turnover in assigned medical records | Quick Win<br>• Provide healthcare providers with a specific timeframe (for ex. 6 months) within which to have their medical records staff properly trained in ICD-10 coding. Thereafter, strictly enforce Philhealth's policy of denying claims due to absence of ICD 10 codes or grossly erroneous codes<br>• Institutionalize the practice of conducting regular consultative meetings (e.g. semi-annually) with | • ICD-10 coding has slowed down medical evaluation during the past months. However, with the medical evaluators' increasing familiarity with the ICD-10 codes, the process has started to cope with its original target.<br>• Philhealth has issued a circular to healthcare providers stating that failure to indicate ICD-10 codes in the claims form is a ground for outright denial of |

## Deliver and Manage Benefits

| Findings | Recommendations | Comments |
|---|---|---|
| staff in hospitals due to resignations<br>o Complexity of the ICD-10 codes<br>o Need by the Philhealth's medical evaluators to reevaluate and correct the erroneous ICD-10 codes<br>o Learning process by Philhealth medical evaluators | healthcare providers with regard to problems encountered in claims applications, including those related to ICD-10 and RVS.<br>• Provide healthcare providers with performance support tools that will aid them in ICD-10 coding, such as, list of frequently used ICD-10 codes, procedures, job aids, etc.<br>• Require trained medical records staff on ICD-10 as prerequisite to accreditation / renewal of accreditation<br>• Assign an ICD-10 coder of the day or week who will focus on ICD-10 coding – as a mechanism to enable the medical evaluators to become thoroughly familiar with ICD-10 codes<br>• Isolate ICD-10 coding from the regular claims process. Encode ICD-10 after the claim has been completely processed.<br><u>Long Term</u><br>• Assign a Healthcare Provider Relations Management Team, composed primarily of personnel from Accreditation and Quality Assurance to:<br>➢ Conduct the regular consultative meetings with the healthcare providers'<br>➢ Gather evidence to support fraudulent claims<br>➢ Monitor compliance of pre-accreditation / accreditation requirements<br>➢ Educate healthcare providers on new Philhealth | claims. The circular, however, is silent on grossly erroneous ICD-10 codes.<br>• Some PROs have either developed their own electronic ICD-10 reference tables or have downloaded the data tables from the internet.<br>• The ICD-10 reference file created by MIS at the Central Office is the most complete. The ICD-10 module to access this file is being pilot tested by the NCR Group.<br>• It would be good for hospitals to prepare a list of frequently-used ICD-10 codes, to avoid having to reference the entire ICD-10 manual.<br>• Assigning an ICD-10 coder of the day or week will not be viable because one or two coders of the day will not be adequate to process all the claims.<br>• Since ICD-10 codes are used primarily for statistical reporting, ICD-10 encoding will be done after a claim has been processed. |

Business Process Review
Summary of Findings and Recommendations

## Deliver and Manage Benefits

| Findings | Recommendations | Comments |
|---|---|---|
| | policies, circulars, accreditation requirements, etc.<br>➢ Identify healthcare providers that need Philhealth claims staff assistance in validating completeness of supporting documentary requirements<br><br>Long-Term<br>• Launch the computerized module for ICD-10 codification nationwide | |
| ➢ Itermized checking of drugs and medicines – need to :<br>o Associate drugs against diagnosis<br>o Check the quantity of dosage vs. illness<br>o Validate drugs dispensed vs. the PDNF and the PHIC short list<br>o Check the cost of drugs charged to the patient | Long-Term<br>• Accelerate the process of defining compensable drugs by case payment - to eliminate tedious checking of drugs and medicines<br><br>• For compensable drugs not identified by case payment —codify the PNDF – to provide medical evaluators with a convenient tool to determine the compensability and prescribed prices of drugs and medicines. | • Guidelines to implement case payment for certain types of illnesses have been developed but not yet implemented.<br><br>• Tedious for Claims<br>• Refer to "Manage Healthcare Provider Relations" for additional comments. |
| ➢ Checking of drugs compounded by the need to check official receipts of drugs bought by the patient – due to nonavailability of prescribed drugs in government hospitals | • Institutionalize the process of LGUs setting up a revolving fund for use in procuring drugs -- frequently dispensed by the government hospitals | • Philhealth segregates payments for drugs and medicines to government hospitals. |

Business Process Review
Summary of Findings and Recommendations

## Deliver and Manage Benefits

| Findings | Recommendations | Comments |
|---|---|---|
| ➢ Lack of information on the veracity of signatures in claims documents (e.g. authorized signatories from employers) | Quick Win<br>• Require corporations / companies to submit updated signature cards of their authorized signing officials – to be used for post-audit of claims. | • MIS will operationalize a system that will capture digitized signatures of authorized signatories from employer companies.<br>• In the long-term, when the Membership and Member Accounts' Databases can be relied upon for eligibility checking, verification of employers' signatures will no longer be necessary.<br>• Signatures of authorized signatories of healthcare providers should be digitized and electronically recorded for online retrieval, as well. |
| ➢ At the PROs, nonavailability of officers to sign checks | Quick Win<br>• Schedule dates for signing of vouchers and checks<br>• As a matter of policy, require one of two signing officers to be present at the office to sign the checks on the designated dates.<br>• Review the list of authorized signatories and their corresponding limits of authority in each region.<br>Medium-Term<br>• Encourage healthcare providers to sign-up for auto-crediting of their accounts for approved claims. | • The issue relates to a potential staffing problem at the PROs. |

Business Process Review
Summary of Findings and Recommendations

## Deliver and Manage Benefits

| Findings | Recommendations | Comments |
|---|---|---|
| ➢ In some PROs, lack of control over Claims-related accounting tasks, such as voucher and check preparation | Quick Win<br>• Assign an accounting staff to be primarily responsible over voucher and check preparation. | |
| ➢ Potential area for lessening data validation<br>o At the Central Office, verification is done after first encoding and validation, after second encoding<br>o In some PROs, a Route Slip is generated after initial encoding, cut, then, attached to the documents.<br>o Reprinting of Benefits Payment Notice (BPN) due to errors identified during voucher and check preparation | Quick Win<br>• Continue to implement the Team Approach at the Central Office. Implement at PROs, where applicable<br>Long-Term<br>• Simplify and streamline the Claims process.<br>➢ Eliminate data verification after first encoding.<br>➢ Implement the following process :<br>o Receive Claims documents<br>o Encode members' PIN / healthcare provider Accreditation No.<br>o Perform medical evaluation<br>o For claims with adjustments or questions, pass through manual processing<br>o Encode the processed claims data (e.g. room and board, drugs, etc)<br>o Validate amount totals.<br>o Generate vouchers and checks<br>o Generate the Benefits Payment Notice (BPN)<br>➢ Allow the medical evaluators and other claims processing staff to sign on the Claims document | • The proposed procedures seek to eliminate the verification of documents after initial encoding and the use of the route slip to track claims documents in process.<br>➢ As explained, initial verification is done to check on the following :<br>o Correctness of members' data encoded into the system<br>o Completeness of documents to support eligibility to avail of Philhealth's benefits as well as currentness of members' contributions<br>➢ On the other hand, the Route Slip is used to track the status of claims documents in process, identify the people responsible for processing claims documents, and logging documentary deficiencies.<br>• The steps mentioned above can be dispensed with when the following conditions have been met :<br>➢ The Claims Processing System |

Business Process Review
Summary of Findings and Recommendations

## Deliver and Manage Benefits

| Findings | Recommendations | Comments |
|---|---|---|
| | itself to eliminate the use of Route Slips<br><br>• Provide Service Office personnel with performance support tools, such as, Operations Manuals, etc. to help them perform their responsibilities effectively | fully integrates with the Membership System (for members' personal data) and the Philhealth Member Accounts Information System (for eligibility checking, based on contributions).<br>➢ The Membership Database is up-to-date and cleansed of erroneous, obsolete, and duplicate data.<br>➢ The Membership Accounts Database is up-to-date with members' contributions.<br>• The implementation of the proposed procedure should, therefore, be recategorized into long-term, rather than quick win. |
| 2) Indications of fraudulent claims have been observed.<br>➢ Higher amount of claims filed by the healthcare providers vs. compensable claims deducted from patients' bills<br>➢ Examples of repeating cases of suspicious claims have been noted<br>➢ Non-prosecution of healthcare providers with repeating cases of fraudulent claims | Quick Win<br>• Require the healthcare providers to attach a copy of the Summary of Statement of Accounts paid for and signed by the member to the Claims documents<br>• Conduct an awareness campaign among members (through the Account Management Team of Marketing) regarding claims benefits<br>• Enforce suspension / revocation of accreditation, based on repeating indications of fraudulent claims<br>• Coordinate with Legal on the level of documentary | • There should be clear policy guidelines on how to handle fraudulent claims and what to look for to prosecute fraudulent cases.<br>• There should also be an Operations Manual for Hospital Monitoring that spells out the following :<br>➢ Qualifications of Philhealth personnel to be involved in Hospital Monitoring<br>➢ Hospital Monitoring procedures to |

Business Process Review
Summary of Findings and Recommendations

## Deliver and Manage Benefits

| Findings | Recommendations | Comments |
|---|---|---|
| | evidence necessary to file a legal case against the hospitals<br>• Authorize the Healthcare Provider Relationship Management Team to conduct onsite inspections of patient admissions and other relevant records (with appropriate permission from the healthcare providers) | be undertaken by the assigned personnel<br>➢ Procedures for handling fraudulent claims and bringing legal action against the erring healthcare provider.<br>• Refer to "Manage Healthcare Provider Relations" for additional comments |
| 3) Lack of information to perform eligibility checking<br>➢ Absence of UCPS interface with the Membership and Member Accounts Information Systems<br>➢ Lack of information to do 45-day eligibility checking<br>o Inability to compile and consolidate all benefits utilized by a member (because of portability of the benefits)<br>o Delayed claims information due to the 60-day grace period to file the claim and the additional 30 or 60 days to process a claim | Quick Win<br>• Include information on previous confinements in the Philhealth Claims form.<br>• Enable the 45-day eligibility checking module of UCPS at the PROs – to, at least, be able to implement the eligibility check within a region.<br>Long-Term<br>• Develop and implement a computerized Claims Processing System that :<br>➢ Integrates with Membership and Member Accounts Information System<br>➢ Keeps a history of past illnesses (ICD-10s) and compensable benefits utilized by member and member dependent<br>➢ Enables claims data sharing across Philhealth offices nationwide<br>• Decentralize the implementation of the integrated | • The 45-day eligibility checking for benefits payment can be strictly enforced only if healthcare providers can :<br>➢ Perform online eligibility checking of members against Philhealth's database<br>➢ Record member or beneficiary admissions to Philhealth's Claims database – immediately upon admission.<br>• With the proposed extension of the claims filing period from 60 days to 120 days, the 45-day eligibility checking, given Philhealth's current technology infrastructure, will become even more difficult.<br>• A proposal has been floated in the past to delete the 45-day eligibility checking |

# Business Process Review
## Summary of Findings and Recommendations

### Deliver and Manage Benefits

| Findings | Recommendations | Comments |
|---|---|---|
| | system to the PROs<br>• Accelerate the implementation of HOMIS by DOH<br>• Enable electronic filing of claims | from the implementing guidelines. The proposal, however, has not been accepted by the Actuarial Group.<br>• HOMIS is being pilot-tested by DOH.<br>• Refer to "Manage Healthcare Provider Relations" for additional comments. |
| 4) Delay in the receipt by the PROs of information about the accredtation / reaccreditation of healthcare providers | PROs<br>Quick Win<br>• Advise healthcare providers of the expiry of their accreditation 4 months in advance<br>• Monitor compliance by hospital providers of requirements for accreditation or re-accreditation<br>• Submit to the Central Office, at least 1 month prior to accreditation expiry, all the mandatory requirements for compliance<br>• Resolve issues that could deter approval of the accreditation by the Accreditation Committee<br>Medium Term<br>• Assign the Healthcare Provider Relationship Management Team to ensure compliance with accreditation requirements<br>Central Office<br>Quick Win<br>• Upon receipt of documentation from the PROs, include the application in the agenda for the | • Clear policy guidelines for accreditation and renewal of accreditation should be developed – so that :<br>➢ Applications that fully comply with Philhealth's accreditation requirements can be reviewed and approved by an Accreditation Group, composed of organic personnel of Philhealth.<br>➢ Only applications with problems and issues are passed on to the Accreditation Committee for deliberations and resolution.<br>• There is an existing interface problem between UCPS and the latest version of the Accreditation System, relating to the Accreditation number generated and issued by the Accreditation System. A workaround has been implemented by MIS to remedy the problem. |

Business Process Review
Summary of Findings and Recommendations

## Deliver and Manage Benefits

| Findings | Recommendations | Comments |
|---|---|---|
| | Accreditation Meeting<br>• Disseminate information on accredited healthcare providers immediately after approval by the Accreditation Committee.<br>Medium-Term<br>• Allow the PROs to update their accreditation databases in their respective sites | • There is a plan to develop a new Claims Processing System to replace UCPS. The Terms of Reference (TOR) is being developed.<br>• Refer to "Manage Healthcare Provider Relations" for additional comments. |
| 5) Policy of allowing individually paying members to avail of benefits after 3 premium payments within a 6-month period – subject to abuse | • Revisit the policy – require at least 12 months premium payments (or as necessary) for specific compensable cases | |
| 6) Coordination and communication lines between the Central Office and the PROs with regard to the issuance of new circulars and guidelines can further be enhanced.<br>➢ Variations in the interpretation of Philhealth circulars<br>➢ Delay in the transmittal of circulars to PROs -- in some cases, healthcare providers have received copies of the circulars, but PROs have not been provided with their copies of the circulars<br>➢ Inability of healthcare providers to receive their copies of Philhealth circulars | Quick Win<br>• Manage the timing of the issuance of circulars<br>• Post new circulars or amendments to existing ones to the Philhealth website. Assign a staff responsible for posting circulars to the Philhealth website as soon as the circular is approved.<br>• Send follow-up emails to the PROs to inform them that new circulars have been released, with an electronic copy of the circular.<br>• Update the mailing / emailing list of healthcare providers. Group email the circulars.<br>• Publish the circulars in newspapers of general circulars and newsletters of medical associations. | • Corplan's SPREAD project will cover the up-to-date posting of circulars to the Philhealth website.<br>• Emphasis was placed on the need for clear guidelines and performance support tools before implementing a new process, policy, or guideline.<br>• Circulars to be mailed through the Central Records Section should be forwarded to Central Records at least two (2) months prior to effectivity. For example, circulars that will take effect in January 2003 should be submitted to Central Records for mailing by |

## Deliver and Manage Benefits

| Findings | Recommendations | Comments |
|---|---|---|
| | include an advisory to visit the Philhealth website to obtain copies of new circulars, guidelines, and updates to existing ones.<br>• Require the hospitals to post Philhealth circulars in areas frequently visited by their medical staff<br>• Consult the affected departments, divisions, or PROs on the viability and clarity of the circulars and guidelines prior to release or implementation<br>• For greater clarity :<br>➢ Anticipate and illustrate potential scenarios that could result from the implementation of the circular<br>➢ Present calculations to illustrate a point, if necessary.<br>• Simulate the implementation of the circular over a designated area, as necessary.<br>• Revisit the procedures of Central Records for releasing circulars to PROs and healthcare providers<br>• Ensure that support systems to implement the circulars or guidelines are ready<br>• Accomplish a Rollout Readiness Checklist to ensure that everything is in place to operationalize a system, new process, etc | November 2002 |

Business Process Review
Summary of Findings and Recommendations

## Deliver and Manage Benefits

| Findings | Recommendations | Comments |
|---|---|---|
| 7) Cases of documents lost in transit from the Service Offices to the PROs | Quick Win<br>• Develop control procedures over the transmittal of documents<br>➢ Bundle and pack the documents safely in boxes, if voluminous<br>➢ Prepare Transmittal Control Slips (one copy to be signed by the recipient as acknowledgment copy)<br>➢ Pinpoint responsibility over the documents | |
| 8) Inaccurate information provided by Information staff to the members | Quick Win<br>• Identify staff who have demonstrated competence in serving as information staff<br>• Continuously train information staff on new Philhealth rulings and member requirements<br>• Provide the information officers with tools (for ex. database of documentary requirements for membership, access to status of claims, etc) to be able to respond promptly to members' / potential members' queries | |

# APPENDIX F

## BUSINESS PROCESS REVIEW

## *IMPLEMENTATION PLAN*

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Upper

| Activities | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Month 7 | Month 8 | Month 9 | Month 10 | Month 11 | Month 12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 |
| General | | | | | | | | | | | | |
| Prioritize Initiatives | | | | | | | | | | | | |
| Create and Mobilize Program Management Secretariat* | | | | | | | | | | | | |
| Identify members and roles | | | | | | | | | | | | |
| Define mandate, guidelines and procedures | | | | | | | | | | | | |
| Issue Office Order | | | | | | | | | | | | |
| Identify Implementation Teams** | | | | | | | | | | | | |
| Identify team composition and roles | | | | | | | | | | | | |
| Issue Office Order | | | | | | | | | | | | |
| Conduct Implementation Planning Workshops (Quick-Win and Medium-Term) | | | | | | | | | | | | |
| Identify implementation goals and metrics; tracking mechanism | | | | | | | | | | | | |
| Conduct detailed impact analysis | | | | | | | | | | | | |
| Identify potential implementation issues; assess change readiness | | | | | | | | | | | | |
| Discuss change management principles | | | | | | | | | | | | |
| Develop detailed workplan and communication plan | | | | | | | | | | | | |
| Identify resource requirements; manpower requirements | | | | | | | | | | | | |
| Update policies, processes, procedures and forms (Operations Manual) | | | | | | | | | | | | |
| Assign implementation roles and responsibilities | | | | | | | | | | | | |
| Identify timetable | | | | | | | | | | | | |
| Roll out quick-win initiatives | | | | | | | | | | | | |
| Prepare foundation for Medium-Term Initiatives | | | | | | | | | | | | |
| Define organization and roles; update job descriptions | | | | | | | | | | | | |
| Enhance systems | | | | | | | | | | | | |
| Develop/update operations manual | | | | | | | | | | | | |
| Design and develop training materials and performance support tools | | | | | | | | | | | | |
| Conduct training and orientation sessions | | | | | | | | | | | | |
| Roll out medium term initiatives | | | | | | | | | | | | |
| Monitor Implementation | | | | | | | | | | | | |
| Assess Results | | | | | | | | | | | | |
| Management Checkpoint | △ | △ | △ | △ | △ | △ | △ | △ | △ | △ | △ | △ |

* The Program Management Secretariat should be led by the Program Management Director, reporting to the CEO.
The various teams, such as BPR for Non-Core Team and Quick-Win Implementation Teams should report to the Program Mangement Director
1-2 Administrative and Technical Staff should assist the Program Management Director

** The Implementation Team should be led by the Process Owner or his/her representative, reporting to the Program Management Director.
The Implementation team should be composed of representatives from operations, HR, and MIS.
The original BPR team member should serve as the resource person.

# APPENDIX G

## BUSINESS PROCESS REVIEW

## *COMMUNICATION PLAN*

## Business Process Review
## General Communication Plan

| Target Audience | Key Messages | Medium | Timing | Responsible | Status |
|---|---|---|---|---|---|
| PhilHealth Employees | • Introduce Business Process Review project; explain:<br>– Rationale<br>– Importance to PhilHealth<br>– Objectives<br>– Scope<br>– Organization and roles | • Memorandum<br>• Newsletter | September 2002 | • Project Team<br>• Corporate Communication | Done |
| PhilHealth Employees | • Discuss status of the project<br>• Discuss next steps | • Memorandum<br>• Newsletter | November 2002 | • Project Team | To be scheduled *(Refer to Appendix H)* |
| Process Owners and Business Process Review Team | • Validate findings and recommendations<br>• Gather comments and feedback | • Presentation / Discussion | November 2002 | • Project Team | Done |
| Executive Committee | • Findings and recommendations<br>• Approval of the recommendations<br>• Implementation Plan<br>• Communication Plan | • Presentation / Discussion | November 2002 | • Project Team | On-going |
| Change Network (FGD Participants) | • Provide update on steps taken after FGDs<br>• Discuss next steps<br>• Discuss future roles | • Letter<br>Memorandum | November 2002 | • Project Team | To be scheduled |
| Process Owners and Implementation Team | • Conduct Implementation Workshop | • Workshop | December 2002 | • Program Management Secretariat | To be scheduled |

November 29, 2002

Greetings!

We would like to reiterate our appreciation for your participation in the Focus Group Discussion (FGD), which we have conducted in relation to the Business Process Review initiative. As small token of our appreciation, we are providing you with a xxxxx and a Certificate of Participation.

We would also like to take this opportunity to give you an update on the status of the Business Process Review. After completing the series of FGDs, we have synthesized the results into an Operations Assessment Report containing our findings and recommendations. The recommendations are envisioned to help PhilHealth achieve operational and process excellence. improve organizational capabilities and address the concerns and issues that you have identified during the FGD.

To gather feedback and comments on the findings and recommendations, we have conducted series of validation meetings with the Process Owners. Presentation and discussion with the Executive Committee are still on-going to get the final management approval to implement the initiatives.

Moving forward, we would like to reiterate your valuable role in implementing the initiatives that will be approved by the Executive Committee, particularly within the next 3 months. As change agents, you are expected to take an active role in espousing the benefits of the initiative to your peers, participate in implementation briefings and training, and act as the role model for the new capabilities that will be rolled out.

The details of the initiative, in terms of scope, duration, extent of change and your specific roles will be communicated to you as soon as they get finalized.

Again, thank you very much.

Business Process Review Team

# PHILIPPINE HEALTH INSURANCE CORPORATION

## OPERATIONS MANUAL
## CORE BUSINESS PROCESSES

January 2003

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# OPERATIONS MANUAL

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| Manage Contributions<br>• Process Flows<br>• Procedural Narratives<br>• Forms<br>• Policies |
| Manage HealthCare Provider Relations<br>• Process Flows<br>• Procedural Narratives<br>• Forms<br>• Policies |
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# MANAGE MEMBERSHIP AND MEMBER RELATIONS

## PROCESS FLOWS

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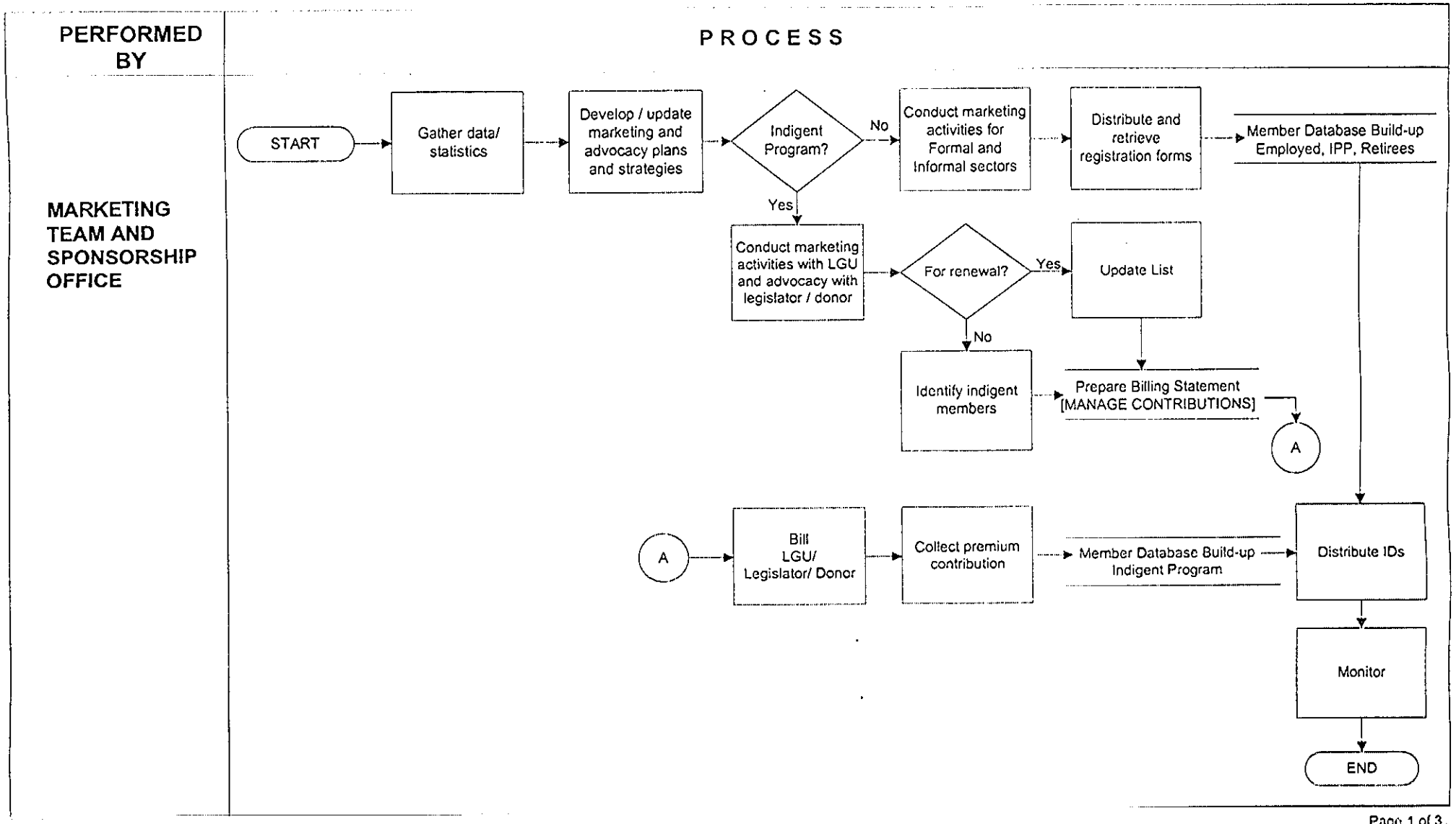
| 2 | Database Buildup – Employed, Individually-Paying, Retirees | 2 |
| 3 | Database Buildup – Indigent Program | 3 |

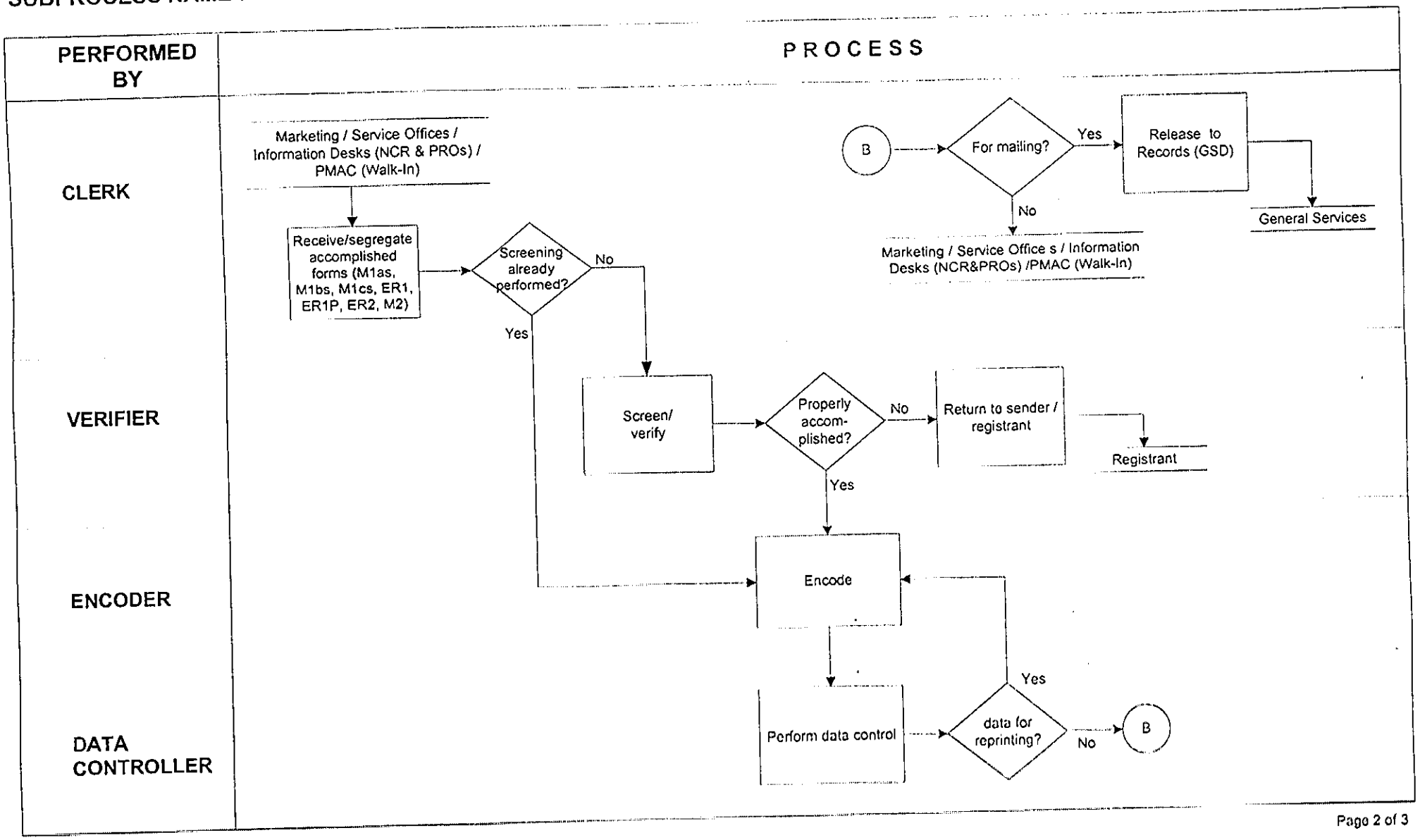
PROCESS NAME : MEMBERSHIP MANAGEMENT
SUBPROCESS NAME : MARKETING FOR FORMAL AND INFORMAL SECTORS






PHILIPPINE HEALTH INSURANCE CORPORATION

PROCESS NAME : MANAGE MEMBERSHIP AND MEMBER RELATIONS
SUBPROCESS NAME : DATABASE BUILDUP - EMPLOYED, INDIVIDUALLY PAYING, RETIREES






PHILIPPINE HEALTH INSURANCE CORPORATION

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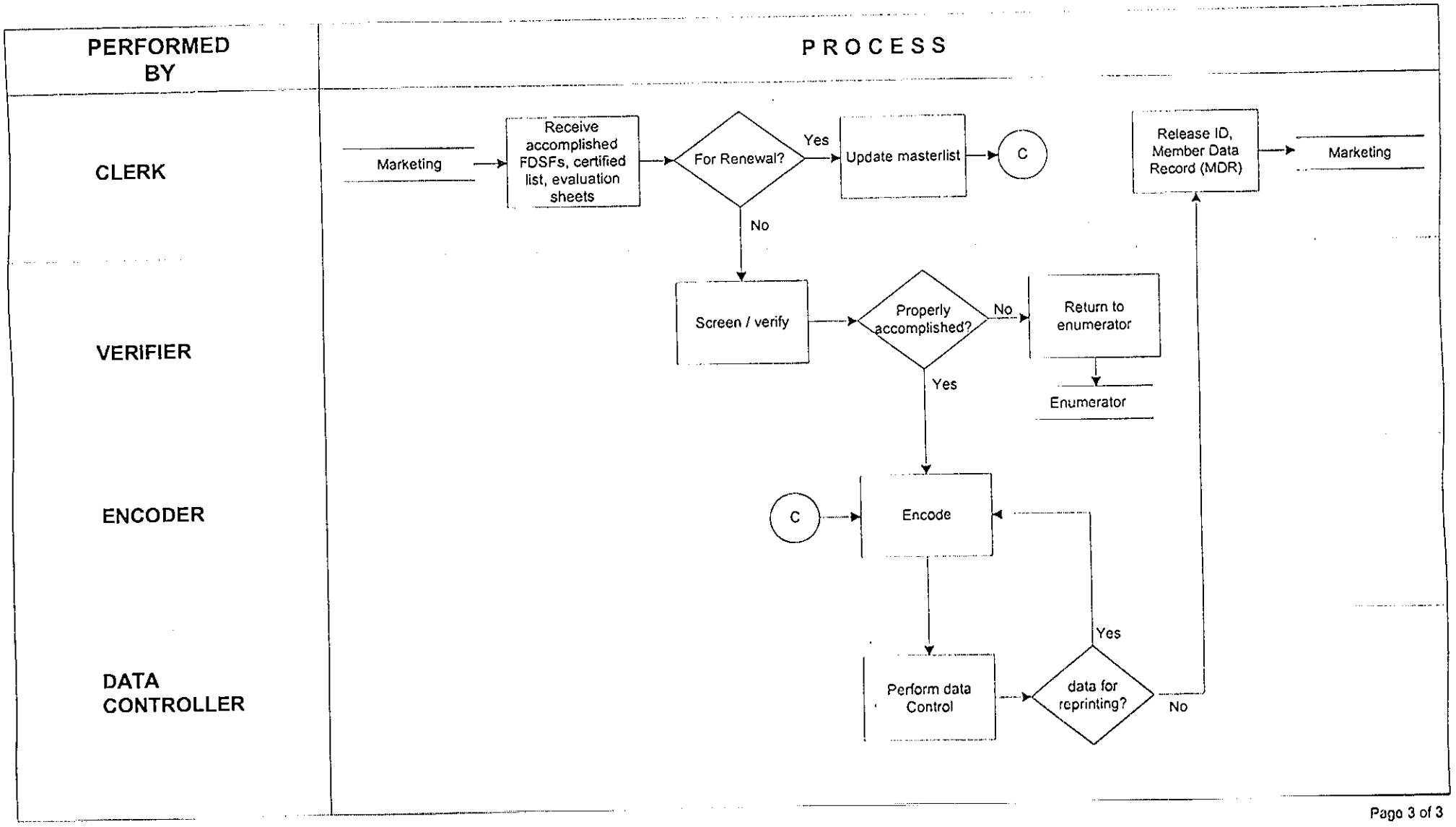
PROCESS NAME : MANAGE MEMBERSHIP AND MEMBER RELATIONS
SUBPROCESS NAME : DATABASE BUILD-UP - INDIGENT PROGRAM






PHILIPPINE HEALTH INSURANCE CORPORATION

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# MANAGE MEMBERSHIP AND MEMBER RELATIONS

## PROCEDURAL NARRATIVES

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| 1 | Marketing of Formal and Informal Sectors | 1 |
| 2 | Database Buildup – Employed, Individually-Paying, Retirees | 12 |
| 3 | Database Buildup – Indigent Program | 13 |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| | reflected in the Memorandum of Agreement (MOA).<br><br>3.1.8 Coordinate MOA signing.<br><br>3.1.8.1 Prepare program of activities and IEC materials.<br><br>3.1.8.2 Coordinate with Corporate Communications Department for tri-media requirement of the event/ activity, if necessary.<br><br>3.1.8.3 Conduct IEC/orientations among local health workers, etc. regarding the Program.<br><br>3.1.8.4 Finalize MOA for signing upon concurrence of PhilHealth and LGU officials.<br><br>3.1.9 Work on the issuance of the certificate of funds availability (CFA).<br><br>3.1.10 Facilitate accreditation in coordination with the Accreditation and Quality Assurance Office in PROs. |
| LEGISLATIVE SPONSORSHIP OFFICE, NCR GROUP, AND PHILHEALTH REGIONAL OFFICES | 3.2 Undertake advocacy activities with the legislators and donors for sponsorship of IP<br><br>3.2.1 Advocate with legislators:<br><br>3.2.1.1 Prepare briefing materials and information kit containing proposal on Legislative Sponsorship Program, action plan, timetable of activities, budget requirement / feasibility study on how to sustain the funding of the Indigent Program.<br><br>3.2.1.2 Prepare and send official letters of communication along with the information kit to proponents.<br><br>3.2.1.3 Conduct orientation / briefing.<br><br>3.2.1.4 Negotiate for commitment to sponsor IP. |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| MARKETING TEAM FOR INDIGENT PROGRAM (IP) | **3. CONDUCT MARKETING ACTIVITIES WITH LGUs AND ADVOCACY WITH LEGISLATORS AND DONORS FOR ADOPTION OF INDIGENT PROGRAM** |
| | 3.1 Market and network with the LGU. |
| | 3.1.1 Schedule briefing / orientation in coordination with respective LGUs' point person / advocate. |
| | 3.1.2 Prepare/update presentation material ("Medicare para sa Masa": A National Priority Program) for orientation. |
| | 3.1.3 Update/enhance IEC materials. |
| | 3.1.4 Conduct orientation seminar / briefing. |
| | 3.1.5 Seek approval / commitment of LGU for the adoption of IP. |
| | 3.1.6 Negotiate for commitment to implement IP: |
| | 3.1.6.1 Propose/coordinate with the city or municipal council the issuance of resolution for IP adoption and passing of ordinance for the allocation of funds and setting up of PhilHealth Capitation Fund (PCF). |
| | 3.1.6.2 Determine the number of indigent families to be enrolled. |
| | 3.1.6.3 Identify accredited health service providers / facilities. Conduct pre-assessment of rural health units (RHUs) and health centers (HCs). |
| | 3.1.7 If necessary, coordinate the creation of aTechnical Working Group in order to : |
| | 3.1.7.1 Clarify the terms and conditions for IP implementation. |
| | 3.1.7.2 Set qualifying standards for the identification of indigent families. |
| | 3.1.7.3 Craft provisions that would be |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| | reflected in the Memorandum of Agreement (MOA). |
| | 3.1.8 Coordinate MOA signing. |
| | 3.1.8.1 Prepare program of activities and IEC materials. |
| | 3.1.8.2 Coordinate with Corporate Communications Department for tri-media requirement of the event/ activity, if necessary. |
| | 3.1.8.3 Conduct IEC/orientations among local health workers, etc. regarding the Program. |
| | 3.1.8.4 Finalize MOA for signing upon concurrence of PhilHealth and LGU officials. |
| | 3.1.9 Work on the issuance of the certificate of funds availability (CFA). |
| | 3.1.10 Facilitate accreditation in coordination with the Accreditation and Quality Assurance Office in PROs. |
| LEGISLATIVE SPONSORSHIP OFFICE, NCR GROUP, AND PHILHEALTH REGIONAL OFFICES | 3.2 Undertake advocacy activities with the legislators and donors for sponsorship of IP |
| | 3.2.1 Advocate with legislators: |
| | 3.2.1.1 Prepare briefing materials and information kit containing proposal on Legislative Sponsorship Program, action plan, timetable of activities, budget requirement / feasibility study on how to sustain the funding of the Indigent Program. |
| | 3.2.1.2 Prepare and send official letters of communication along with the information kit to proponents. |
| | 3.2.1.3 Conduct orientation / briefing. |
| | 3.2.1.4 Negotiate for commitment to sponsor IP. |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| LEGISLATIVE SPONSORSHIP OFFICE, NCR GROUP, AND PHILHEALTH REGIONAL OFFICES | • Coordinate with the Office of the Legislator the submission of the LOI or Letter of Intent (Exhibit 1) and attached Format/ Proforma of Program/ Project Profile (Exhibit 2) for submission to the Committee on Appropriations for allocation from the Priority Development Assistance Fund (PDAF) of premium counterpart to enroll indigent families to the Program.<br><br>• Work on the issuance / release of Special Allotment Release Order (SARO) with a copy furnished to the Office of the Legislator.<br><br>• Coordinate issuance of resolution / ordinance with concerned LGU/s and submit a copy to the Office of the Legislator.<br><br>• Coordinate drafting / finalization and signing of MOA.<br><br>• Prepare/finalize activities for MOA signing ceremonies. |
| PRIVATE AND OTHER DONORS SPONSORSHIP OFFICE,<br>NCR GROUP AND PHILHEALTH OFFICES | 3.2.2 Advocate with private, National Government agencies, other donors for sponsorship:<br><br>3.2.2.1 Prepare and enhance briefing materials and information kit on Private and other Donors Sponsorship Program, feasibility study to sustain sponsorship to IP, information on priority areas the donor intends to cover, number of indigent families proposed to be enrolled, proposed timetable of activities.<br><br>3.2.2.2 Conduct orientation / briefing.<br><br>3.2.2.3 Negotiate for commitment to sponsor IP.<br>• Facilitate the donor's signing the Letter of Intent (Exhibit 3) addressed to the concerned LGU |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| PRIVATE AND OTHER DONORS SPONSORSHIP OFFICE, NCR GROUP AND PHILHEALTH OFFICES | formalizing the sponsorship of IP in its area.<br>• Work on the issuance of resolution / ordinance with concerned LGU, copy of which is furnished to the donor.<br>• Coordinate drafting/ finalization and signing of tripartite MOA.<br>• Draft / finalize MOA for execution of PhilHealth and Sponsor, if multiple areas are proposed for coverage prior to signing of tripartite MOA.<br>• Prepare program of activities for the MOA signing ceremonies.<br>• Work on the issuance of PhilHealth Certificate of Donation to the donor for applicable tax deductions. |
| MARKETING TEAM FOR INDIGENT PROGRAM / LGU / DONORS SPONSORSHIP OFFICES, NCR GROUP AND PROS | 3.3 Identify indigent members.<br>3.3.1 Coordinate conduct of enumeration:<br>3.3.1.1 Tap enumerators and orient / train them in the administration of the Family Data Survey Form (Exhibit 4).<br>3.3.1.2 Coordinate conduct of the survey with the local Social Welfare Development Officer (LSWDO) and concerned city/municipality barangay captain.<br>3.3.1.3 Prepare service contract (Exhibit 5. Enumeration Agreement) for the enumerators.<br>3.3.1.4 Ensure that the enhanced Enumeration Procedures as per PhilHealth Office Order ___ (Exhibit 6) are followed in the conduct of enumeration. |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| MARKETING TEAM FOR INDIGENT PROGRAM / LGU / DONORS SPONSORSHIP OFFICES, NCR GROUP AND PROS | 3.3.2 Retrieve and provide comprehensive review of accomplished Family Data Survey Form (FDSF) based on PhilHealth's set standards.<br><br>3.3.2.1 Return improperly accomplished form to enumerators for correction / clarification.<br><br>3.3.2.2 Facilitate certification of indigent families' masterlist to be issued by the LSWDO and/or barangay captain.<br><br>3.3.2.3 Forward properly accomplished forms for encoding and ID generation.<br>(Refer to sub-process for Database Build-up for Indigent Program) |
| MARKETING TEAM FOR INDIGENT PROGRAM / PROGRAM SPONSORSHIP OFFICE | 3.4 Facilitate renewal of indigent membership.<br><br>3.4.1 Advocate for increased number of indigent membership in addition to renewal of current members.<br><br>3.4.2 Send notice of payment to LGUs / sponsors three months before end of effectivity date of a certain batch of members.<br><br>3.4.2.1 Facilitate updating of masterlist and issuance of certification by the LSWDO/barangay captain.<br><br>3.4.2.2 Encode new names of indigents who replaced old members as indicated in the masterlist for the generation of ID.<br><br>3.4.3 Transmit billing statement to LGU / proponent.<br>(Refer to sub-process for Billing and Collection of LGU Indigent Accounts under "Manage Contributions") |
| MARKETING TEAM FOR INDIGENT PROGRAM / PROGRAM SPONSORSHIP OFFICE | 4. **FACILITATE COLLECTION** of premium payment from:<br><br>4.1 LGUs<br>4.2 Legislators |



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| Job/Unit Responsible | Activity/ Task |
|---|---|
| | 4.3 Donors (NGAs, private, etc.) |
| MARKETING TEAM FOR INDIGENT PROGRAM / PROGRAM SPONSORSHIP OFFICE | 5 **DISTRIBUTE ID** cards in coordination with concerned proponents. If formal ceremonies are necessary:<br><br>5.1 Prepare program of activities.<br><br>5.2 Distribute IEC materials in coordination with local advocates/health workers.<br><br>5.3 Coordinate with CorpComm on the tri-media requirements of the activity/event.<br><br>5.4 Prepare / send communication / invitations to all concerned. |
| MARKETING TEAM FOR INDIGENT PROGRAM / PROGRAM SPONSORSHIP OFFICE | **6. MONITOR AND EVALUATE PROGRAM ACTIVITIES**<br><br>6.1 Coordinate with LGU for the implementation of Out Patient Benefit (OPB) package:<br><br>6.1.1 Ensure requirements are complied with such as:<br><br>▪ Accreditation of RHUs and HCs with PhilHealth.<br><br>▪ Adherence to OPB supplemental guidelines.<br><br>6.1.2 Prepare schedule of release of PhilHealth fund capitation (PCF).<br><br>6.2 Evaluate / assess over-all program implementation.<br><br>6.3 Submit assessment / monitoring and evaluation report.<br><br>6.4 Prepare memo letter addressed to Program Management Group for Membership and Marketing. |
| MARKETING TEAM FOR INDIGENT PROGRAM / PROGRAM SPONSORSHIP OFFICE | **7. CONDUCT CUSTOMER MANAGEMENT.**<br><br>7.1 Ensure members' inquiries / complaints and other concerns are appropriately managed and administered. |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| MARKETING TEAMS FOR FORMAL AND INFORMAL SECTORS | **8. CONDUCT MARKETING ACTIVITIES FOR THE FORMAL AND INFORMAL SECTORS**<br><br>8.1 Undertake marketing with employees and employers in the government and private sectors, and with individually-paying particularly in organized groups / associations in the informal sector.<br><br>8.1.1 Schedule promotional campaign/orientation seminar in coordination with the Human Resources Department (HRD) or unit of agencies in the formal sector and with point person/advocate of organized groups in the informal sector.<br><br>8.1.2 Prepare/update orientation material/s (National Health Insurance Program).<br><br>8.1.3 Use/update/enhance IEC materials.<br><br>8.1.4 Conduct orientation seminar. |
| MARKETING TEAMS FOR FORMAL AND INFORMAL SECTORS | **9. DISTRIBUTE MEMBERSHIP / REGISTRATION FORMS** (Exhibits 7 - 13).<br><br>9.1 For the formal sector:<br><br>• M1a form (Exhibit 7. Member Data Record for Employed Sector)<br><br>• ER1 form (Exhibit 8. Employer Data Record)<br><br>• ER1P form (Exhibit 9. Employer's Data Record for Private Sector)<br><br>• ER2 form (Exhibit 10. Report of Employee Member)<br><br>9.2 For the informal sector:<br><br>• M1b form (Exhibit 11. Member Data Record for Individually Paying)<br><br>9.3 For member retirees:<br><br>• M1c form (Exhibit 12. Member Data Records for Non-Paying Members)<br><br>9.4 For all members of both sectors: |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| MARKETING TEAMS FOR FORMAL AND INFORMAL SECTORS | 12.5 Submit periodic reports. |

| Job / Unit Responsible | Activity / Task |
|---|---|
| CLERK | 1. RECEIVE accomplished registration forms and request for amendments, along with documentary requirements from marketing teams, PMAC/walk-in, employers through mail/correspondence.<br><br>1.1 Sort and segregate forms / required documents according to membership category. (Refer to Step 8 of the sub-process for Marketing for Formal and Informal Sectors)<br><br>1.2 Control/record all incoming documents.<br><br>1.3 Forward documents to concerned unit/section. |
| VERIFIER | 2. SCREEN accomplished registration forms with attached documentary requirements.<br><br>2.1 Verify/evaluate initial or subsequent forms filed.<br><br>2.2 Note for deficiencies. If the form is not properly filled-up, return to sender / registrant (RTS) for corresponding action.<br><br>2.3 Forward properly accomplished forms for encoding. |
| ENCODER | 3. ENCODE screened forms, requests for changes / amendments.<br><br>3.1 Print Member Data Record (MDR). |
| EDITOR / DATA CONTROLLER | 4. PERFORM data control.<br><br>4.1 Review and edit / effect necessary changes on MDR. |
| ENCODER | 5. GENERATE PhilHealth Number Card (PNC):<br><br>5.1 Reprint MDR.<br><br>5.2 Print PNC. |
| CLERK | 6. Release PNC and MDR.<br><br>6.1 Classify, match MDR to corresponding M1a / M1b / M1c and attach PNC.<br><br>6.2 Release PNC, copy of processed registration form, and MDR to: |

| Job / Unit Responsible | Activity / Task |
|---|---|
| | 6.2.1 Walk-in member (PhilHealth Membership Assistance Center or PMAC). |
| | 6.2.2 Marketing staff for distribution to individually paying members (IPMs) through information desks in LGUs and service offices. |
| | 6.2.3 Central records (GSD) for mailing / transmittal to agencies/employers in NCR and PROs. |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| CLERK | 1. **RECEIVE ACCOMPLISHED FAMILY DATA SURVEY FORM (FDSF)** for the Indigent Program along with documentary requirements from marketing team for IP.<br><br>1.1 Control/record incoming documents:<br><br>1.1.1 Properly filled-up FDSFs (Exhibit 4).<br><br>1.1.2 Certified list.<br><br>1.1.3 Evaluation sheets, ES1 and ES2.<br><br>1.2 Label FDSFs by batch according to LGU/sponsor.<br><br>1.3 Forward documents for screening and to encoding documents (ES1 and ES2) that need updating for membership renewal. |
| VERIFIER | 2. **SCREEN ACCOMPLISHED FDSFs** vis-a-vis certified lists.<br><br>2.1 Verify/evaluate FDSFs for completeness of entries, correctness / accuracy as to income vs. poverty threshold.<br><br>2.2 Note for deficiencies and return to enumerator/s for corresponding action.<br><br>2.3 Forward screened forms for encoding. |
| ENCODER | 3. **ENCODE SCREENED FDSFs** for initial membership and replacements based on updated certified list and evaluation sheets for membership renewal. |
| DATA CONTROLLER / EDITOR | 4. **REVIEW / VALIDATE / EDIT** encoded data vis-à-vis FDSFs, Masterlist, evaluation sheets. |
| ENCODER | 5. **GENERATE IDs.**<br><br>5.1 Print ID cards, Member and Dependent masterlists, Member Receiving Sheets.<br><br>5.2 Print summary of replacement report. |
| CLERK | 6. **RELEASE ID CARDS.**<br><br>6.1 Endorse to Marketing staff for distribution. |

# MANAGE MEMBERSHIP AND MEMBER RELATIONS

## FORMS

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| Exhibit No | PARTICULARS |
|---|---|
| 1 | Format of Letter of Intent (Legislative Sponsorship Program) |
| 2 | Proforma / Format of Program / Project Profile |
| 3 | Format of Letter of Intent (Donor Sponsorship Program) |
| 4 | Family Data Survey Form (FDSF) |
| 5 | Enumeration Agreement (Service Contract Proforma for FDSF Enumerators) |
| 6 | Enumeration Procedure (Per Office Order ___) |
| 7 | M1a Form – Member Data Record for Employed Sector |
| 8 | ER1 Form – Employer Data Record |
| 9 | ER1P Form – Employers Data Record for Private Sector |
| 10 | ER2 – Report of Employee – Member |
| 11 | M1b Form – Member Data Record for Individually Paying |
| 12 | M1c Form – Member Data Record for Non Paying |
| 13 | M2 Form – Member Data Amendment Form |

EXHIBIT 1

Format of Letter of Intent (Legislative Sponsorship Program)

09 February 2002

OFFICE ORDER
No. 22, s. 2002

FOR : ALL CONCERNED OFFICIALS AND STAFF

SUBJECT : Guidelines for the Implementation of PhilHealth *"Medicare Para sa Masa"* Through Legislative Sponsorship

---

## 1. RATIONALE

The Philippine Health Insurance Corporation (PhilHealth) is mandated by law to provide a mechanism for every Filipino to gain financial access to health services through the National Health Insurance Program (NHIP). A component of the NHIP is the Indigent Program or the PhilHealth *"Medicare Para sa Masa"* Program which is specifically designed to make quality and affordable health care accessible to the marginalized sector of our society.

Through the said program, the national government and the local government unit (LGU) jointly subsidize the annual premium contributions for indigent families. Due to the financial constraint of some LGUs to pay for their premium counterpart, the Corporation taps other sources of funds. One such possible fund source is the Priority Development Assistance Fund (PDAF) of the members of the House of Representatives.

## 2. COVERAGE

All Legislator-initiated enrollment of indigent families to the PhilHealth *"Medicare Para sa Masa"* Program through PDAF.

## 3. GENERAL FRAMEWORK ON THE DELINEATION OF FUNCTIONS/ACTIVITIES IN THE IMPLEMENTATION OF THE LEGISLATIVE SPONSORSHIP PROGRAM

A delineation of specific functions/activities to be undertaken by the Program Management Group, Legislative Sponsorship Office of the NCR Group and the PhilHealth Regional Office was made for the proper and orderly implementation of the Legislative Sponsorship Program *(Please refer to "Annex A" for the PMG-LSO-PRO Rules of Engagement).*

## 4. OPERATING PROCEDURES *(Refer to Annex "B")*

### 4.1 Legislator's intention to enroll indigent families

a. PhilHealth initiates negotiations with the legislator for the adoption of the **PhilHealth** *"Medicare Plan sa Masa"* Program. If the Legislator manifests intent, then the Legislator coordinates with the **concerned PhilHealth Regional Office (PRO)** and the LGU's regarding his intention to enroll indigent families in his district.

b. The Legislator submits proposal for the allocation of a portion of the Priority Development Assistance Fund (PDAF) to the House Committee on Appropriation to enroll indigent families to the **PhilHealth** *"Medicare Plan sa Masa"* Program *(Please refer to Annex "C")*.

c. When approved, the House Committee on Appropriation endorses the proposal to the Department of Budget and Management (DBM) for approval.

d. The DBM will issue the Special Allotment Release Order (SARO) to the implementing agency, copy furnished the Legislator.

### 4.2 Memorandum of Agreement (MOA)

a. The concerned LGU's shall pass a resolution adopting the Indigent Program and submit said resolution to the Office of the Legislator. The LGU being referred to may be the province, city, municipality or barangay where the indigent member resides.

PhilHealth and the Legislator shall enter into a Memorandum of Agreement. However, the concerned LGU's may directly participate in the Memorandum of Agreement, as may be warranted.

b. The Memorandum of Agreement shall provide for the implementation of Phase I and Phase II of the **PhilHealth** *"Medicare Plan sa Masa"* Program. However, implementation of Phase II shall commence only upon compliance of all requirements and procedures as set forth in the Out Patient Consultation and Diagnostic Package Guidelines.

### 4.3 FDSF survey to identify indigent families

a. PhilHealth, in coordination with the Office of the Legislator, shall coordinate with the concerned LGU's and the local Social Welfare Officer or the barangay social workers on the identification of indigent households.

b. The local Social Welfare Officer or barangay social worker of the covered LGU prepares a list of indigent families included in the survey. The said list will be certified by the local Social Welfare Officer or barangay social worker, in the case of barangay, and concurred in by the Local Chief Executive (LCE). A Local Chief Executive may be a Provincial Governor, city/Municipal Mayor or a Barangay Captain.

c. The accomplished FDSFs with the Certified List of Eligible Indigent Families shall be transmitted to PhilHealth, copy furnished the Legislator .

d. If the surveyed indigent family does not qualify, the concerned LGU's is notified for possible replacement or coverage under the IPP.

4.4 PhilHealth *Medicare Para sa Masa* ID generation and distribution

a. After validation, PhilHealth encodes and generates PhilHealth *Medicare Para sa Masa* IDs for distribution to target beneficiaries by the Congressman and the LGU's concerned.
b. The space allotted at the back portion of the ID may be utilized by the Congressman for his signature, logo, or any message he wants to place therein.
c. PhilHealth and the concerned LGU's conducts an Information Education Campaign to beneficiaries to orient on the benefits of the Program.

4.5 Effectivity of Membership

Membership is effective on the date indicated in the ID and is valid for one year. Membership to the Program shall be renewed annually.

4.6 Remittance of Premium Contribution

a. From the time the SARO is released, a continuous follow-up by PhilHealth, LGU and the Office of the Legislator for the release of the NCA should be undertaken.
b. Once the PhilHealth *Medicare Para sa Masa* IDs are distributed, PhilHealth bills the LGU for the remittance of the LGU premium counterpart if the NCA is coursed through the LGU. However, if the NCA is released to PhilHealth, it will no longer be necessary to bill the LGU.
c. As soon as the LGU premium counterpart is remitted, PhilHealth bills DBM for the release of the corresponding national government premium counterpart.

5. EFFECTIVITY

This Order shall take effect immediately.

FRANCISCO T. DUQUE III, M.D., M.Sc.
*President and Chief Executive Officer*

Annex "C"
Sample Letter of Intent

Republic of the Philippines
House of Representatives
Quezon City, Metro Manila

OFFICE OF THE CONGRESSMAN
_____ District
Province/City of _____

(Date)

HON. ROLANDO ANDAYA, JR.
Chairman
Committee on Appropriations
House of Representatives
Batasan Hills, Quezon City

Dear Chairman Andaya:

I hereby request the allocation of _____ (P_____.00) for the payment of the LGU premium counterpart for the enrollment of qualified indigent families in my district to the PhilHealth *Medicare Para sa Masa* Program of the Philippine Health Insurance Corporation (PhilHealth). The requested amount shall be chargeable against the Priority Development Assistance Fund (PDAF) of my District.

For details, attached herewith is the Program/Project Profile.

Thank you and look forward for the immediate approval of this request.

Very truly yours,

_____
Legislator

EXHIBIT 2

Proforma / Format of Program / Project Profile

PROGRAM/PROJECT PROFILE

| PROGRAM/PROJECT DESCRIPTION | LOCATION | PROGRAM/ PROJECT COST | IMPLEMENTING AGENCY |
|---|---|---|---|
| 1. Financial assistance to the City/ Municipality/Barangay of _____ in the Province of _____ to be released to the Philippine Health Insurance Corporation (PhilHealth) as payment for the local government premium counterpart for the enrollment of qualified indigent families to the PhilHealth *Kalusugan Para sa Masa* Program. | LGU's concerned | Pxxx,xxx.00 | Philippine Health Insurance Corporation |

BEST AVAILABLE COPY

# EXHIBIT 3

## Format of Letter of Intent (Donor Sponsorship)

## SAMPLE LETTERS OF INTENT (For PhilHealth and LGU)

FRANCISCO T. DUQUE III, M.D., MSc
*President & Chief Executive Officer*
Philippine Health Insurance Corporation
CityState Centre Building
709 Shaw Blvd., Pasig City

Dear Sir:

Greetings!

The _____(name of organization)_____ is interested in being part of PhilHealth *"Medicare Para Sa Masa"* Program and sponsor (*number to be enrolled*) indigent members from the _____(name of LGU and area)_____ .As such, we shall be assuming the required premium counterpart of aforesaid local government with the understanding that PhilHealth shall be providing the national government premium counterpart.

We believe that this would be a significant step in making social health insurance accessible to the Filipino poor.

Thank you.

Very truly yours,

LEONARD G. CASTAÑEDA
*President*
ABC Corporation

HON. JOSE ATIENZA
*Mayor*
City of Manila

Dear Sir:

Greetings!

The _____(name of organization)_____ is interested in being part of PhilHealth *'Medicare Para Sa Masa'* Program and sponsor (*number to be enrolled*) indigent members from the _____(name of LGU and area)_____. As such, we shall be assuming the required premium counterpart of aforesaid local government with the understanding that PhilHealth shall be providing the national government premium counterpart.

We believe that this would be a significant step in making social health insurance accessible to the Filipino poor.

Thank you.

Very truly yours,

LEONARD G. CASTAÑEDA
*President*
ABC Corporation

Draft Letter of Intent

Republic of the Philippines
House of Representatives
Quezon City, Metro Manila

HON. _____
Representative
_____ District _____

FRANCISCO T. DUQUE III, M.D., MSc
President and Chief Executive Officer
Philippines Health Insurance Corporation
CityState Center Building
709 Shaw Blvd., Pasig City

Dear Sir:

This is to acknowledge with thanks receipt of the project proposal "Medicare para sa Masa" that was presented to my office.

I believe in the advocacy for better and more accessible health services for the underprivileged. As such, I am allocating part of my Priority Development Assistance Fund (PDAF) for the fiscal year 2002, in the amount of _____ (P_____) as premium payment for the enrollment of underprivileged families in my District to the Indigent Program of PhilHealth.

Thank You.

Very truly yours,

*Legislator*



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EXHIBIT 4

Family Data Survey Form (FDSF)

Revised July 2002

Annex A

Republic of the Philippines

OFFICE OF THE SOCIAL WELFARE AND DEVELOPMENT OFFICER

FAMILY ADDRESS

Street Name

Barangay

REGION

PROVINCE

CITY/MUNICIPALITY

BARANGAY

GREATER MEDICARE ACCESS

# FAMILY DATA SURVEY FORM

FAMILY COMPOSITION

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | NAME (including the member) Surname First Name Middle Initial | RELATION TO MEMBER | SEX | CIVIL STATUS | DATE OF BIRTH | EDUCATION | OCCUPATION | OCCUPATIONAL STATUS | MONTHLY INCOME | ACTIVE MEMBER OF PHILHEALTH | (For Disabled) NATURE OF DISABILITY | HEALTH/ NUTRITION STATUS | IMMUNIZATION |
| | MEMBER | | | | | | | | P | | | | |
| 1 | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | |
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| 13 | | | | | | | | | | | | | |
| 14 | | | | | | | | | | | | | |

TOTAL MONTHLY HOUSEHOLD/FAMILY INCOME P

TOTAL ANNUAL HOUSEHOLD/FAMILY INCOME P

ANNUAL PER CAPITA INCOME (APCI) P

| | A | B |
|---|---|---|
| | APCI Validation | Recommendation |
| | | |

NAME OF RESPONDENT

(Signature over Printed Name)

ADMINISTERED BY

DESIGNATION

DATE

NOTE: Use black or blue colored ink pen. Write legibly and do not abbreviate.

201

# REMINDERS (*Paalala*)

Qualified dependents of a member under RA 7875 are: (*Ang mga karapatdapat na makikinabang ng isang miyembro/kasapi alinsunod sa R.A. 7875 ay ang mga sumusunod*:)

1. The legitimate spouse who is not a member of PhilHealth: (*tunay na asawa na hindi kasapi ng PhilHealth*)

2. The unmarried and unemployed legitimate, legitimated, acknowledged and illegitimate children as appearing in the birth certificate, legally adopted or stepchildren below twenty-one (21) years of age: (*walang asawa at walang trabaho na anak, anak sa tunay na asawa* (legitimate o legitimated), *kinikilalang anak na nakasaad sa Birth Certificate, ampon ayon sa batas o kaya'y anak sa unang asawa na ang edad/gulang ay mababa sa 21*).

3. Children who are twenty-one years old or above but suffering from congenital disability, either physical or mental, or any disability acquired before the age of 21 that renders them totally dependent on the member for support. (*mga anak na ang edad/gulang ay 21 o pataas subalit may likas na kapansanang pangkatawan o pangkaisipan o ano pa mang uri ng kapansanan na natamo bago sumapit sa edad na 21 na maglalagay sa kanila para lubusang umasa sa kasapi para sa kanyang ikabubuhay*);

4. The parents who are sixty (60) years old or above who are not enrolled members of PhilHealth whole montly income is not more than One Thousand Pesos (P 1,000.00). (*mga magulang na ang edad/gulang ay 60 o pataas at hindi kasapi ng PhilHealth na ang buwanang kita ay hindi hihigit sa Isang Libong Piso* (P 1,000.00)

101

EXHIBIT 5

Enumeration Agreement (Service Contract Proforma for FDSF Enumerators)

# ENUMERATION AGREEMENT

*KNOW ALL MEN BY THESE PRESENTS:*

This Agreement entered into by and between:

The **PHILIPPINE HEALTH INSURANCE CORPORATION**, a government corporation organized and existing by virtue of Republic Act No. 7875, otherwise known as the National Health Insurance Act of 1995, duly represented herein by _____, Assistant Vice-President, PhilHealth Regional Office- ___, with office address at _____ herein referred to as **PhilHealth**, the **Corporation** or the **First Party**;

-and-

Mr./Ms. _____, of legal age, Filipino, with postal address at _____ herein referred to as the **Local Social Welfare and Development Officer (LSWDO)** of the **City/Municipality** of _____ or the **Second Party**.

**WITNESSETH:**

**WHEREAS**, the Philippine Constitution mandates the State to adopt an integrated and comprehensive approach to health development, which shall endeavor to make essential goods, health and social services available to all citizens at affordable cost;

**WHEREAS**, the National Health Insurance Act of 1995, in recognition of the need to provide all citizens with the mechanism to gain financial access to health services, created the National Health Insurance Program (NHIP) to serve as the means to help the people pay for the same;

**WHEREAS**, the Provincial/City/Municipal Government of _____ and PhilHealth acknowledge their joint responsibility, through a Memorandum of Agreement signed and executed between the aforementioned parties, to provide a basic package of needed personal health services for the social and economic well being of the residents of the former, specifically the marginalized and the underprivileged, with the implementation of the Indigent Program or PhilHealth *(Medicare para sa Masa)*;

**WHEREAS**, the identification/renewal of the indigent households under the Community-Based Information System – Minimum Basic Needs (CBIS-MBN) Approach, spearheaded by the Local Social Welfare and Development Office (LSWDO), requires the services of the contractors/enumerators, with appropriate qualifications to facilitate and expedite the identification/renewal process.

**WHEREAS**, Section 22 of the Implementing Rules and Regulations of Republic Act 7875 stipulates that the Corporation and other concerned government agencies shall provide technical, manpower and financial assistance, if necessary, in the conduct, administration, and management of CBIS-MBN;

**NOW THEREFORE**, for and in consideration of the foregoing premises, the parties hereto have agreed, as they hereby agree and bind themselves, as follows:

1. The **Local Social Welfare and Development Officer (LSWDO)** shall facilitate the enumeration/accomplishment of the Family Data Survey Form (FDSF) or Evaluation Sheets (ES Form 1 with corresponding FDSF) which shall be conducted by the contractors/enumerators for _____ households within _____ days after the execution of this Agreement;

2. For Services rendered, the **Corporation** shall pay the contractors/enumerators through an official Payroll to be executed by the **LSWDO** the amount of **TEN PESOS ONLY (P 10.00)** for every household actually interviewed/surveyed as evidenced by a duly accomplished FDSF. Provided that the aggregate number of FDSFs/ES shall not exceed one hundred ten percent (110%) of the committed households as agreed upon between the Local Government Unit (LGU) concerned and PhilHealth. In exceptional circumstances, the OVP-NCR/PRO-AVP may determine a reasonable number of FDSFs allowed for submission;

3. The LSWDO shall issue a certification as to the completion of the enumeration process for a certain number of households after full completion of the identification/renewal process which shall be the basis of disbursing the required enumerator's fees/administrative cost;

4. Upon full completion of the interview/survey process, the LSWDO shall gather all documents and survey forms from the contractors/enumerators for validation as to the qualification of the household based on the Poverty Threshold of the Local Government Unit (LGU) concerned and the Annual Per Capita Income of the family as defined in PhilHealth Circular No. 36, s. 2001;

5. This Agreement shall remain valid until the completion of the identification/renewal process, unless sooner terminated by either party by giving a prior five (5) days written notice to the other party or by an action by the PhilHealth Board terminating the identification/renewal process.

IN WITNESS WHEREOF, the parties herein have signed this Agreement on this _____day of _____ 2002 at _____. Philippines.

| | |
|---|---|
| **Philippine Health Insurance Corporation (PhilHealth)** | **Office of the L.S.W.D. Officer City/Municipality of _____** |
| By: | |
| _____ | _____ |
| **Assistant Vice-President** | **LSWDO** |

**SIGNED IN THE PRESENCE OF**

_____ _____

## ACKNOWLEDGEMENT

**Republic of the Philippines )**
**_____ ) s.s.**

**BEFORE ME**, on this _____ day of _____ 2002 at _____. Philippines, personally appeared:

| | Comm. Tax Cert. No. | Date/Place of Issue |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

known to me to be the same persons who executed the foregoing instrument and acknowledged that the same is their free act and voluntary deed and that of the corporation being represented. This Agreement consists of two (2) pages including the page in which this Acknowledgement is written.

**WITNESS MY HAND** and **SEAL** on this date and in the place first above-written.

**NOTARY PUBLIC**

Doc. No. _____;
Page No. _____;
Book No. _____;
Series of 2002.

# ENUMERATION AGREEMENT

*KNOW ALL MEN BY THESE PRESENTS:*

This Agreement entered into by and between:

The **PHILIPPINE HEALTH INSURANCE CORPORATION**, a government corporation organized and existing by virtue of Republic Act No. 7875, otherwise known as the National Health Insurance Act of 1995, duly represented herein by _____, Assistant Vice-President, PhilHealth Regional Office- ___, with office address at _____ herein referred to as **PhilHealth, the Corporation** or the **First Party;**

-and-

Mr./Ms. _____, of legal age, Filipino, with postal address at _____ herein referred to as the **Barangay Chairperson of Barangay** _____, **City/Municipality of** _____ or the **Second Party.**

**WITNESSETH:**

**WHEREAS**, the Philippine Constitution mandates the State to adopt an integrated and comprehensive approach to health development, which shall endeavor to make essential goods, health and social services available to all citizens at affordable cost;

**WHEREAS**, the National Health Insurance Act of 1995, in recognition of the need to provide all citizens with the mechanism to gain financial access to health services, created the National Health Insurance Program (NHIP) to serve as the means to help the people pay for the same;

**WHEREAS**, the Provincial/City/Municipal Government of _____ and PhilHealth acknowledge their joint responsibility, through a Memorandum of Agreement signed and executed between the aforementioned parties, to provide a basic package of needed personal health services for the social and economic well being of the residents of the former, specifically the marginalized and the underprivileged, with the implementation of the Indigent Program or PhilHealth *"Medicare para sa Masa"*;

**WHEREAS**, the identification/renewal of the indigent households under the Community-Based Information System – Minimum Basic Needs (CBIS-MBN) Approach, spearheaded by the Local Social Welfare and Development Office (LSWDO), requires the services of the contractors/enumerators, with appropriate qualifications to facilitate and expedite the identification/renewal process.

**WHEREAS**, Section 22 of the Implementing Rules and Regulations of Republic Act 7875 stipulates that the Corporation and other concerned government agencies shall provide technical, manpower and financial assistance, if necessary, in the conduct, administration, and management of CBIS-MBN;

**NOW THEREFORE**, for and in consideration of the foregoing premises, the parties hereto have agreed, as they hereby agree and bind themselves, as follows:

1. The **Barangay Chairperson/Representative** shall facilitate the enumeration/accomplishment of the Family Data Survey Form (FDSF) or Evaluation Sheets (ES Form 1 with corresponding FDSF) which shall be conducted by the contractors/enumerators for _____ households within _____ days after the execution of this Agreement;

2. For Services rendered, the **Corporation** shall pay the contractors/enumerators through an official Payroll to be executed by the **Barangay Chairperson/Representative** the amount of **TEN PESOS ONLY (P 10.00)** for every household actually interviewed/surveyed as evidenced by a duly accomplished FDSF. Provided that the aggregate number of FDSFs/ES shall not exceed one hundred ten percent (110%) of the committed households as agreed upon between the Local Government Unit (LGU) concerned and PhilHealth. In exceptional circumstances, the OVP-NCR/PRO-AVP may determine a reasonable number of FDSFs allowed for submission;

3. The **Barangay Chairperson/Representative** shall issue a certification as to the completion of the enumeration process for a certain number of households after full completion of the

identification/renewal process which shall be the basis of disbursing the required enumerator's fees/administrative cost;

4. Upon full completion of the interview/survey process, the **Barangay Chairperson/Representative** shall gather all documents and survey forms from the contractors/enumerators for validation as to the qualification of the household based on the Poverty Threshold of the Local Government Unit (LGU) concerned and the Annual Per Capita Income of the family as defined in PhilHealth Circular No. 36, s. 2001;

5. This Agreement shall remain valid until the completion of the identification/renewal process, unless sooner terminated by either party by giving a prior **five (5) days** written notice to the other party or by an action by the **PhilHealth** Board terminating the identification/renewal process.

**IN WITNESS WHEREOF**, the parties herein have signed this Agreement on this _____day of _____ 2002 at _____. Philippines.

| | |
|---|---|
| **Philippine Health Insurance Corporation (PhilHealth)** | **Office of the Barangay Chairperson City/Municipality of _____** |
| By: | |
| _____ | _____ |
| **Assistant Vice-President** | **Barangay Chairperson/Representative** |

**SIGNED IN THE PRESENCE OF**

_____ _____

## ACKNOWLEDGEMENT

**Republic of the Philippines )**
**_____ ) s.s.**

**BEFORE ME**, on this _____ day of _____ 2002 at _____. Philippines, personally appeared:

| | Comm. Tax Cert. No. | Date/Place of Issue |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

known to me to be the same persons who executed the foregoing instrument and acknowledged that the same is their free act and voluntary deed and that of the corporation being represented. This Agreement consists of two (2) pages including the page in which this Acknowledgement is written.

**WITNESS MY HAND** and **SEAL** on this date and in the place first above-written.

**NOTARY PUBLIC**

Doc. No. _____;
Page No. _____;
Book No. _____;
Series of 2002.

# CONTRACT OF SERVICE

*KNOW ALL MEN BY THESE PRESENTS:*

This Contract entered into by and between:

The LOCAL SOCIAL WELFARE AND DEVELOMENT OFFICE (LSWDO) of _____, with office address at _____, herein represented by its Head, _____, herein referred to as LSWDO;

-and-

Mr./Ms. _____ of legal age, Filipino with postal address at _____ herein referred to as the CONTRACTOR/ENUMERATOR;

## WITNESSETH

**WHEREAS,** the LSWDO shall facilitate the identification/renewal of indigent members through the conduct of enumeration within their area of responsibility;

**WHEREAS,** due to the limited manpower of the LSWDO to undertake enumeration process, the said activity requires the services of the CONTRACTOR/ENUMERATOR, with appropriate qualifications to facilitate and expedite the identification / renewal process.

**NOW, THEREFORE,** for and in consideration of the foregoing premises, the parties hereto have agreed, as they hereby agree and bind themselves, as follows:

1 The CONTRACTOR/ENUMERATOR shall undertake the enumeration/accomplishment of the Family Data Survey Form (FDSF)/Evaluation Sheets (ES Form 1 with corresponding FDSF) for _____ households within _____ days after the execution of this Contract;

2. The CONTRACTOR/ENUMERATOR shall perform such functions and services assigned by the LSWDO or its duly designated representative, subject to the submission of report of his/her output in full matters relevant to the identification process;

3. The CONTRACTOR/ENUMERATOR shall diligently and with utmost truthfulness carry out the survey/interview to determine qualified indigents within the territorial jurisdiction of the City/Municipality of _____;

4. Upon full completion of the interview/survey process, the CONTRACTOR/ENUMERATOR shall submit all documents and Family Data Survey Forms to the LSWDO;

5. It shall be the responsibility of the CONTRACTOR/ENUMERATOR to submit and report to the Bureau of Internal Revenue the corresponding income tax for compensation received from the Philippine Health Insurance Corporation (PhilHealth) for services rendered; and

6. This Contract shall remain valid until the completion of the identification/renewal process, unless sooner terminated by either party by giving a prior five (5) days written notice to the other party or by an action by the PHIC Board terminating the identification process.

IN WITNESS WHEREOF, the parties have hereunto signed this Contract of Service this ___ day of _____ 2002, at _____, Philippines.

By:

_____ (Head)
Local Social Welfare Officer

_____ (Contractor/ Enumerator)

SIGNED IN THE PRESENCE OF

_____ _____

EXHIBIT 6

Enumeration Procedure (Per Office Order ___)

*Republic of the Philippines*
PHILIPPINE HEALTH INSURANCE CORPORATION
CITYSTATE CENTRE BUILDING
709 Shaw Boulevard, Pasig City
Tel. Nos. 637-9999 Loc. 1908, 637-6454, Fax 637-6459

20 February 2002

*Annex "H"*

DRAFT

# OFFICE ORDER

No. _____, s. 2002

TO : THE SENIOR VICE PRESIDENTS, VICE PRESIDENTS, ASSISTANT VICE PRESIDENTS, DEPARTMENT MANAGERS, OPERATIONAL UNIT HEADS, AND ALL OTHERS CONCERNED

SUBJECT : ENHANCED ENUMERATION PROCEDURES

---

## 1.0 PURPOSE

For greater efficiency and effectiveness in the identification of the National Health Insurance Program's (NHIP) indigent members, the following revised Family Data Survey Form (FDSF)-based enumeration procedures are hereby prescribed:

## 2.0 CONDUCT OF ENUMERATION

### 2.1 CITY/MUNICIPAL-BASED CERTIFICATION

2.1.1 The NCR Group (NCRG)/PhilHealth Regional Office (PRO) shall transmit the revised FDSFs (Annex E) to the concerned Local Social Welfare and Development Office (LSWDO);

2.1.2 The NCRG/PRO shall orient the enumerators on the proper accomplishment of the FDSFs and on the conduct of survey in coordination with the LSWDO and concerned Barangay;

2.1.3 The contractors/enumerators shall interview any knowledgeable and responsible member of the household nominated for enrollment to the National Health Insurance Program (NHIP);

2.1.4 The contractors/enumerators shall accomplish the FDSFs and review the completeness and accuracy of information gathered;

2.1.5 The Barangay Chairperson or his/her representative shall gather the FDSFs and recommend/endorse the surveyed family/household based on the qualification for enrollment by checking the appropriate box in the FDSF;

2.1.6 The Barangay Chairperson or his/her representative shall transmit the FDSFs to the Head of the LSWDO using the pro-forma letter of transmittal (Annex E.1);

2.1.7 The LSWDO shall validate the qualification of the families/households based on the Annual Per Capita Income (APCI) vis-à-vis Annual Per Capita Poverty Threshold of the locality by checking the appropriate box in the FDSF;

2.1.8 The LSWDO shall prepare a Certified List of Eligible Indigent Families based on validated FDSFs (Annex E.2) and endorse the same to the City/Municipal Mayor using the pro-forma transmittal letter (Annex E.3);

2.1.9 The City/Municipal Mayor shall endorse the Certified List of Eligible Indigent Families together with the corresponding FDSFs to the Office of the Vice-President for NCR (OVP-NCR)/Office of the Assistant Vice-President (OAVP) of the PRO concerned for processing using the pro-forma letter of transmittal (Annex E.4);

2.1.10 For Sponsorship Programs, the City/Municipal Mayor may forward the FDSFs and Certified List of Eligible Indigent Families thru the sponsor concerned who endorses the same to the OVP-NCR/OAVP concerned using the pro-forma transmittal letter (Annex E.5);

2.1.11 The NCRG/PRO shall verify/validate/review the FDSFs and the Certified List and encode it for ID generation.

## 2.2 BARANGAY-BASED CERTIFICATION

2.2.1 The NCRG/PRO shall transmit the revised Family Data Survey Forms (FDSFs) to the concerned Barangay;

2.2.2 The NCRG/PRO shall orient the enumerators on the proper accomplishment of the FDSFs and on the conduct of survey in coordination with the Barangay;

2.2.3 The contractors/enumerators shall interview any knowledgeable and responsible member of the household nominated for enrollment to the NHIP;

2.2.4 The contractors/enumerators shall accomplish the FDSFs and review the completeness and accuracy of information gathered;

2.2.5 The Barangay Chairperson or his/her representative shall gather and recommend/endorse the surveyed family/household based on the qualification for enrollment by checking the appropriate box in the FDSF;

2.2.6 The Barangay Chairperson or his/her representative shall validate the qualification of the families/households based on the Annual Per Capita Income vis-à-vis Annual Per Capita Poverty Threshold of the locality by checking the appropriate box in the FDSF;

2.2.7 The Barangay Chairperson shall prepare a Certified List of Eligible Indigent Families based on validated FDSFs (Annex E.7) together with the corresponding FDSFs to the OVP-NCR/OAVP concerned using the pro-forma letter of transmittal (Annex E.6);

2.2.8 For Sponsorship Programs, the Barangay Chairperson may forward the FDSFs and Certified List of Eligible Indigent Families thru the sponsor concerned (e.g. legislator, private entity/individual, national government agency, etc.) who endorses the same to the OVP-NCR/OAVP using the pro-forma transmittal letter (Annex E.5)

## 3.0 ENUMERATION RULES AND ENUMERATION FEES

3.1 The total number of Family Data Survey Forms (FDSFs) submitted to NCRG/PRO shall not exceed one hundred ten percent (110%) of the committed number of households as agreed upon between the Local Government Unit (LGU) concerned and PhilHealth. In exceptional circumstances, the OVP-NCR/OAVP-PRO may determine a reasonable number of FDSFs allowed for submission;

3.2 Each enumerator shall survey a maximum of two hundred (200) households or any reasonable number as may be determined by the LSWDO/Barangay, provided that enumeration process does not exceed a period longer than forty five (45) calendar days or such other reasonable time frame as may be agreed upon between the LSWDO/Barangay and PhilHealth .

3.3 The Corporation shall pay the contractors/enumerators an amount not exceeding TEN PESOS (P10.00) per FDSF for the enumeration process for both urban and rural areas. FDSF-based evaluation procedure for the renewal of NHIP membership under the Indigent Program shall also be covered by this TEN PESOS (P10.00) per FDSF rule, subject to any procedural enhancements as may be prescribed by the Corporation.

3.4 The LSWDO shall receive from the Corporation ONE HUNDRED PESOS (P100.00) per fifty (50) FDSFs accomplished and submitted to NCRG/PROs to cover for administrative costs such as transportation expenses, photocopying, etc. and/or honorarium. This provision for the administrative cost shall be released to the LSWDO and shall be distributed as follows: 50% to the Head of LSWDO and the remaining 50% to the other LSWDO staff directly involved in the conduct of enumeration;

3.5 In case of Barangay-based Certification, the honorarium of ONE HUNDRED PESOS (P100.00) per fifty (50) FDSFs accomplished and submitted to NCRG/PROs shall be payable to the Barangay, in accordance with Section 23 (p), Article V of Republic Act 7875.

## 4.0 ENUMERATION AGREEMENT AND OTHER LEGAL DOCUMENTS

4.1 The conduct of enumeration shall be covered by an Enumeration Agreement (Annex A/A.1) which shall define the institutional arrangement between the Philippine Health Insurance Corporation and the Local Social Welfare and Development Office (LSWDO)/Barangay;

4.2 The signatories of the Enumeration Agreement shall be the Vice President for NCR/Assistant Vice-President of the PRO concerned and the Head of the LSWDO/Barangay Chairperson;

4.3 The NCRG/PRO shall ensure that appropriate logistic support are available such as the reproduction of forms and purchase of enumeration paraphernalia for the identification of indigent households within its area of jurisdiction;

4.4 The NCRG/PRO shall orient the Head of the LSWDO/Barangay Chairperson regarding the uniform computation of poverty threshold in consideration of the Poverty Threshold Income based on the 2000 National Statistical Coordination Board (NSCB) data and pursuant to PhilHealth Circular No. 36, series of 2001;

4.5 The NCRG/PRO units concerned should ensure that all Agreements/Contracts are forwarded immediately to the OVP-NCR/ OAVP-PRO for signing and notarization. (Annexes A/A.1 and B/B.1) including its supporting documents (Annexes C/C.1 and D/D.1);

4.6 The Head of the Local Social Welfare and Development Office (LSWDO)/ Barangay Chairperson or his representative shall oversee the conduct of survey/enumeration and shall be responsible for the compliance by the enumerators to the requirements/rules set forth herein as basis for disbursing the enumerator's fees/administrative cost;

4.7 Preparation of the disbursement voucher shall be done by NCRG/PRO concerned after full completion of the identification of qualified members, attachments of which include the (a) Enumeration Agreement (b) Certificate of Accomplishment (c) Certified List of Eligible Indigent Members and (d) Contract of Service;

4.8 For the proper dispensation of enumeration fees and administrative costs, the LSWDO, in the case of Municipal-based Certification, and the Barangay Chairperson in the case of Barangay-based Certification, shall be responsible for the accomplishment of an official payroll whose original copy thereof shall be forwarded to the NCRG/PRO concerned (Annex D/D.1);

4.9 Provision for administrative costs shall be released after the submission of the Payroll signed by the contractors/enumerators and duly certified by the LSWDO/Barangay Chairperson as to the authenticity of the contractors'/enumerators' signatures;

4.10 Payment of enumeration fees shall be chargeable to the enumeration budget of the NCRG/PRO and/or Program Management for Membership and Marketing.

## 5.0 EFFECTIVITY

This Office Order shall take effect immediately and shall supersede Office Order Nos. 306, s-1999 and 223, s-2001.

FRANCISCO T. DUQUE III, M.D., M.Sc.
*President and Chief Executive Officer*

| | | | |
|---|---|---|---|
| | | | |
| VAL S. VALILA<br>VP for Membership & Marketing | Date | GREGORIO C. RULLODA<br>OIC, OSVP for Operations | Date |
| | | | |
| MELINDA C. MERCADO<br>Chief Operating Officer | Date | MA. OFELIA O. ALCANTARA, M.D., M.P.H.<br>Head Executive Assistant | Date |

# CONTRACT OF SERVICE

*KNOW ALL MEN BY THESE PRESENTS:*

This Contract entered into by and between:

BARANGAY _____, a political entity organized and existing under the laws of the Republic of the Philippines, represented herein by its Barangay Chairman _____, hereinafter referred to as the BARANGAY.

-and-

Mr./Ms. _____ of legal age, Filipino with postal address at _____ herein referred to as the CONTRACTOR/ENUMERATOR;

## WITNESSETH

WHEREAS, the BARANGAY shall facilitate the identification/renewal of indigent members through the conduct of enumeration within their area of responsibility;

WHEREAS, due to the limited manpower of the BARANGAY to undertake enumeration process, the said activity requires the services of the CONTRACTOR/ENUMERATOR, with appropriate qualifications to facilitate and expedite the identification/renewal process.

NOW, THEREFORE, for and in consideration of the foregoing premises, the parties hereto have agreed, as they hereby agree and bind themselves, as follows:

1. The CONTRACTOR/ENUMERATOR shall undertake the enumeration/accomplishment of the Family Data Survey Form (FDSF)/Evaluation Sheets (ES Form 1 with corresponding FDSF) for _____ households within _____ days after the execution of this Contract;

2. The CONTRACTOR/ENUMERATOR shall perform such functions and services assigned by the BARANGAY or its duly designated representative, subject to the submission of report of his/her output in full matters relevant to the identification process;

3. The CONTRACTOR/ENUMERATOR shall diligently and with utmost truthfulness carry out the survey/interview to determine qualified indigents within the territorial jurisdiction of Barangay _____;

4. Upon full completion of the interview/survey process, the CONTRACTOR/ENUMERATOR shall submit all documents and Family Data Survey Forms to the BARANGAY;

5. It shall be the responsibility of the CONTRACTOR/ENUMERATOR to submit and report to the Bureau of Internal Revenue the corresponding income tax for compensation received from the Philippine Health Insurance Corporation (PhilHealth) for services rendered; and

6. This Contract shall remain valid until the completion of the identification/renewal process, unless sooner terminated by either party by giving a prior five (5) days written notice to the other party or by an action by the PHIC Board terminating the identification process.

IN WITNESS WHEREOF, the parties have hereunto signed this Contract of Service this ___ day of _____ 2002, at _____, Philippines.

By:

_____ **(Head)**
Barangay Chairperson

_____ **(Contractor/ Enumerator)**

SIGNED IN THE PRESENCE OF

_____ _____

Republic of the Philippines

PROVINCE of _____

City/Municipality of _____

OFFICE OF THE LOCAL SOCIAL WELFARE AND DEVELOPMENT OFFICER

## CERTIFICATE OF ACCOMPLISHMENT

This is to certify that the Family Data Survey Forms (FDSFs)/Evaluation Sheets (ES Forms 1 & 2 with corresponding FDSF) hereto attached were accomplished completely, truthfully, and legibly by _____, Contractor/Enumerator, who conducted the enumeration of the attached list of proposed members to the National Health Insurance Program (NHIP).

_____

*Local Social Welfare and Development Officer*

Republic of the Philippines

PROVINCE of _____

City/Municipality of _____

Barangay _____

OFFICE OF THE BARANGAY CHAIRPERSON

# CERTIFICATE OF ACCOMPLISHMENT

This is to certify that the Family Data Survey Forms (FDSFs)/Evaluation Sheets (ES Forms 1 & 2 with corresponding FDSF) hereto attached were accomplished completely, truthfully, and legibly by _____, Contractor/Enumerator, who conducted the enumeration of the attached list of proposed members to the National Health Insurance Program (NHIP).

_____

*Barangay Chairperson*

Annex D (pro-forma)

Page ___
Journal Voucher No. ___

# PAYROLL FOR CONTRACTORS/ENUMERATORS

PO - _____
PU - _____

WE HEREBY ACKNOWLEDGE to have received from Philippine Health Insurance Corporation, through the Local Social Welfare and Development Officer the sums therein specified opposite our respective names being in full compensation for our services for the period _____, except as noted otherwise in the Remarks Column.

| No. | Name | No. of FDSFs Accomplished | Total Amount Received | Signature | Remarks |
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I hereby certify that the enumerators/contractors whose authentic signatures appear above duly received their full compensation for services rendered as evidenced by their signatures.

_____
Local Social Welfare and Development Officer

117

Annex D.1 (pro-forma)

Page ___
Journal Voucher No. ___

# PAYROLL FOR CONTRACTORS/ENUMERATORS

RO - _____
GU - _____

WE HEREBY ACKNOWLEDGE to have received from Philippine Health Insurance Corporation, through the Barangay Chairperson the sums therein specified opposite our respective names being in full compensation for our services for the period _____, except as noted otherwise in the Remarks Column.

| No. | Name | No. of FDSFs Accomplished | Total Amount Received | Signature | Remarks |
|---|---|---|---|---|---|
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| TAL | | | | | |

I hereby certify that the enumerators/contractors whose authentic signatures appear above duly received their full compensation for services rendered as evidenced by their signatures.

_____
Barangay Chairperson/Representative

Annex E.1

Republic of the Philippines
PROVINCE of _____
City/Municipality of _____
Barangay of _____

# OFFICE OF THE BARANGAY CHAIRPERSON

*(date)*

_____
*Local Social Welfare and Development Officer*
City/Municipality of _____

Dear _____:

I would like to formally indorse for your concurrence/validation the herewith list of household/families for possible enrollment to the PhilHealth *Medicine Para sa Masa'* Program

Based on the accomplished Family Data Survey Forms (FDSFs), the listed names of households/families whose annual per capita income fall below the poverty threshold for this locality are hereby certified as poor households/families of our barangay.

The determination of poor households/families was based on existing poverty threshold levels pursuant to PhilHealth Circular No. 36 s. 2001, and in conjunction with the Community-Based Information System Minimum Basic Needs (CBIS-MBN) approach.

Attached are the corresponding FDSFs of the above-mentioned households/families.

Thank you very much.

Very truly yours,

_____
*Barangay Chairperson*

Republic of the Philippines
PROVINCE of _____
City/Municipality of _____
Barangay of _____

# OFFICE OF THE LOCAL SOCIAL WELFARE AND DEVELOPMENT OFFICER

## LIST OF POOR HOUSEHOLDS/FAMILIES

| BARANGAY | NAME OF HOUSEHOLD/FAMILY HEAD *(in alphabetical order)* *(Surname, First Name, Middle Initial)* |
|---|---|
| | 1. |
| | 2. |
| | 3. |
| | 4. |
| | 5. |
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| | 34. |
| | 35. |

Noted by :

_____
*Barangay Chairperson*

Certified true and correct :

_____
*City/Municipal Social Welfare and Development Officer*

Republic of the Philippines
PROVINCE of _____
City/Municipality of _____

# OFFICE OF THE LOCAL SOCIAL WELFARE AND DEVELOPMENT OFFICER

*(date)*

The HONORABLE

_____
*Governor/Mayor*
Province/City/Municipality of _____

Dear Governor/Mayor _____:

May I formally indorse for your concurrence the herein list of household/families for possible enrollment to the PhilHealth *'Medicare Para sa Masa'* Program.

Based on the accomplished Family Data Survey Forms (FDSFs), the listed names of households/families whose annual per capita income fall below the poverty threshold for this locality are classified and certified as poor households/families.

The determination of poor households/families was based on existing poverty threshold levels in conjunction with the Community-Based Information System Minimum Basic Needs (CBIS-MBN) approach of the Department of Social Welfare and Development (DSWD).

Attached are the corresponding FDSFs of the above-mentioned households/families.

Thank you very much.

Very truly yours,

_____
*Local Social Welfare and Development Officer*

Annex E.4

Republic of the Philippines
PROVINCE of _____
City/Municipality of _____

# OFFICE OF THE GOVERNOR/MAYOR

(*date*)

**FRANCISCO T. DUQUE, M.D., MSc.**
*President and Chief Executive Officer*
Philippine Health Insurance Corporation
Citystate Centre Bldg., Pasig City

ATTENTION: _____
*Vice-President for NCR/Assistant Vice-President for PRO* ___

Dear **President Duque** :

I am pleased to submit herewith the list of beneficiaries for possible enrollment to the PhilHealth *'Medicare para sa Masa'* Program.

Attached are the duly Certified List of Indigent Households/Families and the corresponding Family Data Survey Forms (FDSFs) for your perusal and appropriate action.

Thank you very much.

Very truly yours,

_____
*Governor or City/Municipal Mayor*

( S P O N S O R )

(*date*)

FRANCISCO T. DUQUE, M.D., MSc.
*President and Chief Executive Officer*
Philippine Health Insurance Corporation
Citystate Centre Bldg., Pasig City

ATTENTION: _____
*Vice-President for NCR/Assistant Vice-President for PRO* ___

Dear **President Duque**:

I am pleased to submit herewith the list of beneficiaries for possible enrollment to the PhilHealth *'Medicare Para sa Masa'* Program.

Attached are the duly Certified List of Indigent Households/Families and the corresponding Family Data Survey Forms (FDSFs) for your perusal and appropriate action.

Thank you very much.

Very truly yours,

_____
*Sponsor*

Republic of the Philippines
PROVINCE of _____
City/Municipality of _____
Barangay _____

# OFFICE OF THE BARANGAY CHAIRPERSON

(*date*)

FRANCISCO T. DUQUE, M.D., MSc.
*President and Chief Executive Officer*
Philippine Health Insurance Corporation
Citystate Centre Bldg., Pasig City

ATTENTION: _____
*Vice-President for NCR/Assistant Vice-President for PRO* ___

Dear **President Duque**:

I am pleased to submit herewith the list of beneficiaries for possible enrollment to the PhilHealth *"Medicare para sa Masa"* Program.

Attached are the duly Certified List of Indigent Households/Families and the corresponding Family Data Survey Forms (FDSFs) for your perusal and appropriate action.

Thank you very much.

Very truly yours,

_____
*Barangay Chairperson*

Republic of the Philippines
PROVINCE of _____
City/Municipality of _____
Barangay _____

# OFFICE OF THE BARANGAY CHAIRPERSON

## LIST OF POOR HOUSEHOLDS/FAMILIES

| NAME OF HOUSEHOLD/FAMILY HEAD *(In alphabetical order)* *(Surname, First Name, Middle Initial)* |
|---|
| 1. |
| 2. |
| 3. |
| 4. |
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| 35. |

Certified true and correct :

_____
*Barangay Chairperson*

# ENUMERATION PROCESS FLOW

## CITY/MUNICIPAL-BASED CERTIFICATION

RT

**PhilHealth (NCR Group/PRO)**

- transmits the Family Data Survey Forms (FDSFs) to the Local Social Welfare and Dev't Officer (LSWDO)
- orients the enumerators on the proper accomplishment of the FDSFs and conduct of survey in coordination with LSWDO

**Contractor/Enumerator**

- interviews responsible member of households nominated for enrollment to NHIP
- accomplishes FDSFs
- reviews completeness and accuracy of information gathered

**Barangay Chairperson/Representative**

- gathers FDSFs
- recommends/endorses the surveyed family/household based on the qualification for enrollment by checking on the appropriate box in the FDSF
- transmits FDSFs to the LSWDO using the pro-forma letter of transmittal (Annex E.1)

**Local SWDO**

- validates qualification of family/household based on computed APCI
- certifies List of Eligible Indigent Families using pro-forma list (Annex E.2)
- endorses certified list to the City/Municipal Mayor for concurrence using the pro-forma transmittal letter (Annex E.3)

**City/Municipal Mayor**

- concurs with the certified List of Eligible Indigent Families
- endorses FDSFs to PhilHealth (PRO and NCR Group) together with Certified List of Indigent Families for processing using pro-forma letter of transmittal (Annex E.4)
- *Optional for Sponsorship Programs:* forwards FDSFs and certified list of eligible indigent families thru the sponsor concerned who endorses the same to the NCR Group/PRO using the pro-forma letter of transmittal (Annex E.5)

**PhilHealth (NCR Group and/or PRO)**

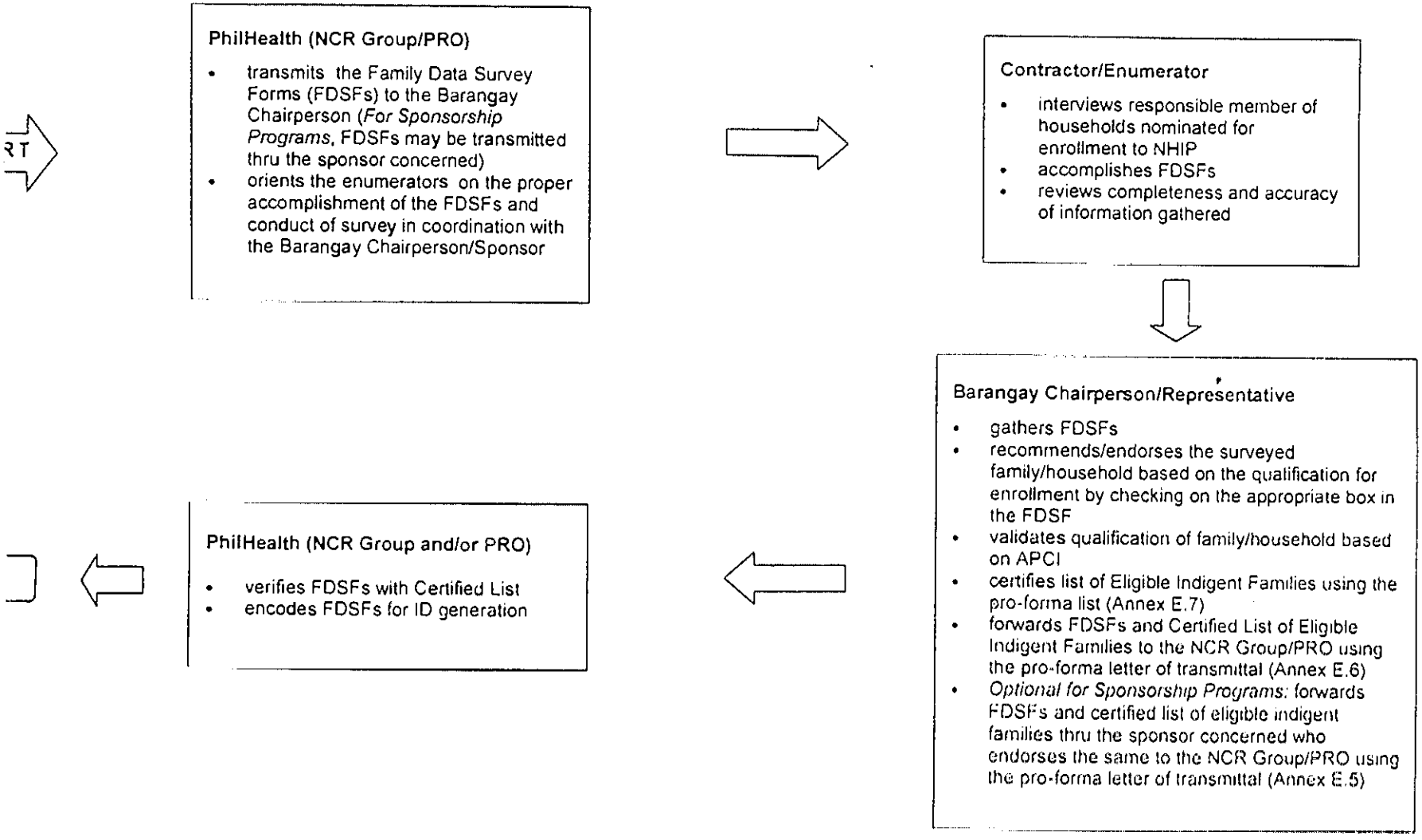
- verifies FDSFs with Certified List
- encodes FDSFs for ID generation.

)

KETING\enumeration flow

# ENUMERATION PROCESS FLOW

## BARANGAY-BASED CERTIFICATION



# EXHIBIT 7

## M1a Form – Member Data Record for Employed Sector

* Please read instructions at the back before accomplishing this form.

Member's PhilHealth Number

*Republic of the Philippines*
PHILIPPINE HEALTH INSURANCE CORPORATION
8/F, Philippine Heart Center Bldg.
East Ave., Diliman, Quezon City

# M1a

MEMBER DATA RECORD
FOR EMPLOYED SECTOR
(PARA SA MGA NAMAMASUKAN)
August 1999

1. Surname (Apelyido) | Given name (Pangalan) | Middle Name (G. Apelyido) | 1a. TIN

2. Permanent Address (Tirahan) | 2a. Postal Code | 2b. Tel. No.

Number & Street ( Numero at kalye) | Barangay | Town/City (Bayan/Lungsod) | Province(Lalawigan)

3. Sex (Kasarian)
☐ Male (Lalaki)
☐ Female (Babae)

3a. Date of Birth (Kapanganakan)
m m d d y y y y

3b. Place of Birth (Lugar ng Kapanganakan)

3c. Name and Address of Office (Pangalan at lugar ng opisina)

4. Employment Classification (Uri ng Manggagawa)
☐ Private (Manggagawa sa Pribado) SSS No. _____
☐ Gov't (Manggagawa sa Gobyerno) GSIS Policy No. _____

4a. Civil Status (Katayuang Sibil)
☐ Single (Walang Asawa) ☐ Widowed (Balo)
☐ Married (May Asawa) ☐ Separated (Hiwalay)

If married, name of spouse: _____ Surname _____ Given Name _____ Middle Name

Occupation: _____ Spouse's PhilHealth Number: _____

5. **DEPENDENTS**
(MGA MAKIKINABANG)

Use back page for additional dependent(s), if necessary. (Gamitin ang kabilang pahina para sa dagdag na makikinabang, kung kinakailangan.)

| PhilHealth Number (To be filled up by PhilHealth) | Name of Dependents (Pangalan ng Makikinabang) Last Name, First Name M.I. | SEX (M) or (F) | Relationship of Dependents to Member (Relasyon ng Makikinabang sa Miyembro) | Date of Birth (Kapanganakan) mm-dd-yyyy |
|---|---|---|---|---|
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If child has congenital disability acquired before age 21, please attach a copy of Medical Certificate
(Kung ang anak ay nagkaroon ng kapansanan bago sumapit sa gulang na 21, ilakip ang medical certificate)

I hereby certify that the above statements are true and correct and further declare that the above-named dependents have not been declared by my spouse/brother/sister.

(Ako ay nagpapatunay na ang nasa itaas na mga pahayag ay totoo at tama at dagdag kong inihahayag na ang mga nasabing makikinabang sa itaas ay hindi inihayag ng aking asawa o kapatid.)

_____
Signature (Lagda)

THIS PORTION IS TO BE FILLED UP BY PHILHEALTH

Date received: Received by. _____
Name and Signature

Note: This form can be reproduced but is not for sale, to be accomplished in duplicate.

# EXHIBIT 8

## ER1 Form – Employer Data Record

PhilHealth Employer No.:

*Republic of the Philippines*
**PHILIPPINE HEALTH INSURANCE CORPORATION**
City State Centre Bldg.,
709 Shaw Blvd., Pasig City

# ER1
EMPLOYER DATA RECORD

| | |
|---|---|
| 1. Name of Agency/Office/Department/(for Gov't. Sector)/Business/Firm/Employer(for Private Sector) | TIN |
| 2. Address of Agency/Office/Department/Business/Firm/Employer | 2a. Tel. No. |
| 3. E-Mail Address | 3a. Postal Code |

| | | |
|---|---|---|
| 4.If Regional/Branch Office, State the name and address of Main/Head Office | 4a. Main/Head Office/Employer | 4b. Date Operation Started |
| | | 4c. No. of Employees |

5. Services Rendered/Nature of Business/Operation (for private Sector)

6. Type of Agency (For Gov't. Sector) ○ Local ○ Corporation ○ Special Project ○ National ○ Constitutional

Loca(For Private/Business/Operation) ○ Single Proprietorship ○ Partnership ○ Corporation

I hereby certify that the above data are true and correct to the best of my knowledge and belief.

| Date | Head of Agency or Representative | Signature | Title or Position |
|---|---|---|---|

This portion is to be filled-up by PhilHealth

| | | |
|---|---|---|
| Date Received: | Evaluated by: Name and Signature | Date of Evaluation: |

Print | Back

# EXHIBIT 9

## ER1P Form – Employers Data Record for Private Sector

To be accomplished in duplicate.

PhilHealth
EMPLOYER NO.

*Republic of the Philippines*
PHILIPPINE HEALTH INSURANCE CORPORATION
8/F, Philippine Heart Center Bldg.
East Ave., Diliman, Quezon City

# Er1P

EMPLOYER'S DATA RECORD
(FOR PRIVATE SECTOR)
August 1999

1. NAME OF REMITTING BUSINESS / FIRM / EMPLOYER

1a. TIN

2. ADDRESS OF REMITTING BUSINESS / FIRM / EMPLOYER

Number & Street (Numero at kalye) | Barangay | Town/City (Bayan/Lungsod) | Province (Lalawigan)

2a. Tel. No.

3. E-MAIL ADDRESS

3a. Postal Code

4. IF REMITTING AGENCY / OFFICE IS BRANCH OFFICE, STATE THE NAME AND ADDRESS OF MAIN / HEAD OFFICE.

4a. No. of Employees

5. SERVICES RENDERED

5a. Date Operation Started

6. TYPE OF BUSINESS / AGENCY ☐ SINGLE PROPRIETORSHIP ☐ PARTNERSHIP ☐ CORPORATION

I HEREBY CERTIFY THAT THE ABOVE DATA ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE | HEAD OF AGENCY / REPRESENTATIVE | SIGNATURE | TITLE / POSITION

THIS PORTION IS TO BE FILLED UP BY PHILHEALTH

Date received:

Evaluated by:
Name and Signature

Date of Evaluation:

Note: This form can be reproduced but is not for sale.

# EXHIBIT 10

## ER2 – Report of Employee – Member

PLEASE READ INSTRUCTIONS AT THE BACK BEFORE ACCOMPLISHING THIS FORM

# PHILHEALTH
## REPORT OF EMPLOYEE-MEMBERS

(CHECK APPLICABLE BOX) ☐ INITIAL LIST (Attach to PhilHealth Form Er1) ☐ SUBSEQUENT LIST

**Er2**

NAME OF EMPLOYER/FIRM:

Employer No.:

ADDRESS:

E-MAIL ADDRESS :

| PHILHEALTH/SSS/GSIS NUMBER | NAME OF EMPLOYEE | POSITION | SALARY | DATE OF EMPLOYMENT | (DO NOT FILL) EFF. DATE OF COVERAGE | PREVIOUS EMPLOYER (IF ANY) |
|---|---|---|---|---|---|---|
| | | | | | | |

TOTAL NO. LISTED ABOVE:

PAGE ____ OF ____ SHEETS

CERTIFIED CORRECT:

SIGNATURE OVER PRINTED NAME

TO BE ACCOMPLISHED IN DUPLICATE.

Note: This form can be reproduced but is not for sale.

135

# EXHIBIT 11

## M1b Form – Member Data Record for Individually Paying

*Please read instructions at the back before accomplishing this form.

Member's PhilHealth Number

*Republic of the Philippines*
PHILIPPINE HEALTH INSURANCE CORPORATION
Membership Operations Department
11th Flr. CityState Centre Bldg. 709 Shaw Blvd
Pasig City P.O. Box 876
Telefax No. 637-64-52 - 637-9999 locs. 1120-1128, 1130

# M1b

MEMBER DATA RECORD
FOR INDIVIDUALLY PAYING
(PARA SA MGA NAGBABAYAD NA PANSARILI)
January 2001

1. Surname (Apelyido) | Given name (Pangalan) | Middle Name (G. Apelyido) | 1a. TIN

2. Address (Tirahan) | 2a. Postal Code

Number & Street (Numero at Kalye) | Barangay | Town/City(Bayan/Lungsod) | Province(Lalawigan) | 2b. Tel. No.

3. Sex (Kasarian)
☐ Male (Lalaki)
☐ Female (Babae)

3a. Date of Birth (Kapanganakan) m m d d y y y y

3b. Place of Birth (Lugar ng Kapanganakan)
Town/City | Province

3c. Civil Status (Katayuang Sibil)
☐ Single (Walang Asawa)
☐ Married (May Asawa)
☐ Widowed (Balo)
☐ Separated (Hiwalay)

4. Type of Individually Paying Member:
☐ Self-Employed ☐ OFW ☐ Separated from Employment ☐ Others (Specify) _____

4a. Monthly Net Income
P _____

If member of SSS/GSIS/OWWA/RSBS/PNP-BPA, prior to application as individually-paying, check appropriate box and indicate corresponding number. (Kung dating kasapi sa SSS/GSIS/OWWA/RSBS/PNP-BPA, lagyan ng tsek ang naaraapat na kahon at isulat ang kaukulang bilang) ☐ SSS ☐ GSIS ☐ OWWA ☐ PNP UNIFORMED

SSS No.
GSIS Policy No.
OWWA/MEC No.

If married, name of spouse: _____
Surname | Given Name | Middle Name

Occupation. _____ Spouse's PhilHealth Number: _____

5. **DEPENDENTS**
(MGA MAKIKINABANG)

**Use back page for additional dependent(s), if necessary. (Gamitin ang kabilang pahina para sa dagdag na makikinabang, kung kinakailangan.)**

| PhilHealth Number (To be filled up by PhilHealth) | Name of Dependents (Pangalan ng Makikinabang) Last Name, First Name, MI | SEX (M) or (F) | Relationship of Dependents to Member (Relasyon ng Makikinabang sa Miyembro) | Date of Birth (Kapanganakan) mm-dd-yyyy |
|---|---|---|---|---|
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**If child has congenital disability acquired before age 21, please attach a copy of Medical Certificate.**
**(Kung ang anak ay nagkaroon ng kapansanan bago sumapit sa gulang na 21, ilakip ang medical certificate.)**

I hereby certify that the above statements are true and correct and further declare that the above-named dependents have not been declared by my spouse/brother/sister.

(Ako ay nagpapatunay na ang nasa itaas na mga pahayag ay totoo at tama at dagdag kong inihayag na ang mga nakabang makikinabang sa itaas ay hindi inihayag ng aking asawa o kapatid.)

_____
Signature/Lagda

THIS PORTION IS TO BE FILLED UP BY PHILHEALTH

| Date received: | Evaluated by: | Approved Monthly Premium: |
|---|---|---|
| | Name and Signature | Date of Evaluation |

To be accomplished in duplicate.
Note: This form can be reproduced but is not for sale

# EXHIBIT 12

## M1c Form – Member Data Record for Non Paying

* Please read instructions at the back before accomplishing this form.

*Republic of the Philippines*

# PHILIPPINE HEALTH INSURANCE CORPORATION

City State Centre Building
709 Shaw Boulevard, Pasig City

# M1c

MEMBER DATA RECORD
FOR NON-PAYING MEMBERS
(PARA SA MGA MIYEMBRONG
HINDI NA MAGBABAYAD)
June 2001

1 X 1
ID PHOTO

**Member's PhilHealth Identification Number (if any):**

☐☐-☐☐☐☐☐☐☐☐☐-☐

1a. Surname (Apelyido) | Given name (Pangalan) | Middle Name (G. Apelyido)

2a. Address (Tirahan)

Number & Street (Numero at kalye) | Barangay | Town/City (Bayan/Lungsod)

Province(Lalawigan) | Zip Code | Telephone Number

2b. Civil Status (Katayuang Sibil)
- ☐ Single (Walang Asawa)
- ☐ Married (May Asawa)
- ☐ Widowed (Balo)
- ☐ Separated (Hiwalay)

3a. Sex (Kasarian)
- ☐ Male (Lalaki)
- ☐ Female (Babae)

3b. Date of Birth (Kapanganakan)
m m d d y y y y

3c. Place of Birth (Lugar ng Kapanganakan)
Town/City | Province

4a. Existing SSS/GSIS No.

4b. Name and Address of last employer

4c. Date/effectivity of retirement (Petsa/bisa ng pagretiro)

5. Type of Non-Paying Member:

- ☐ Old-age Retirees and Pensioners of the GSIS (also includes non- uniformed members of the AFP, PNP, BJMP and BFP; uniformed members of the AFP, PNP, BFP and BJMP who have reached the compulsory age of retirement before June 24, 1997 ) & PD 408 retirees
- ☐ GSIS Disability Pensioners prior to March 4, 1995
- ☐ Retirees who are members of Constitutional Commissions and other constitutional offices
- ☐ Retirees and pensioners who are members of the Judiciary
- ☐ SSS Pensioners prior to March 4, 1995
  - ☐ SSS Permanent Disability pensioners
  - ☐ SSS Death/survivorship pensioners
- ☐ SSS Old-Age Retirees/Pensioners
- ☐ Former employees from the gov't &/ or private sectors who have accumulated/ paid at least 120 monthly contributions as provided for by law but separated from employment before reaching sixty (60) years old & thereafter have reached age sixty (60)
- ☐ Uniformed members of the AFP, PNP, BFP and BJMP who have reached the compulsory age of retirement on or after June 24, 1997, being the effectivity date of RA 8291 which excluded said individuals in the compulsory membership of the GSIS
- ☐ Former employees from the gov't &/or private sectors who separated from employment w/o completing 120 monthly contributions but continued to pay their contributions as IPM until completing the required 120 monthly contributions and have reached age 60 as provided for by law
- ☐ Individually-Paying members who have reached age sixty (60) and have paid at least 120 monthly contributions

6. **DEPENDENTS** (MGA MAKIKINABANG)

**Use back page for additional dependent(s), if necessary. (Gamitin ang kabilang pahina para sa dagdag na makikinabang, kung kinakailangan.)**

| PhilHealth Number (To be filled up by PhilHealth) | Name of Dependents (Pangalan ng Makikinabang) Last Name, First Name M.I. | SEX (M) or (F) | Relationship of Dependents to Member (Relasyon ng Makikinabang sa Miyembro) | Date of Birth (Kapanganakan) mm-dd-yyyy |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**(Kung ang anak ay nagkaroon ng kapansanan bago sumapit sa gulang na 21, ilakip ang Medical Certificate)**
**If child has congenital disability acquired before age 21, please attach a copy of Medical Certificate**

I hereby certify that the above statements are true and correct and further declare that the above-named dependents have not been declared by my spouse/brother/sister.

(Ako ay nagpapatunay na ang nasa itaas na mga pahayag ay totoo at tama at dagdag kong inihahayag na ang mga nasabing makikinabang sa itaas ay hindi inihayag ng aking asawa o kapatid.)

Signature (Lagda) | LEFT THUMBMARK | RIGHT THUMBMARK

**THIS PORTION IS TO BE FILLED UP BY PHILHEALTH**

Date received: | Evaluated by: Name and Signature | Date of Evaluation:

To be accomplished in duplicate

Note: This form can be reproduced but is not for sale.

# EXHIBIT 13

## M2 Form – Member Data Amendment Form

TO BE ACCOMPLISHED IN DUPLICATE

PLEASE READ INSTRUCTIONS AT THE BACK.

*Republic of the Philippines*

# PHILIPPINE HEALTH INSURANCE CORPORATION

(ADDRESS)

# M2

MEMBER DATA AMENDMENT FORM

October, 2002

PhilHealth Identification No.

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |

1. Surname (*Apelyido*) Given Name (*Pangalan*) Middle Name (*Gitnang Apelyido*)

2. Address (No. & Street, Town/City, Province) (*Tirahan (Numero at Kalye, Bayan/Lungsod, at Lalawigan)*) Postal Code

3. Correction / Change of Name of Member or Dependent(s) (*Pagwawasto/Pagpapalit ng Pangalan ng Miyembro o Tangkilik/Makikinabang*)

From _____ To _____

4. Correction of Date/Place of Birth of Member or Dependent(s) (*Pagwawasto ng Petsa/Lugar ng Kapanganakan ng Miyembro o Tangkilik/Makikinabang*)

From _____ To _____

5. Change of Civil Status (*Pagpapalit ng Katayuang Sibil*)

- ☐ From Single (Walang Asawa) To Married (May Asawa)
- ☐ From Married (May Asawa) To Widowed (Balo)
- ☐ From Widowed (Balo) To Married (May Asawa)
- ☐ From Married (May Asawa) To Single/Annulled (Pinawalang Bisang Kasal)
- ☐ From Annulled/Single (Pinawalang Bisang Kasal) To Married (May Asawa)

**To be filled up by women only** (*para sa mga babae lamang*)

Maiden Name:

Married Name:

6. Change of Address (No. & Street, Town/City, Province) (*Tirahan (Numero at Kalye, Bayan/Lungsod, at Lalawigan)*)

Previous:

Present:

7. Dependent's (*Tangkilik/Makikinabang*) ☐ *Additional* ☐ *Omission due to active NHIP membership, marriage, etc.*

| Surname (*Apelyido*) | Given Name (*Pangalan*) | Middle Initial (*Gitnang Inisyal*) | Sex | Relationship of Dependent to Member (*Relasyon ng Tangkilik/Makikinabang sa Miyembro*) | Date of Birth (*Kapanganakan*) mm dd yy |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

8. Change of Membership Category (*Pagpapalit ng Kategorya*)

**From:**
- ☐ Government Sector Employed
- ☐ Private Sector Employed
- ☐ Individually-Paying Member
- ☐ Non-Paying Member
- ☐ Indigent

**To:**
- ☐ Government Sector Employed
- ☐ Private Sector Employed
- ☐ Individually-Paying Member
- ☐ Non-Paying Member
- ☐ Indigent

} *With accompanying Form 5r2 (Report of Employee-Member)*

9. For Formally-Employed Only

Name of Employer: _____

Address of Employer: _____

Employer's Contact No.

I hereby certify that the above statements are true and correct, and further declare that the named dependents have not been declared by my spouse / brother / sister. (*Ako ay nagpapatunay na ang nasa itaas na mga sahayag ay totoo at tama at dagdag kong inihahayag na ang mga nasabing tangkilik/makikinabang ay hindi inihayag ng aking asawa o kapatid*).

_____

Signature (*Lagda*)

**THIS PORTION IS TO BE FILLED UP BY PHILHEALTH**

| Date received: | Processed by: | Approved: | Date: |
|---|---|---|---|
| | | | |

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Note: This form can be reproduced but is not for sale.

# *MANAGE MEMBERSHIP AND MEMBER RELATIONS*

# EXISTING POLICIES

1. EMPLOYED AND INDIVIDUALLY PAYING PROGRAM

1.1 Any person shall be eligible to participate in the National Health Insurance Program if the following conditions are met :

1.1.1 Accomplished and submitted the appropriate membership registration form, together with any of the following:

- Birth Certificate
- Baptismal Certificate
- GSIS/SSS Member's ID
- Passport
- Any other valid ID/document acceptable to the Corporation

1.1.2 Submitted a copy of the following supporting documents for the declaration of dependents, whichever is applicable :

- Marriage Contract – for dependent spouse
- Marriage Contract and Birth / Baptismal Certificate – for dependent legitimate children
- Birth / Baptismal Certificate – for illegitimate children
- Adoption papers or court resolution / decision – for dependent adopted children
- Birth / Baptismal Certificate of registrant – for dependent parents
- Marriage Contract of the parent and stepfather / stepmother and Birth Certificate of the dependent stepchildren – for dependent stepchildren
- Duly notarized joint affidavit of two (2) disinterested persons and other relevant information (date of birth, etc.) attesting to the fact of the relationship of the dependents to the supposed members
- Certificate from the Department of Social Welfare and development (DSWD) or Barangay captain attesting to the fact of the relationship of the dependents to the supposed members
- Any other valid ID or document acceptable to the Corporation.

1.1.3 Submitted any of the following documents, whichever is applicable, to substantiate the request for revision / amendment in the data previously

furnished to the Corporation. The nature of this request may be any of the following:

- Correction / Change of name – submit Affidavit or Birth Certificate
- Correction of date of Birth – submit Birth Certificate
- Change of Civil Status – submit Marriage Contract
- New / Additional / Change of Dependent/s – submit Birth Certificate of the dependent
- Change of address – submit written notice

1.2 All government and private sector employees shall be compulsory members of the NHIP. In addiition, all officers and uniformed personnel and non-uniformed employees of the Armed Forces of the Philippines (AFP), Philippine National Police (PNP), Bureau of Jail Management and Penology (BJMP), and Bureau of Fire protection (BFP) who entered the service after the effectivity of Republic Act 8291, otherwise known as the new GSIS Act on June 24, 1997, shall be compulsory members of the NHIP.

1.3 All self-employed and voluntary paying members of the SSS who are enrolled in the Medicare Program I / NHIP before July 1, 1999 shall be required to update their membership records with the Corporation.

1.3.1 Enrollment for membership as an individually paying member shall be made through the Corporation's offices or through some other mechanisms as may be prescribed by the Corporation.

1.3.2 A member of the NHIP separated from employment may continue membership by enrolling as an individually paying member within three (3) months after separation to avoid suspension of benefit entitlement.

2. EMPLOYERS

2.1 All government and private employers including branches, regional offices and other sub-units that deduct premium contribution of their respective employees and subsequently remit the same together with the employer counterpart to PhilHealth shall be required to register with the Corporation and each shall be issued a permanent PhilHealth Employer Number (PEN). Branches / regional offices and sub-units possessing the above-mentioned characteristics shall, therefore, register separately from their central / main offices with the Corporation.

2.1.1 Employer shall update PhilHealth by properly accomplishing ER1 and ER2 forms

2.1.2 Employer shall submit the accomplished amendment form for any request for revision / amendment of employee's data, whichever is applicable:

- Correction or change of business name or legal personality, submit :
  - Certificate of filing of business name with the Bureau of Domestic Trade; or
  - Articles of Partnership/Incorporation
- Temporary suspension of operation
  - If due to bankruptcy, submit :
    - Financial Statement, or
    - Income Tax Return, or
    - Board Resolution
  - If due to separation of employee/s, submit :
    - Latest submitted prescribed PhilHealth form
    - Separation paper of last employee
  - If due to fire / demolition, submit :
    - Certification from the Fire Department of the municipality, or
    - Certification from City Hall
- Termination / dissolution
  - For single proprietorship, submit approved application for business retirement by the Municipal Treasurer's Office
  - For partnership or corporation, submit Deed of Dissolution approved by the Securities and Exchange Commission (SEC) or Minutes of the Meeting certified by the corporate secretary
  - Death certificate in case the owner dies
- Merger, submit Deed of Merger/Merger Agreement duly certified by SEC or Memorandum of Agreement filed with SEC
- Change of ownership, submit Deed of Sale / Transfer / Assignment
- Resumption of operation, submit prescribed PhilHealth form reporting newly-hired or re-hired employees

2.1.3 The employer shall be obliged to report to the Corporation its newly-hired employees within thirty (30) calendar days from assumption to office. The report shall indicate whether the employee is an old or new member of the NHIP and shall reflect the PIN, in case the said employee is an old member.

2.1.4 The employer shall be obliged further to give notice to the Corporation of an employee's separation within thirty (30) calendar days from separation. Employer shall be liable for reimbursement of payment for a properly filed claim in case the employer failed to give notice of the separated employee, or the dependent/s, who avail of NHIP benefits, without prejudice to the imposition of other penalties provided for in this Rules.

3. RETIREES AND PENSIONERS

3.1 The following persons shall register with PhilHealth as non-paying members for the issuance of the PhilHealth Identification (ID) Card :

3.1.1 Old-age retirees and pensioners of GSIS [also includes non-uniformed personnel of the AFP, PNP, BFP & the BJMP; uniformed members of the Armed Forces of the Philippines (AFP), Philippine National Police (PNP), Bureau of Fire Protection (BFP) and the Bureau of Jail Management and Penology (BJMP) who have reached the compulsory age of retirement before June 24, 1997] and Retirees under presidential Decree 408;

3.1.2 GSIS Disability Pensioners prior to March 4, 1995;

3.1.3 SSS Pensioners prior to March 4, 1995;

- SSS Permanent Total Disability Pensioners
- SSS Death / Survivorship Pensioners;

3.1.4 SSS Old-Age Retirees / Pensioners and Underground Mine Worker or Miner;

3.1.5 Uniformed members of the AFP, PNP, BFP and the BJMP who have reached the Compulsory age of retirement on or after June 24, 1997, being the effectivity date of RA 8291 which excluded said individuals in the compulsory membership of the GSIS;

3.1.6 Retirees and Pensioners who are members of the Judiciary;

3.1.7 Retirees who are members of Constitutional Commissions and other Constitutional offices;

3.1.8 Former employees from the government and/or private sectors who have accumulated / paid at least 120 monthly Medicare contributions as provided

for by law but separated from employment before reaching sixty (60) years old and thereafter have reached age sixty (60);

3.1.9 Former employees from the government and/or private sectors who separated from employment without completing 120 monthly Medicare contributions but continued to pay their Medicare premium contributions as individually-paying members (IPM) until completing the required 120 monthly Medicare contributions and have reached age sixty (60) as provided for by law;

3.1.10 Individually-paying members (IPM), including SSS self-employed and voluntary members, who continued paying premium contributions to PhilHealth, have reached age sixty (60) and have met the required 120 monthly Medicare contributions as provided for by law.

3.2 For registration as non-paying member, the following shall be submitted:

3.2.1 Two (2) copies of duly-accomplished M1c (Member Data Record for Non-Paying Members) [attached herewith for reference];

3.2.2 Two latest "1 x 1" ID Photos;

3.2.3 Certified true copy/ies of retirement documents;

The underground mine worker/miner-enrollee shall submit a Certification of Retirement from the SSS stating that he/she is a miner-retiree;

3.2.4 Certified true copy of Birth Certificate. In the absence of the Birth Certificate, any two (2) of the following documents shall be presented:

- Certified true copy of Baptismal Certificate of the registrant;
- Certified true copy of Marriage Certificate/Contract, if married;
- Passport
- Driver's License;
- SSS Member ID;
- Alien Certificate of Registration (ACR);
- Service Record(s);
- Employee ID;
- School Records;
- Voter's Identification Card;

- A duly-notarized joint affidavit of two (2) disinterested persons attesting to the fact of birth of the registrant

3.3 Registrant/s shall submit the certified true copies of the following document(s), whichever is/are applicable for the Eligibility of Dependents.:

3.3.1 Marriage Certificate/Contract - for dependent spouse;

3.3.2 Birth Certificate(s) - for dependent legitimate or illegitimate child(ren);

3.3.3 Court Decree of adoption - for dependent adopted child(ren);

3.3.4 Birth Certificate of registrant and any proof attesting the date of birth of the parent(s) - for dependent parent(s);

3.3.5 Marriage Certificate between the natural parent and stepfather / stepmother and Birth Certificate(s) of the dependent stepchild(ren) - for dependent stepchild(ren);

3.3.6 Birth Certificate or Court Decree of adoption and Certification from Attending Physician stating that dependent is disabled (with description of extent of disability) - for disabled dependent(s) 21 years old and above.

3.4 The following procedures will be observed by the Nonpaying Program (NPP) units / divisions at the Central and Regional Offices to effectively determine the qualification of the disabled dependents:

3.4.1 The NPM enrollee-registrant shall submit a Medical Certification issued by the Attending Physician stating the extent of disability of his child/ren to the NPM Unit at the Central Office/PRO concerned, in addition to the usual NPM documentary requirements.

3.4.2 The NPM Unit / Division shall transmit the said Medical Certification to the Medical Officer/s of the Claims Department/Unit for proper evaluation.

3.4.3 The Medical Officer shall validate the said certification/s and affix his/her printed name and signature thereto, affirming the eligibility of the individual to be a disabled dependent, and forward the same to the NPP Unit/Division concerned.

3.4.4 The NPP Unit/Division will process, through the PRMRS, the data of the disabled dependents of the non-paying member.

3.4.5 The registrant shall submit a photocopy of any of the above-mentioned documents but the original copy/document shall be presented to PhilHealth for authentication.

3.4.6 A member who has enrolled / registered under this membership category shall be issued a PhilHealth Identification (ID) Card as Non-Paying Member after the submission of the required documents.

4. INDIGENT PROGRAM

4.1 For the implementation of the Indigent Program in their area, the Local Government Unit and with other concerned parties shall sign the Memorandum of Agreement (MOA), as initiated by PhilHealth. The indigent members shall be identified, based on the following mechanisms :

4.1.1 Conduct of a social research survey referred to as the means test to determine the current socio-economic and health profile of the indigent sector in each LGU. The LGU shall take the lead role and supervision in the installation, maintenance and updating of the Community Based Information System – Minimum Basic Needs (CBIS-MBN) in coordination with the Department of Social Welfare and Development (DSWD). The Corporation and other concerned government agencies shall provide technical, manpower and financial assistance, where necessary, in the conduct, administration and management of CBIS – MBN.

4.1.2 Agree on the scoring system on the prioritization in the grant of membership in the Indigent Program or submit the "List of Eligible NHIP members" for approval in the absence of a scoring system. The LGU and the Corporation shall give priority to the enrollment of the elderly, disabled, orphans and paupers in the Program, especially when premium donors are involved.

4.1.3 Evaluate the list of indigent members every year through a procedure prescribed by the Corporation in coordination with the concerned LGU.

4.2 Membership in the Indigent Program shall be revoked / cancelled by the Corporation for any of the following reasons:

4.2.1 Non-compliance by the indigent member or any of the dependents, with NHIP rules and regulations; or

4.2.2 Employment of the indigent member.

4.3 The LGU shall propose for the replacement of the indigent member during the membership year. The 'replacement member' shall also be certified by the CSWDO / MSWDO. The dependents of the deceased member shall continue to avail of NHIP benefits for the unexpired portion of the coverage in case of death of the member.

5. SPONSORSHIP

5.1 Legislative sponsorship

5.1.1 Legislators shall be advocated to adopt the PhilHealth Indigent Program. Once the Legislator manifests intent, his/her office shall coordinate with the concerned PhilHealth Regional Office (PRO) and the LGU/s regarding

his/her intention to enroll indigent families in his/her district. The Legislative Sponsorship Program will be undertaken through the following:

- Proposal/s shall be submitted by the Legislator for the allocation of a portion of the Priority Development Assistance Fund (PDAF) to the House Committee on Appropriation to enroll indigent families to the Indigent Program.

- The House Committee on Appropriation shall endorse the proposal to the Department of Budget and Management (DBM) for approval.

- The DBM shall issue the Special Allotment Release Order (SARO) to the implementing agency, copy furnished the Legislator.

5.1.2 The concerned LGU/s shall pass a resolution adopting the Indigent Program and submit said resolution to the Office of the Legislator. The LGU referred hereto may be the province, city, municipality or barangay where the indigent member resides.

- PhilHealth and the Legislator shall enter into a Memorandum of Agreement. However, the concerned LGU/s may directly participate in the Memorandum of Agreement, as may be warranted.

- The Memorandum of Agreement shall provide for the implementation of Phase I and Phase II of the Indigent Program. However, implementation of Phase II shall commence only upon compliance of all requirements and procedures as set forth in the Out Patient Consultation and Diagnostic Package Guidelines.

5.1.3 PhilHealth, in coordination with the Office of the Legislator, shall coordinate with the concerned LGU/s and the Local Social Welfare Development Officer (LSWDO) or the barangay social workers on the identification of indigent households.

- The LSWDO or barangay social worker of the covered LGU prepares a list of indigent families included in the survey. The said list shall be certified by the LSWDO or barangay social worker, in the case of barangay, and concurred in by the Local Chief Executive (LCE). A Local Chief of barangay, and concurred in by the Local Chief Executive may be a Provincial Governor, City/Municipal Mayor or a Barangay Captain.

- The accomplished FDSFs with the Certified List of Eligible Indigent Families shall be transmitted to PhilHealth, a copy furnished the Legislator.

- The concerned LGU/s shall be notified for possible replacement or coverage under the Individually Paying Program (IPP), if the surveyed indigent family does not qualify.

5.1.4 After validation, PhilHealth shall encode and generate identification (ID) cards for distribution to target beneficiaries by the Legislator and the LGU/s concerned.

- The space allotted at the back portion of the ID shall be utilized by the Legislator for his/her signature, logo, or any message he/she wanted to be placed therein.
- PhilHealth and the concerned LGU/s shall conduct an Information Education Campaign to beneficiaries to orient on the benefits of the Program.
- Membership shall be effective on the date indicated in the ID and is valid for one year. Membership to the Program shall be renewed annually.

5.2 Private sponsorship

5.2.1 The sponsor shall be primarily responsible for the payment of the LGU premium counterpart for the enrollment of indigent members. Payment / remittance of the donation shall be made directly to PhilHealth or co-payment in coordination with the LGU. Accordingly, the sponsor shall have the following responsibilities in the enrollment of indigent families:

- Identification of the areas/intended for coverage;
- Initial determination of indigent families proposed for enrollment;
- Participation in the enumeration/survey activities using the Family Data Survey Form (FDSF); and
- Participation in the information and education campaigns.

5.2.2 The Sponsor / Donor shall formally signify his intention to participate in the Sponsorship Program of the PhilHealth's Indigent Program through a Letter of Intent (LOI) addressed to the Local Government Unit concerned and/or PhilHealth. In the LOI, Sponsor/Donor may identify the particular beneficiary community / area / LGU that he/she intends to cover.

5.2.3 The Sponsor / Donor, PhilHealth and the local government/s whose constituents are covered shall execute a tripartite Memorandum of Agreement. Local government units referred hereto include provinces, cities, municipalities and barangays. The local government unit is further required to pass the following:

- Issuance of a Sanggunian resolution adopting the Indigent Program and authorizing the Local Chief Executive, i.e. Governor, Mayor, Barangay Chairman to enter into a Memorandum of Agreement (MOA); and



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- Issuance of an Ordinance creating a PhilHealth Capitation Fund (PCF) in areas targeted for Out Patient Consultation and Diagnostic Package Implementation.

5.2.4 Identification of indigent members shall be done using the Family Data Survey Form (FDSF). The survey results indicating the qualifying indigent households shall be certified by the LSWDO and/or Barangay Chairman of the concerned LGU. Proposed members who do not qualify for membership under the Indigent Program may be enrolled under the Individually Paying Program.

5.2.5 PhilHealth and the local government unit shall be primarily responsible for the conduct of the information campaign, but the Sponsor/Donor may opt to participate during the distribution of ID cards and the information drive.

5.2.6 Membership is effective on the date indicated in the ID card and is valid for one year. Membership to the Program shall be renewed annually.

5.2.7 The following steps, subject to confirmation and/or amendatory rules as may be prescribed by the Bureau of Internal revenue (BIR), shall be observed in the availment of full tax deduction on donations made to the Indigent Program:

- As soon as a Certificate of Donation has been issued by PhilHealth, the Donor shall proceed to their respective Bureau of Internal Revenue (BIR) Regional / District Offices to request for a confirmatory document, termed as a Ruling, that said donation is fully deductible from taxable income. The following documents should be attached to the request for the issuance of the Ruling:

  - Certified true copy of the original Certificate issued by NEDA that the PhilHealth Indigent Program is part of the National Priority Program;

  - Original copy of the Certificate of Donation issued to the donor/sponsor by PhilHealth;

  - Official Receipt for the donated amount issued by PhilHealth specifying the stated donated amount as premium payment for the LGU counterpart under the PhilHealth Indigent Program; and

  - Certified true copy of the tripartite memorandum of Agreement with PhilHealth and the local government.

- The Ruling confirming that the donation is fully tax deductible shall be attached to the BIR form used in filing Income Tax Returns for the implementation of Sec. 34 (H) (2) (a) of the National Internal Revenue Code (NIRC) of 1997.

5.2.7.1 In case of non-continuance of the sponsor, or should the donated amount be insufficient to cover qualified indigent households, the local

government concerned shall assume the role as payor of the premium counterpart. Alternatively, the LGU may seek for other Sponsor / Donor to sustain the implementation of the Program.

5.3 Philippine Charity Sweepstakes Office (PCSO) Sponsorship to the Indigent Program dubbed as Greater Medicare Access (GMA) Program.

5.3.1 PhilHealth shall inform the Department of Interior and Local Government (DILG) about the "PCSO GMA Program" for proper dissemination to all LGUs nationwide. In addition, PhilHealth of the "PCSO GMA Program" shall notify all LGUs through a letter with the following attachments:

- Joint PhilHealth-PCSO Circular No. 001
- Pro-forma Letter of Intent
- Pro-forma LGU Resolution
- Pro-forma Memorandum of Agreement

5.3.2 The "PCSO GMA Program" shall be open to all Local Government Units. All LGUs may implement the program provided they pay their premium counterpart and they do not exceed the pre-determined number of indigent families allowed for enrollment under the "PCSO GMA Program". For the Calendar year 2002, each LGU shall be allocated a number of indigent families subsidized by PCSO for enrollment in the Program. The LGU shall communicate to PhilHealth its intent to participate in the Program within three (3) months reckoned from the receipt of these Guidelines.

5.3.3 PhilHealth, PCSO and the participating LGU shall execute a Memorandum of Agreement (MOA) for the implementation of the Program. The LGU shall be required to submit the following:

- A Sanggunian Resolution adopting the "PCSO GMA Program" and authorizing the Local Chief Executive i.e. Governor, Mayor to enter into a memorandum of Agreement; and
- An Ordinance creating a PhilHealth Capitation fund (PCF) in areas targeted for OPB Program implementation.

5.3.4 All participating LGUs shall identify indigent families for enrollment in the Program based on the following procedures:

- The targeted indigent families shall undergo the CBIS-MBN means test using the Family Data Survey Form (FDSF) to validate their qualification to the Program.
- The Barangay Chairman shall submit a list of indigent families to the Local Social Welfare and Development Officer (LSWDO) for enumeration and subsequent certification.

- PhilHealth shall transmit the FDSFs and Enumerator's Manual to the LSWDO who shall orient the enumerators on the proper conduct of the survey. PhilHealth, upon request of the LGU, shall assist in the accomplishment of the FSDFs to expedite the conduct of the enumeration/survey.

- The LGU workers and trained volunteers shall identify families whose income falls below poverty threshold using the annual per capita poverty income threshold per region.

- The LSWDO shall certify the List of Eligible Indigent Families including the accomplished FDSFs, which shall be endorsed to the mayor for notation.

- The Mayor shall endorse the Certified List of Eligible Indigent Families to PhilHealth.

- PhilHealth shall conduct verification of the FDSFs and the Certified List prior to encoding and ID generation.

- PhilHealth shall furnish PCSO a copy of the final List of Eligible Indigent families printed by PhilHealth.

- The indigent families shall consist of the members and their qualified dependents. Qualified dependents include:

  - Legitimate spouse who is not a member;

  - Unmarried and unemployed legitimate, legitimated, acknowledged and illegitimate children appearing in the birth certificate, and legally adopted or children below twenty-one (21) years of age;

  - Children who are twenty-one (21) years old but suffering from congenital disability, either physical or mental, or any disability acquired that renders them totally dependent on the member for support; and

  - Parents who are sixty (60) years old or above

5.3.5 PhilHealth shall generate "PCSO GMA Program" IDs to be distributed by the concerned LGU, in coordination with PCSO, subject to existing PhilHealth rules on the release of IDs.

5.3.6 The LGU, with the assistance of PhilHealth, shall conduct IEC for the benefit of the beneficiaries to help them understand the program and maximize benefit availment.

5.3.7 Membership in the Program shall be effective on the date indicated in the ID Card. This shall be valid for one (1) year and may be renewed annually.

5.3.8 PhilHealth, in coordination with PCSO, shall identify areas for expansion should there be unutilized PCSO funds after the three-month period had lapsed. The prioritization shall be as follows:

- First priority will be LGUs with HCs/RGHUs that comply with PhilHealth accreditation standards
- LGUs with commitment to expand enrollment beyond PCSO coverage including those declared by PCSO and PhilHealth shall also be treated as priority areas

5.3.9 All expansion areas shall be allowed to enroll additional beneficiaries as determined by the Program Management Committee (PMC) subject to availability of funds.

5.3.10 In order to ensure the smooth and effective implementation of the program, the following committees shall be established:

| Role | Responsibilities |
|---|---|
| Steering Committee | This shall be the policy-making body of the program and, as such, shall set the direction, thrusts, and priorities of the program. The Committee shall meet on a semestral basis or as may be deemed necessary.<br>▪ Approve policies and guidelines related to program implementation<br>▪ Exercise related functions as may be necessary to attain the program objectives |
| Program Management Committee | The Program Management Committee (PMC) shall be responsible for the over-all administration of the "PCSO GMA Program".<br><br>The specific functions and composition shall be as follows:<br>▪ Formulate, recommend and review policies, guidelines, systems and procedures to ensure effective and efficient implementation of the program;<br>▪ Conduct monthly meetings to assess program implementation; |

| Role | Responsibilities |
|---|---|
| Program Secretariat | ▪ Conduct regular monitoring and evaluation, specifically on LGU participation and utilization of the PCSO fund;<br>▪ Provide regular feedback to the PCSO Chairperson and PhilHealth President<br>▪ Perform other functions that may be deemed necessary<br>▪ The technical secretariat shall provide staff support services throughout the implementation of the "PCSO GMA Program". It shall be composed of representatives from PCSO and PhilHealth. |

5.3.11 Monitoring and Evaluation

- Program monitoring shall be made through Monthly Status Reports to be provided by the PhilHealth Regional Offices (PROs) and the National Capital Region Group (NCRG).
- An evaluation of program implementation shall be conducted quarterly by the PMC.

# MANAGE CONTRIBUTIONS

# PROCESS FLOWS

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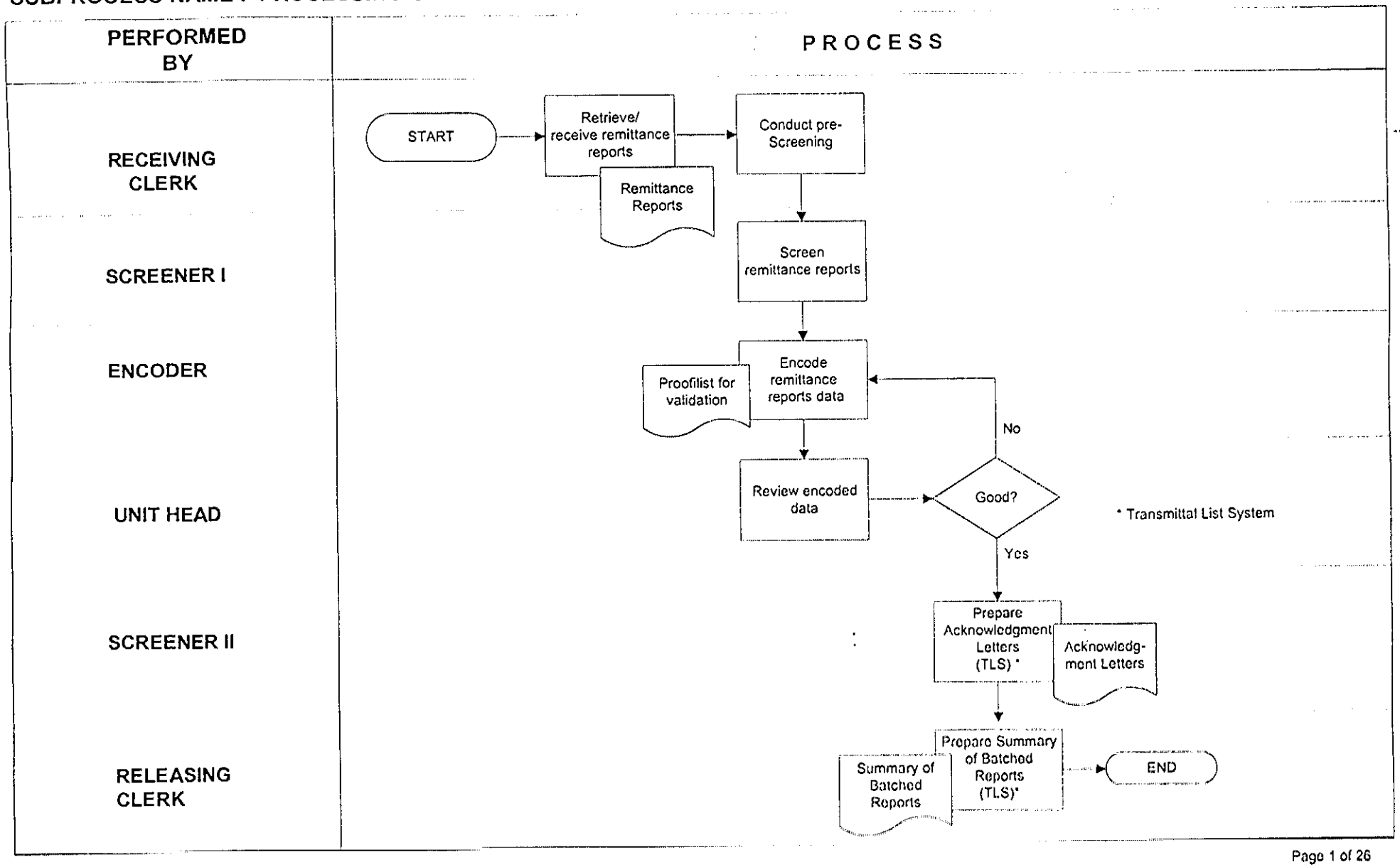




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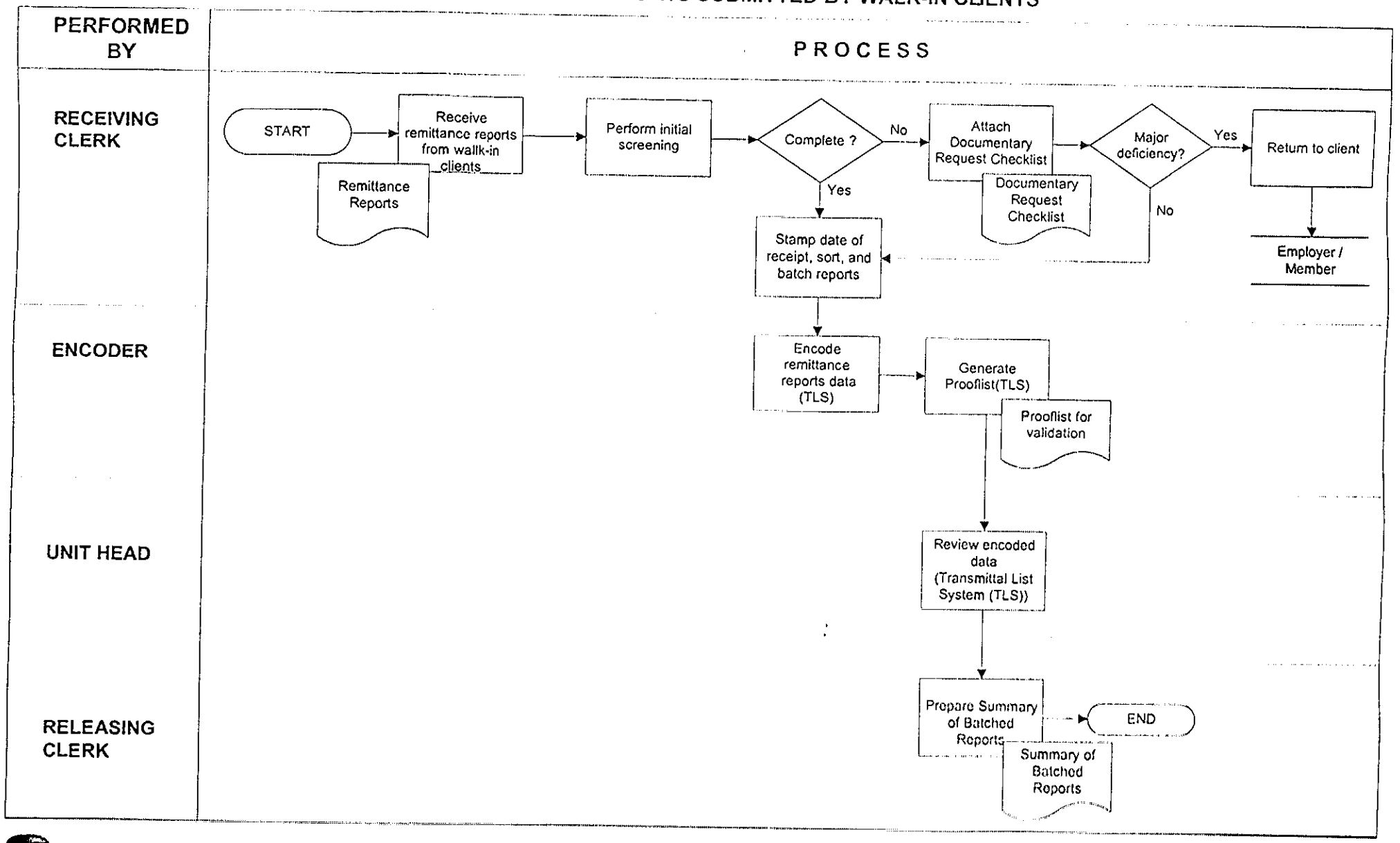




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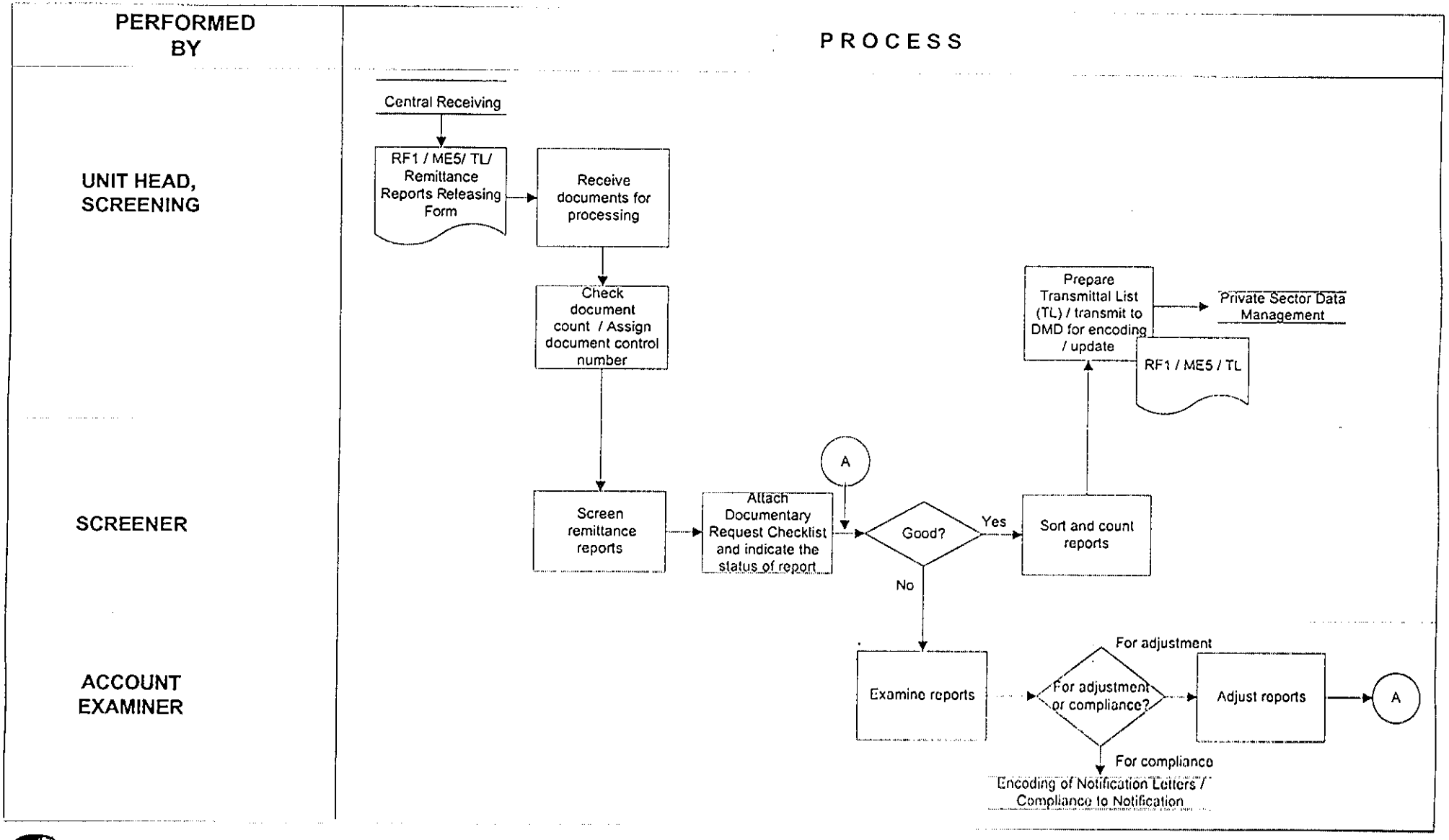


PHILIPPINE HEALTH INSURANCE CORPORATION

PROCESS NAME : MANAGE CONTRIBUTIONS
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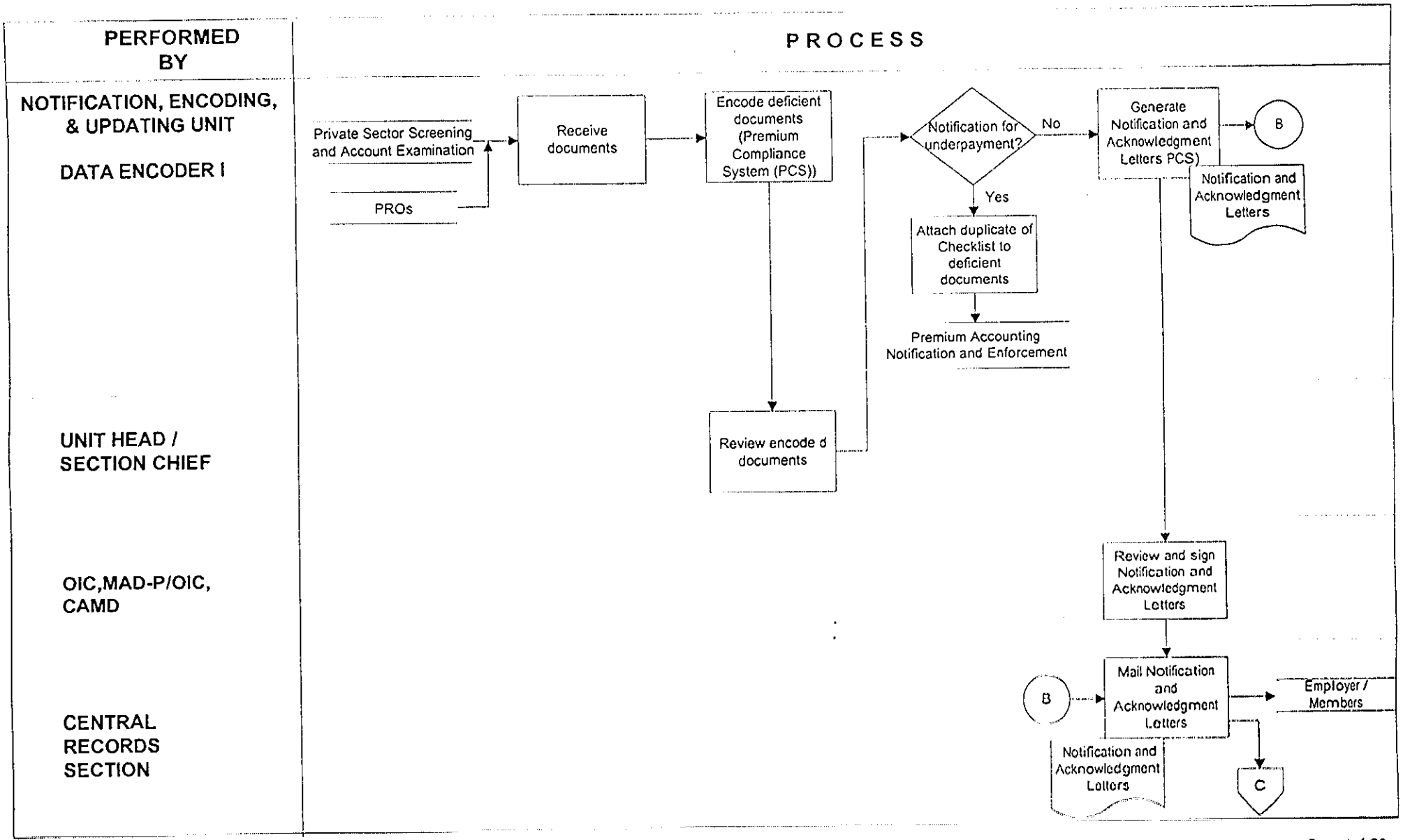




PHILIPPINE HEALTH INSURANCE CORPORATION

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SUBPROCESS NAME : ENCODING OF NOTIFICATION LETTER AND COMPLIANCE TO NOTIFICATION LETTER

| PERFORMED BY | PROCESS |
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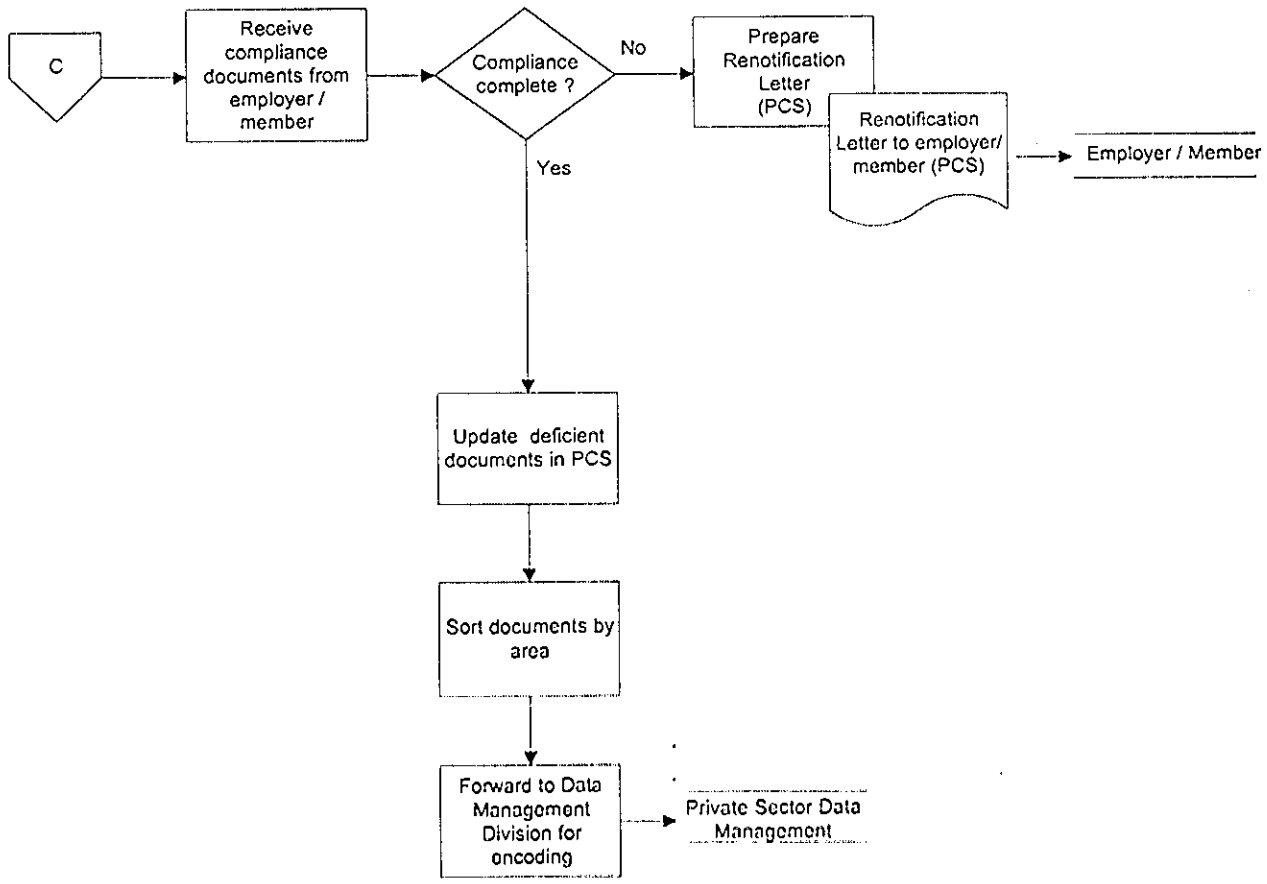




PHILIPPINE HEALTH INSURANCE CORPORATION

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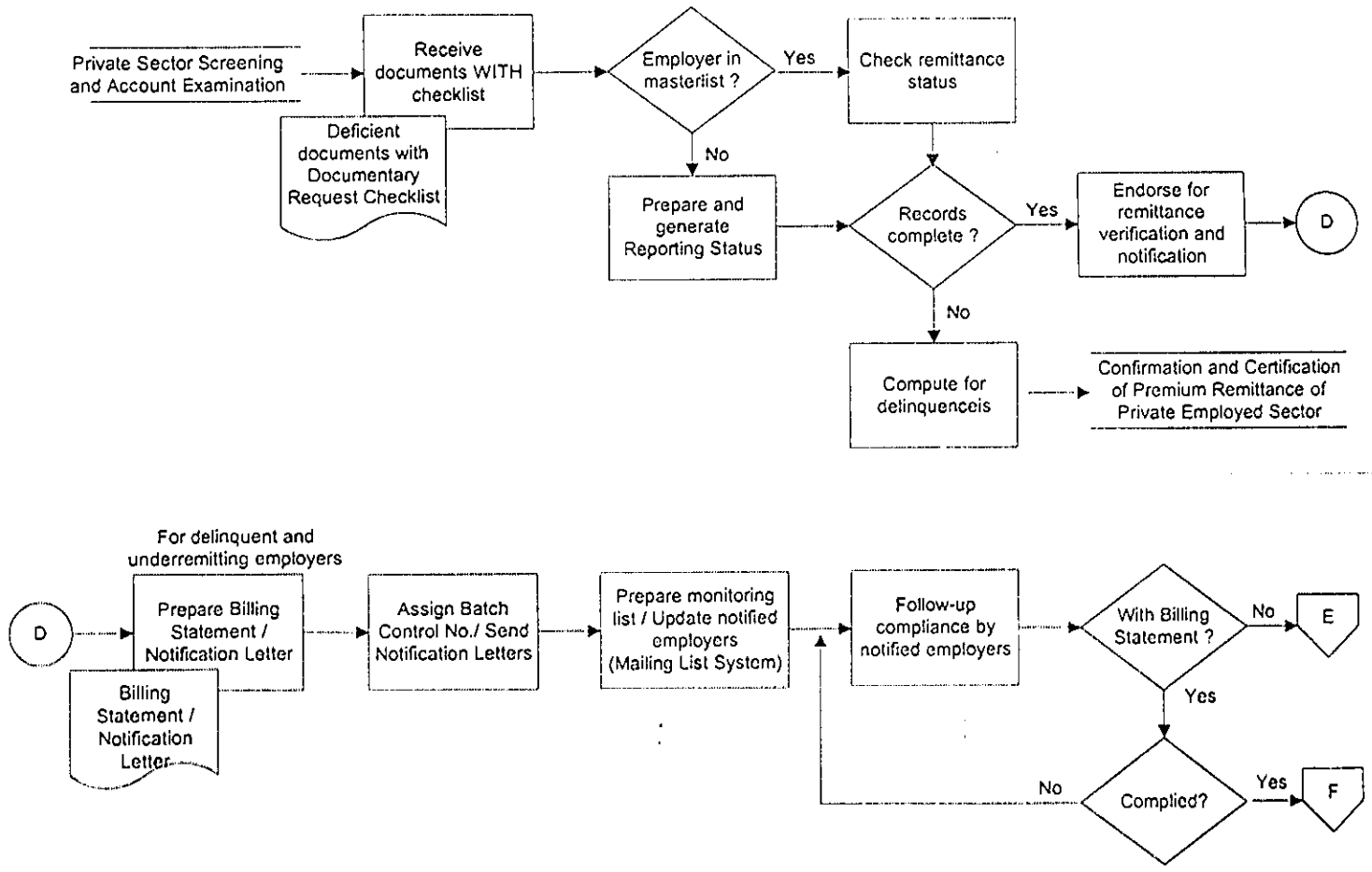
PROCESS NAME : MANAGE CONTRIBUTIONS
SUBPROCESS NAME : PRIVATE SECTOR COMPLIANCE ENFORCEMENT

| PERFORMED BY | PROCESS |
|---|---|
| ACCOUNT MONITORING<br><br>ACCOUNT MANAGEMENT ANALYST | |
| REMITTANCE NOTIFICATION<br><br>ACCOUNT MANAGEMENT ANALYST | |



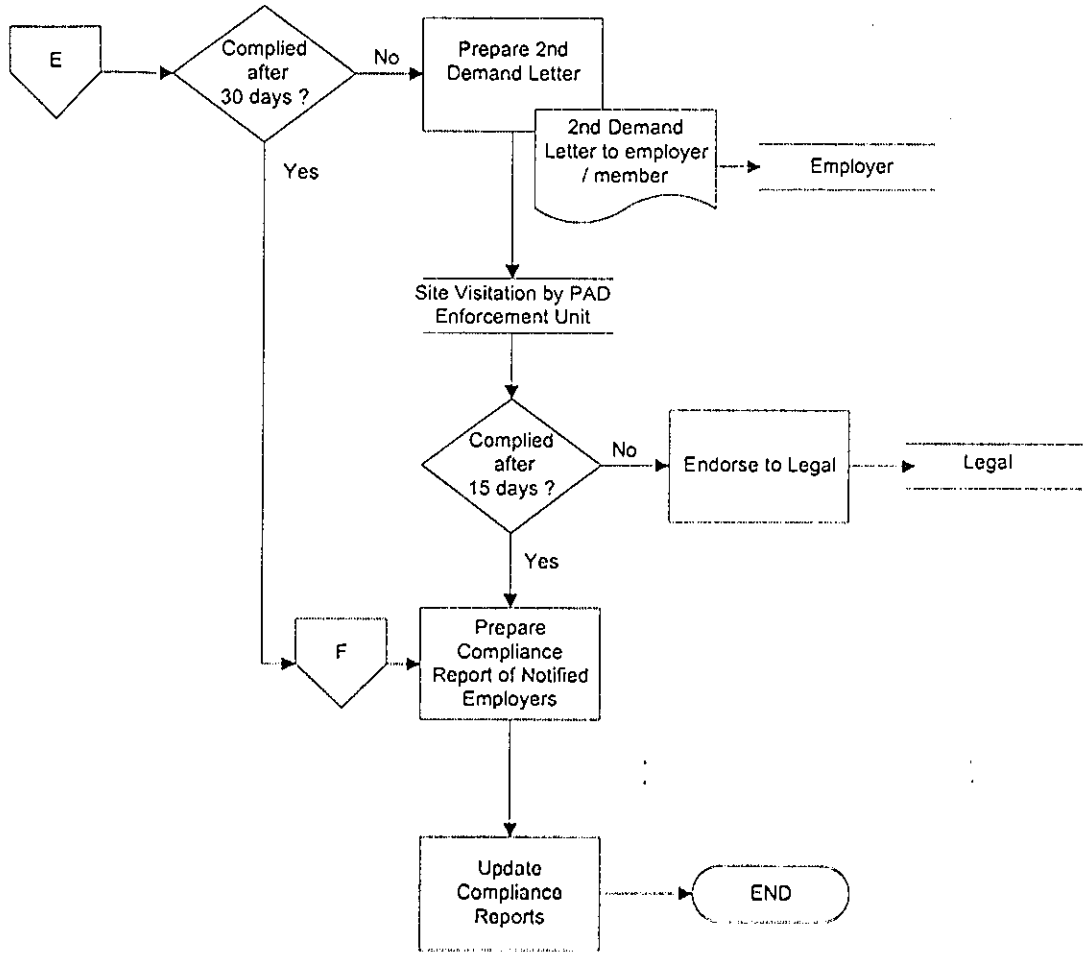



PHILIPPINE HEALTH INSURANCE CORPORATION

164

PROCESS NAME : MANAGE CONTRIBUTIONS
SUBPROCESS NAME : PRIVATE SECTOR COMPLIANCE ENFORCEMENT

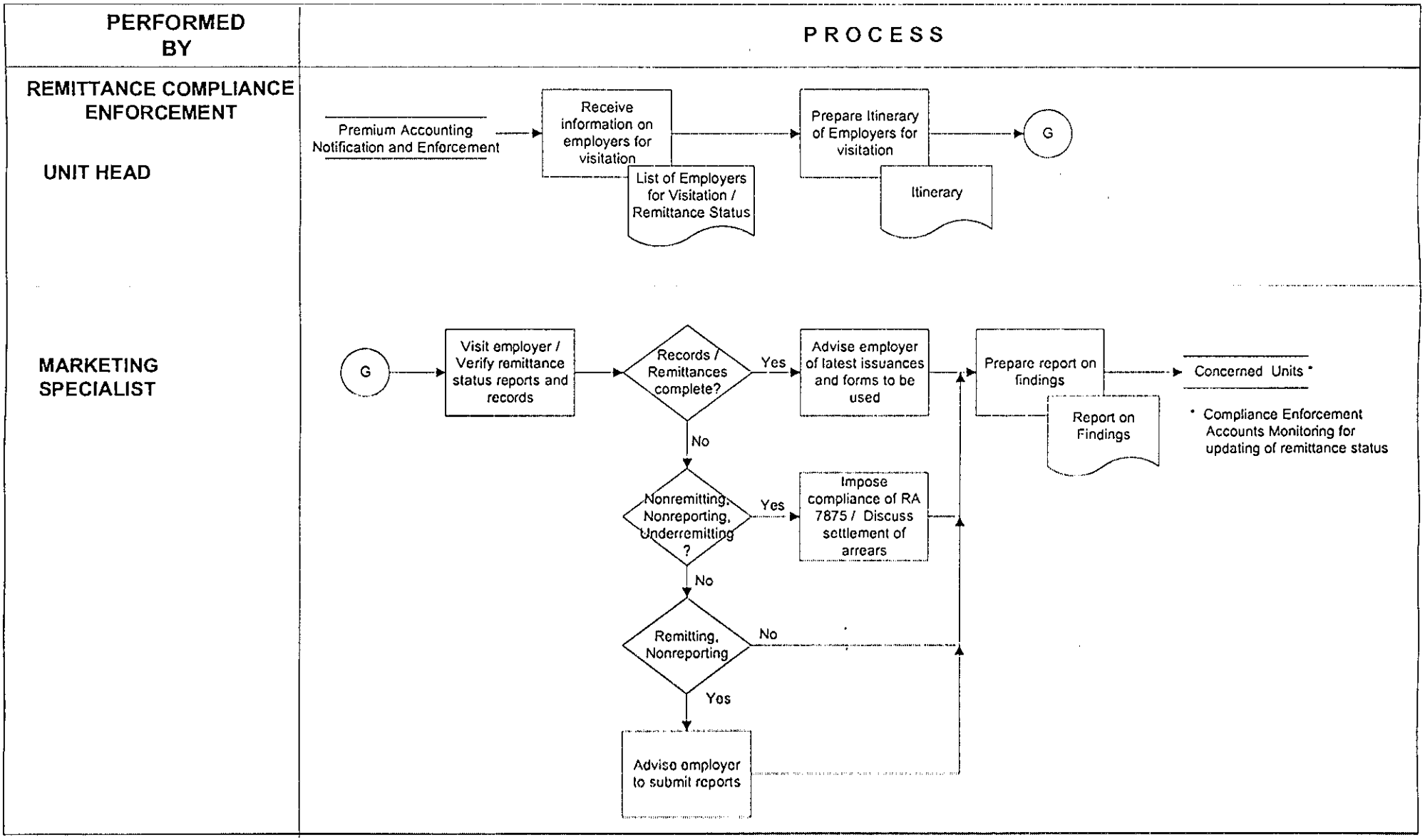
| PERFORMED BY | PROCESS |
|---|---|
| REMITTANCE NOTIFICATION<br><br>ACCOUNT MANAGEMENT ANALYST | |
| ACCOUNT MONITORING<br><br>ACCOUNT MANAGEMENT ANALYST | |






PHILIPPINE HEALTH INSURANCE CORPORATION

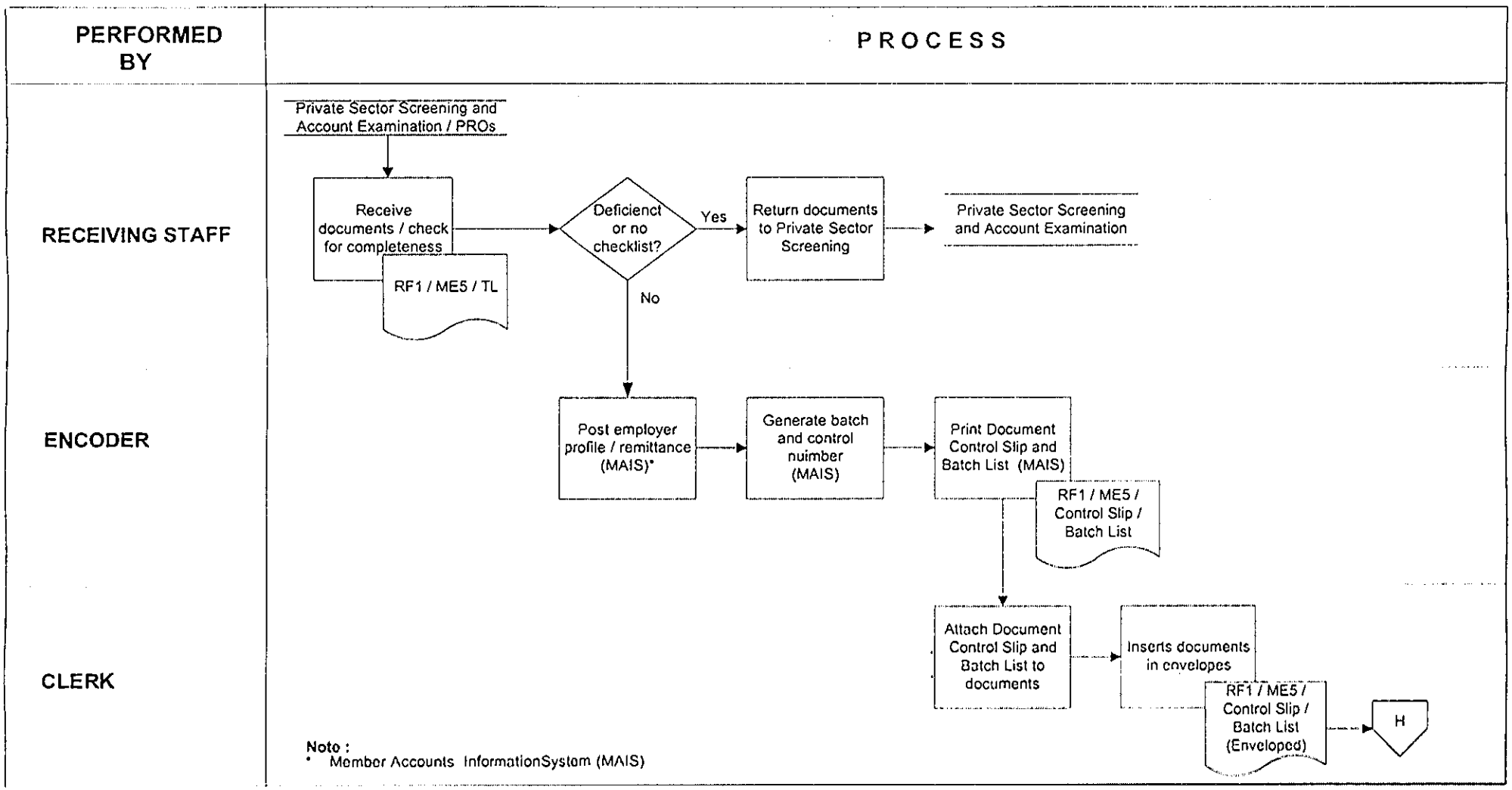
PROCESS NAME : MANAGE CONTRIBUTIONS
SUBPROCESS NAME : PRIVATE SECTOR SITE VISITATION






PHILIPPINE HEALTH INSURANCE CORPORATION

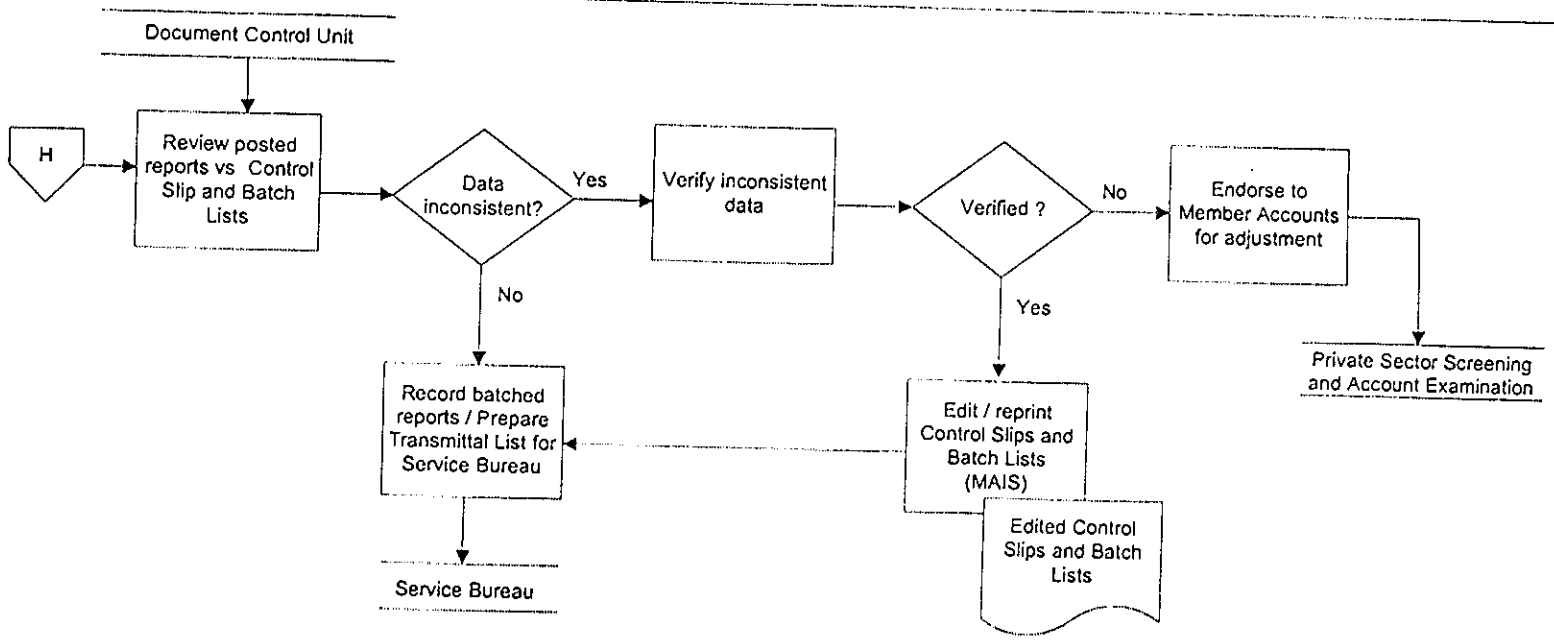
PROCESS NAME : MANAGE CONTRIBUTIONS
SUBPROCESS NAME : PRIVATE SECTOR - DATA MANAGEMENT






PHILIPPINE HEALTH INSURANCE CORPORATION

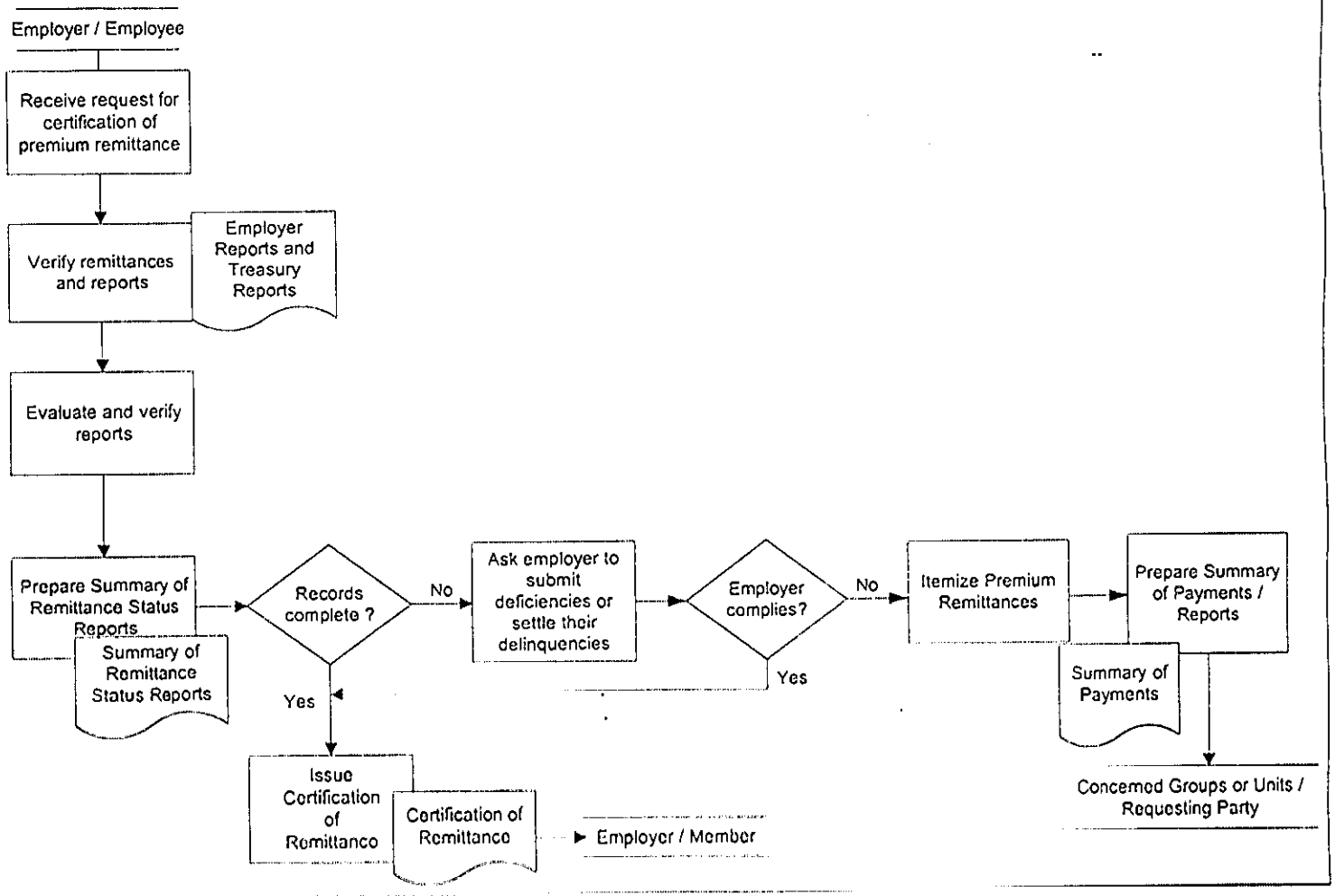
PROCESS NAME : MANAGE CONTRIBUTIONS
SUBPROCESS NAME : PRIVATE SECTOR - DATA MANAGEMENT

| PERFORMED BY | PROCESS |
|---|---|
| DOCUMENT REVIEWER |  |



Note :
* Member Accounts InformationSystem (MAIS)

PROCESS NAME : MANAGE CONTRIBUTIONS
SUBPROCESS NAME : CONFIRMATION AND CERTIFICATION OF PREMIUM REMITTANCE FOR PRIVATE SECTOR

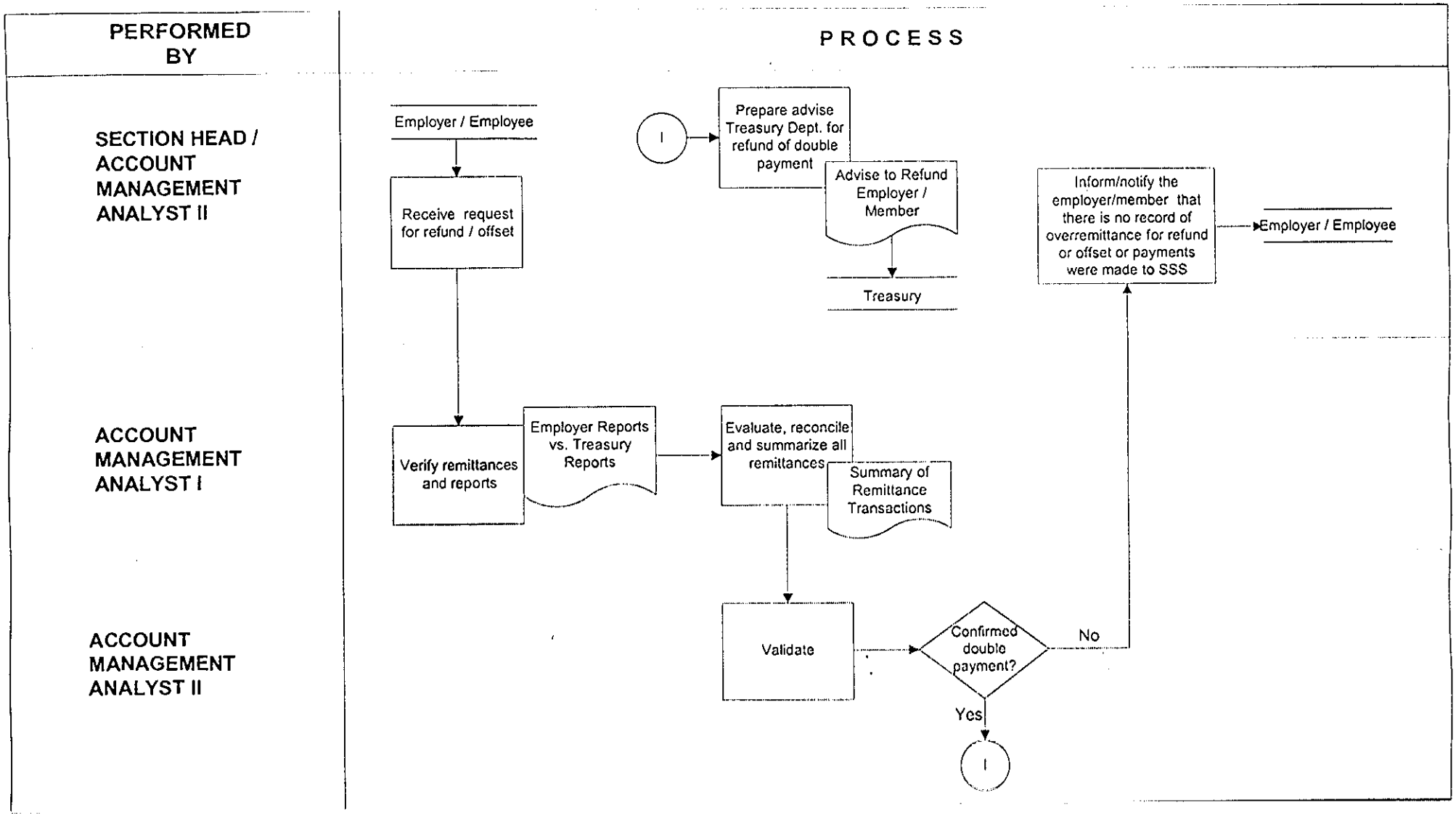
| PERFORMED BY | PROCESS |
|---|---|
| ACCOUNT MANAGEMENT ANALYST |  |





PHILIPPINE HEALTH INSURANCE CORPORATION

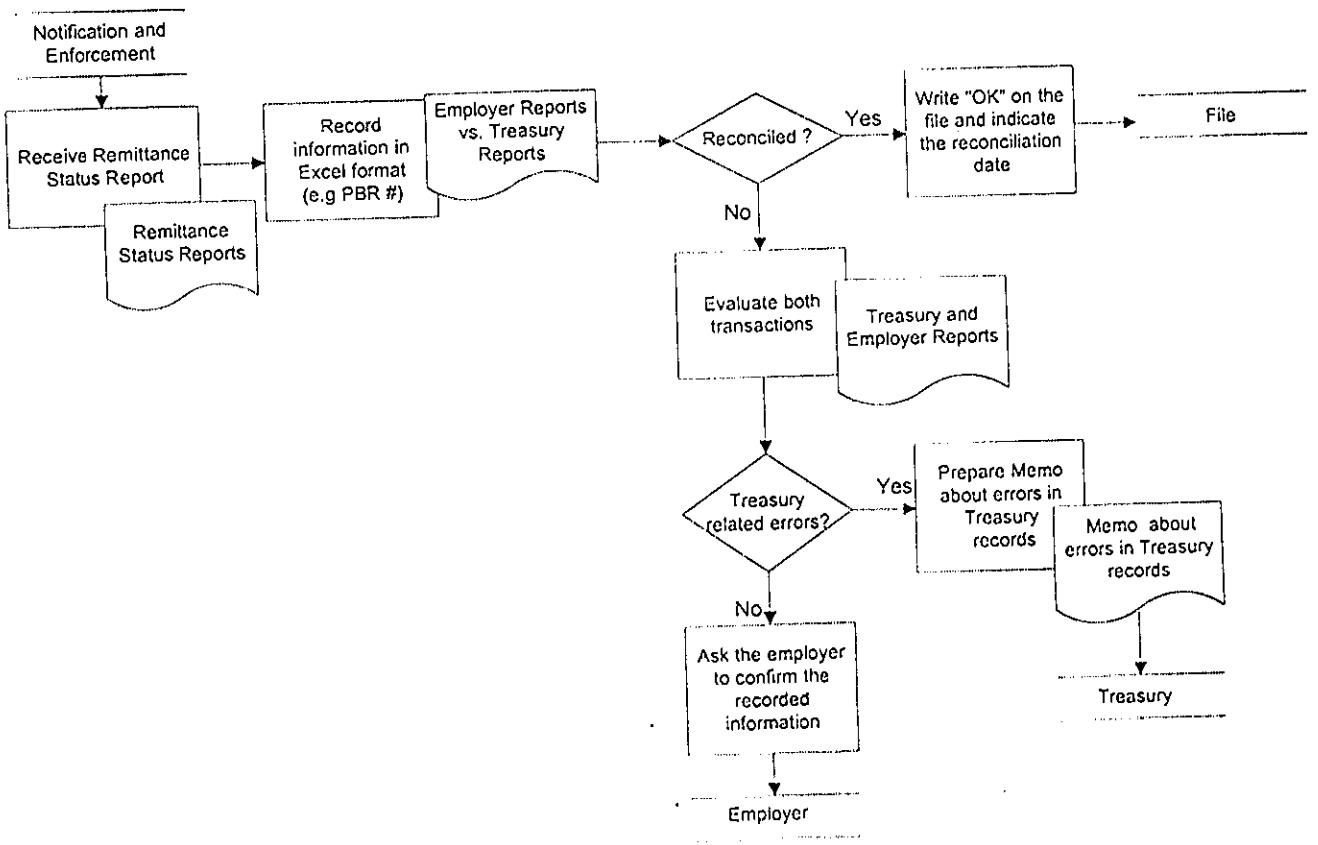
PROCESS NAME : MANAGE CONTRIBUTIONS
SUBPROCESS NAME : REQUEST FOR REFUND / OFFSET OF PREMIUMS






PHILIPPINE HEALTH INSURANCE CORPORATION

PROCESS NAME : MANAGE CONTRIBUTIONS
SUBPROCESS NAME : MANUAL RECONCILIATION OF EMPLOYER REPORTS

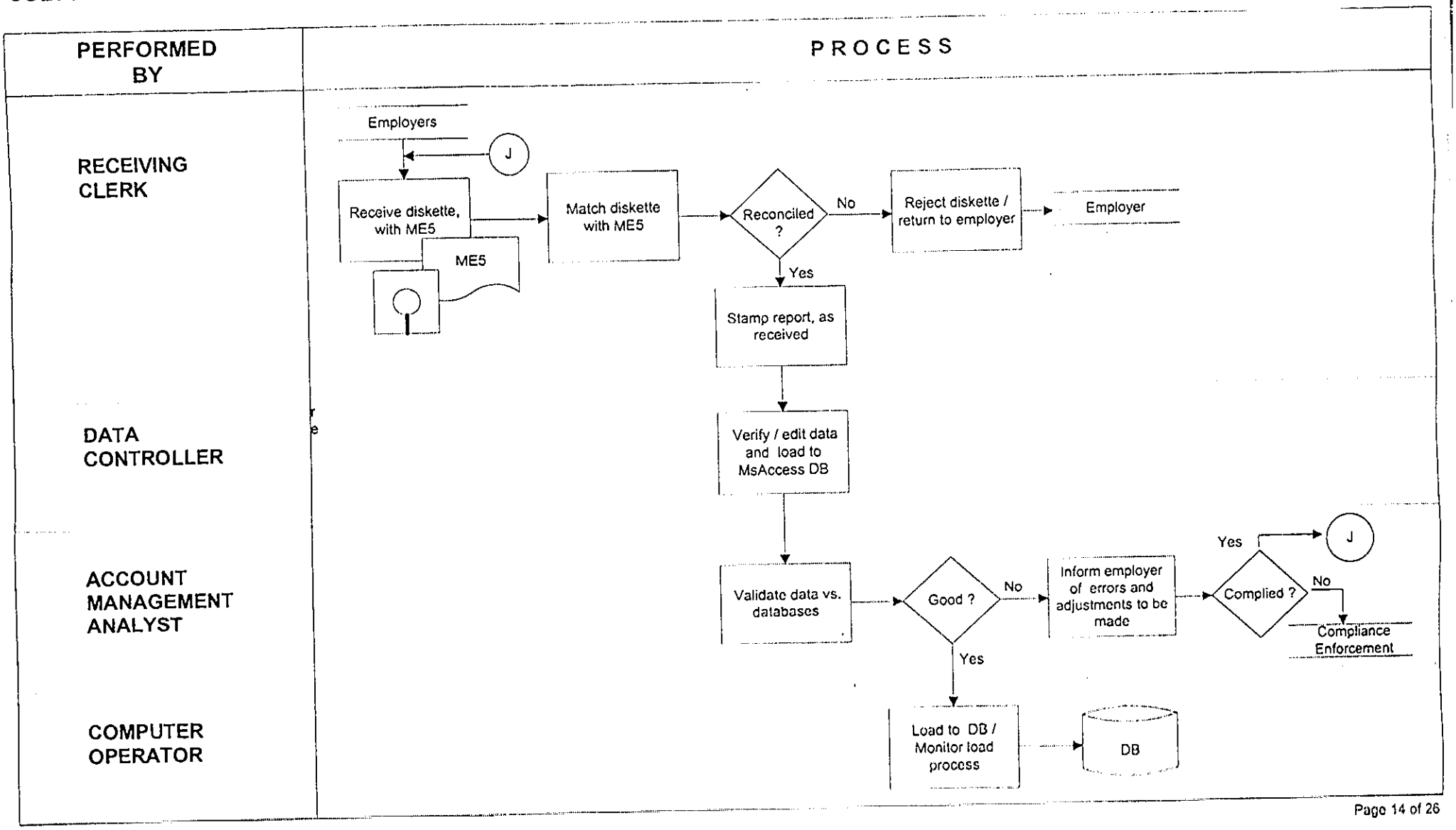
| PERFORMED BY | PROCESS |
|---|---|
| PREMIUM ACCOUNTING - RECONCILIATION<br><br>ACCOUNTS MANAGEMENT ANALYST I |  |





PHILIPPINE HEALTH INSURANCE CORPORATION

SUBPROCESS NAME : PROCESSING OF PRIVATE SECTOR REMITTANCE REPORTS SUBMITTED THRU DISKETTES

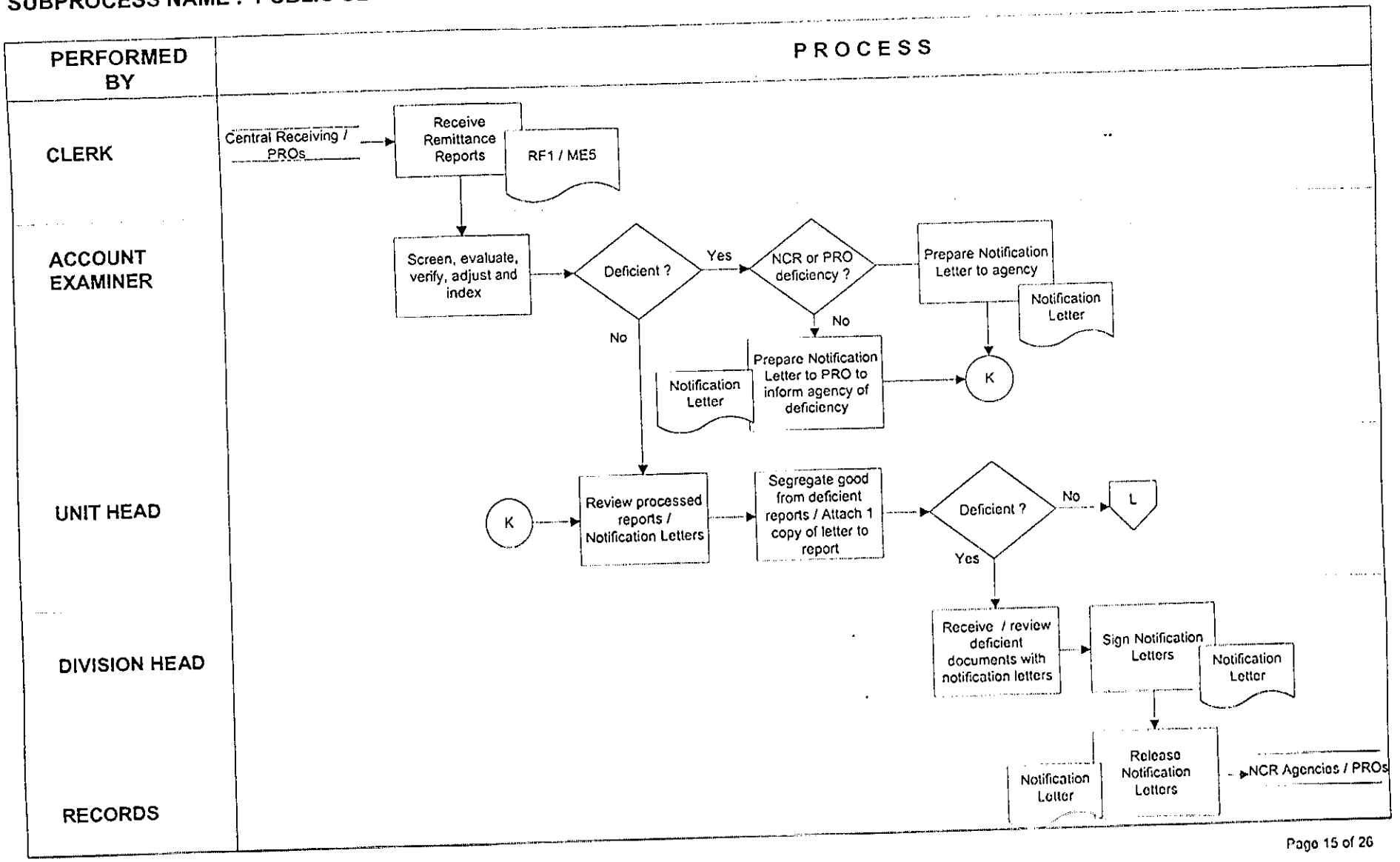





PHILIPPINE HEALTH INSURANCE CORPORATION

172

PROCESS NAME : MANAGE CONTRIBUTIIONS
SUBPROCESS NAME : PUBLIC SECTOR DATA MANAGEMENT

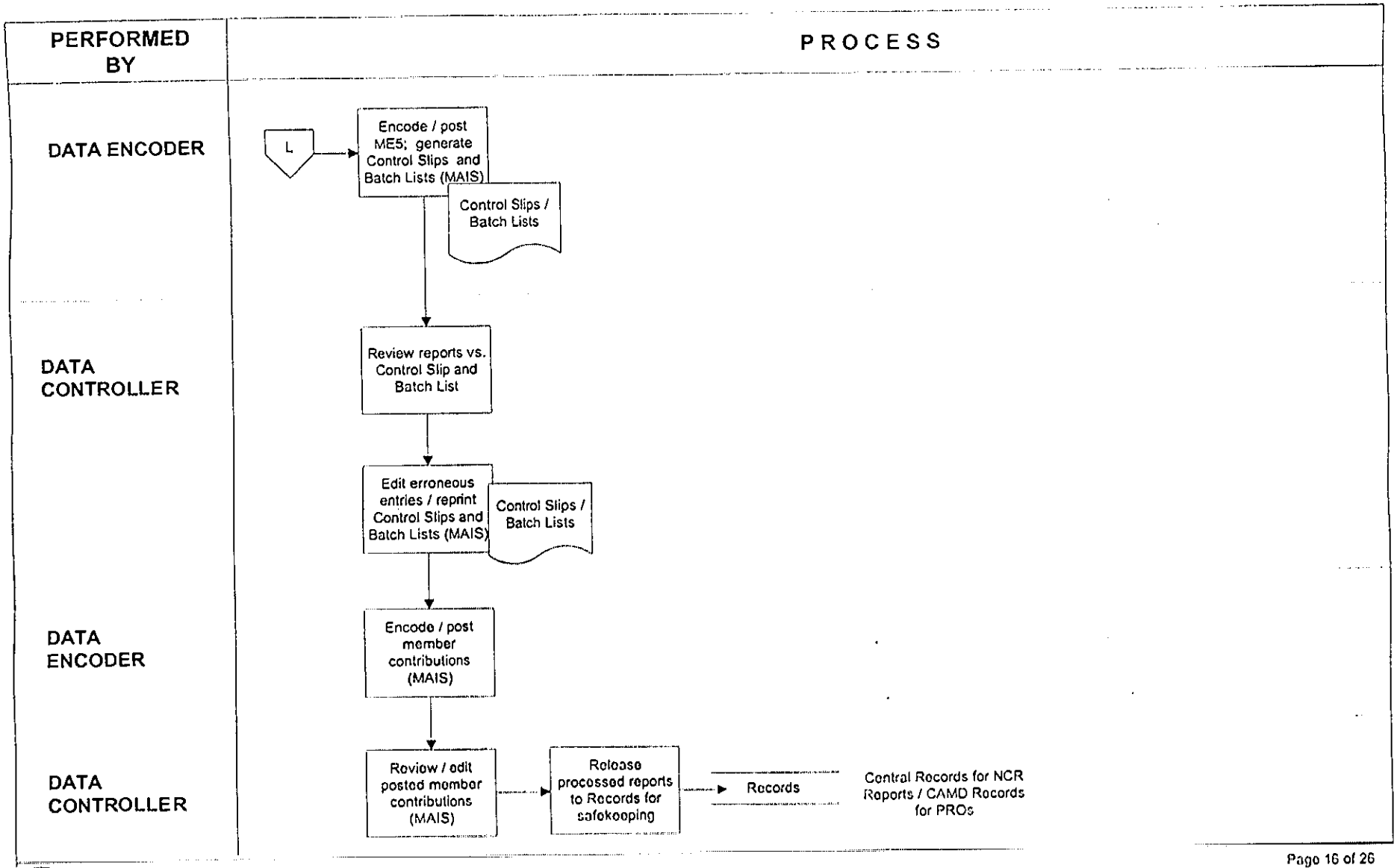





PHILIPPINE HEALTH INSURANCE CORPORATION

173

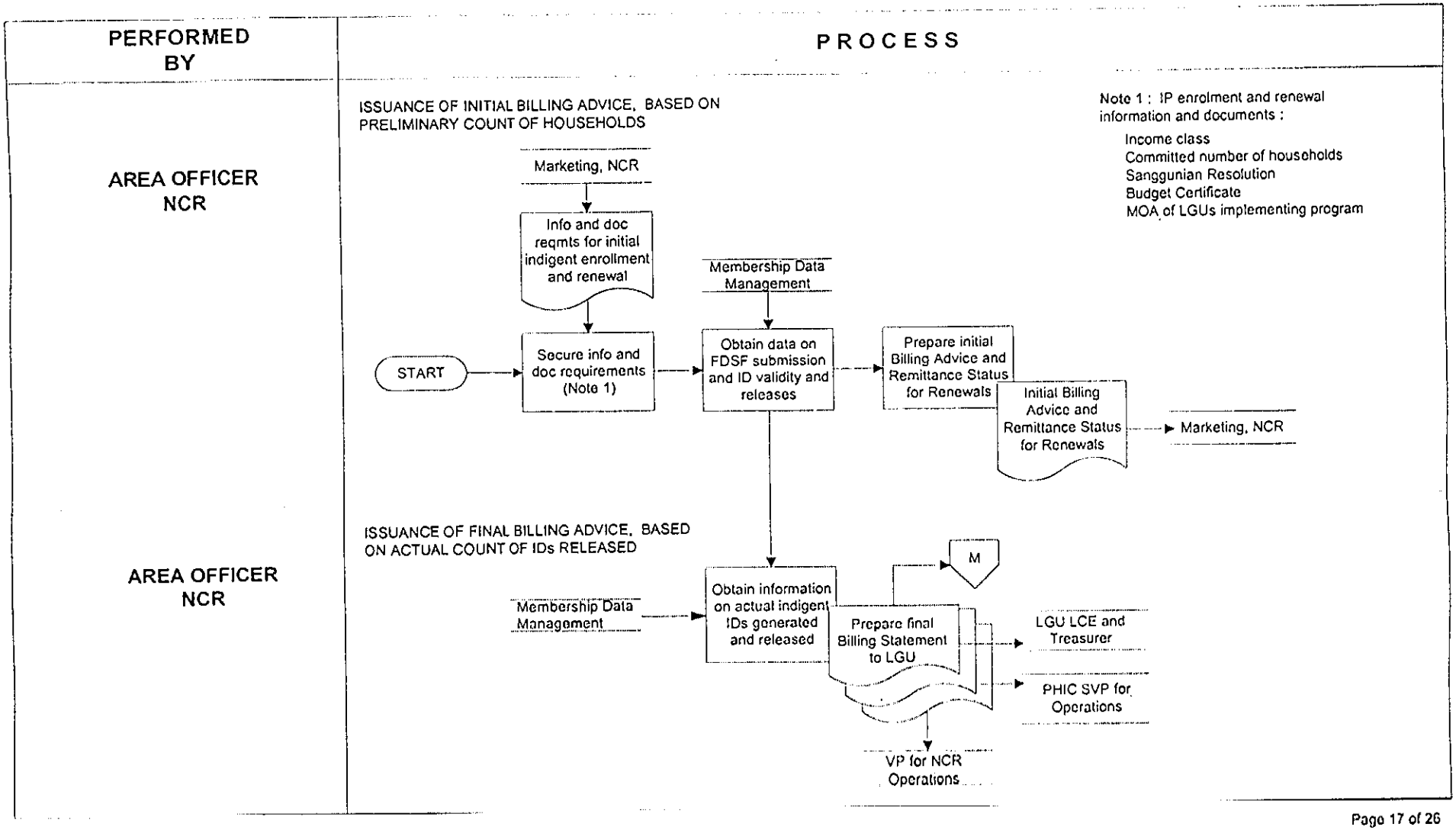
PROCESS NAME : MANAGE CONTRIBUTIONS
SUBPROCESS NAME : PUBLIC SECTOR DATA MANAGEMENT






PHILIPPINE HEALTH INSURANCE CORPORATION

PROCESS NAME : MANAGE CONTRIBUTIONS
SUBPROCESS NAME : BILLING AND COLLECTION OF INDIGENT PREMIUM ACCOUNTS
ISSUANCE OF INITIAL AND FINAL BILLING STATEMENTS



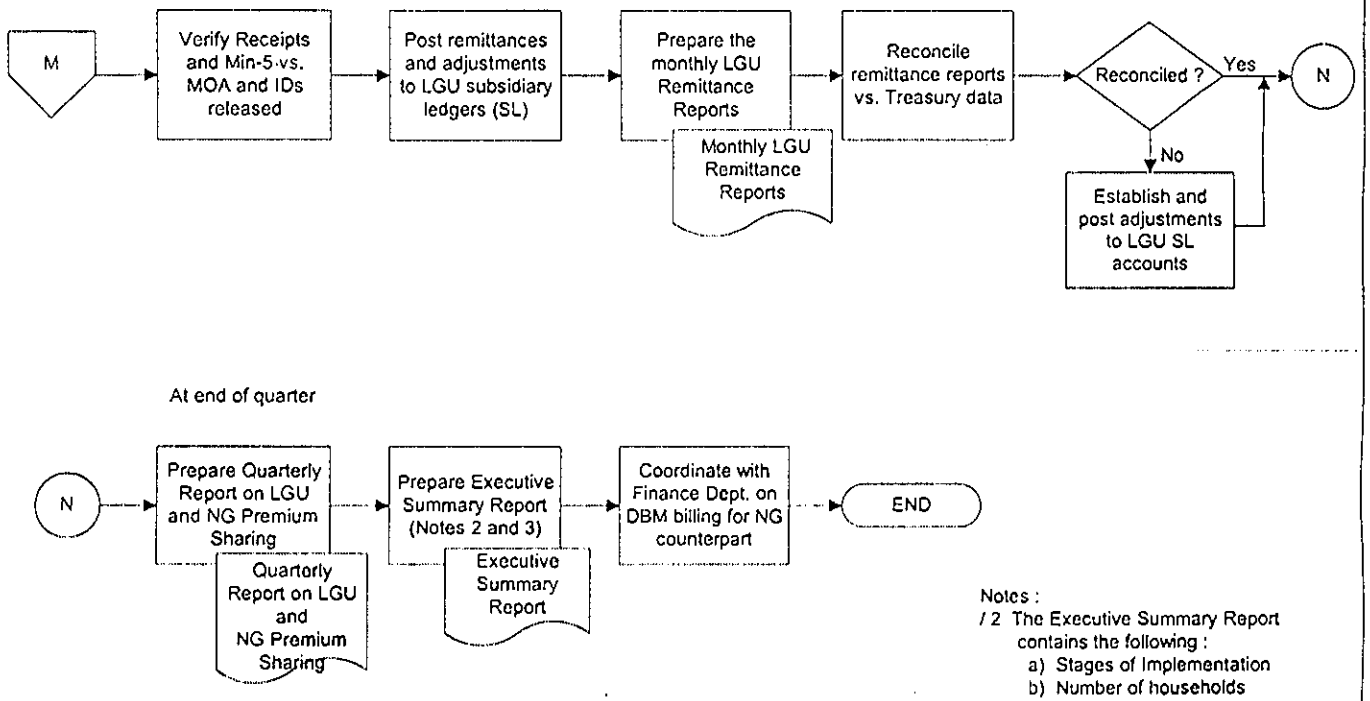



PHILIPPINE HEALTH INSURANCE CORPORATION

175

PROCESS NAME : MANAGE CONTRIBUTIONS
SUBPROCESS NAME : BILLING AND COLLECTION OF INDIGENT PREMIUM ACCOUNTS
COLLECTION AND REPORTING OF LGU PREMIUM REMITTANCES

| PERFORMED BY | PROCESS |
|---|---|
| AREA OFFICER | |
| DEVELOPMENT MANAGEMENT OFFICER | |




Notes :
/ 2 The Executive Summary Report contains the following :
a) Stages of Implementation
b) Number of households
c) Total premium contributions
d) LGU / NG shares in premiums

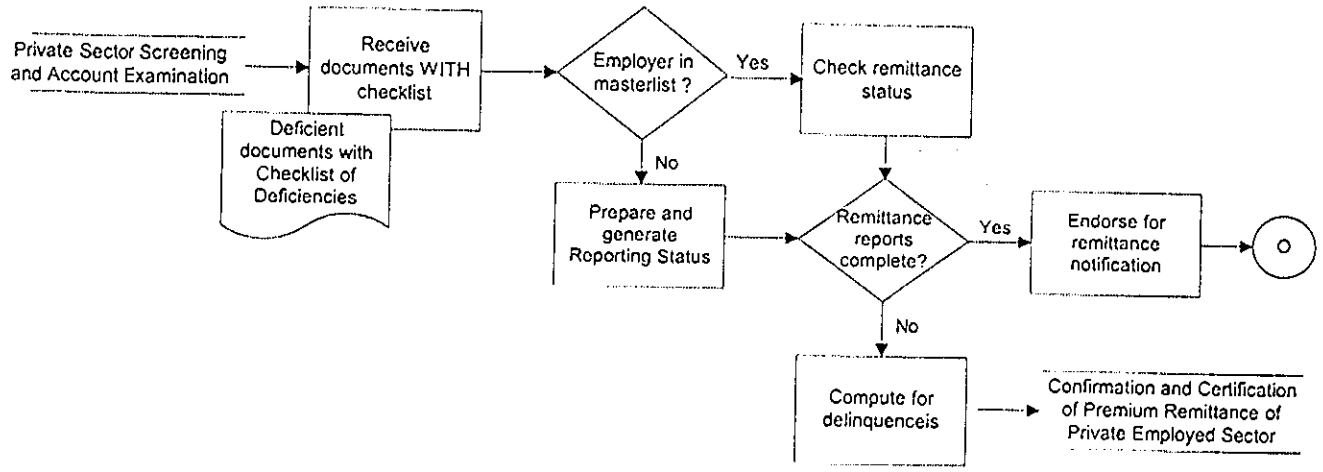
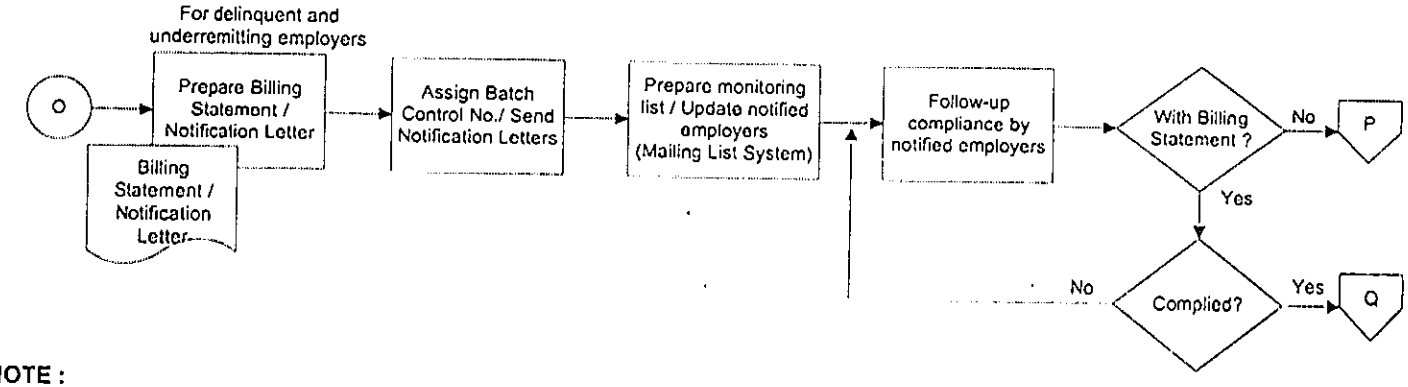
/3 The Executive Summary must be recommended by the OIC for CAMD , noted by the VP for MCMG, and certified by the Accountant for funds availability





176

PROCESS NAME : MANAGE CONTRIBUTIONS
SUBPROCESS NAME : PRIVATE SECTOR COMPLIANCE ENFORCEMENT ("TO BE")

| PERFORMED BY | PROCESS |
|---|---|
| ACCOUNT MONITORING<br><br>ACCOUNT MANAGEMENT ANALYST |  |
| REMITTANCE NOTIFICATION<br><br>ACCOUNT MANAGEMENT ANALYST |  |

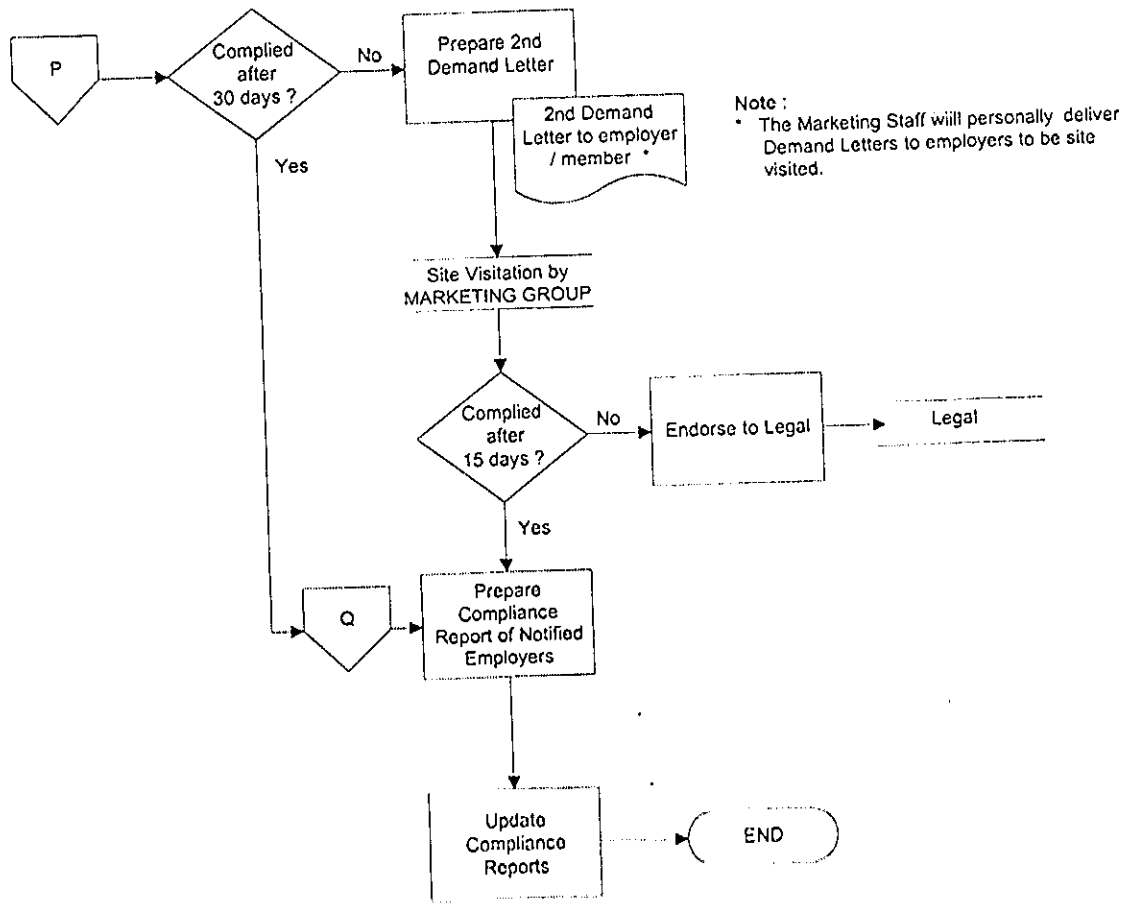




NOTE :

Same as the existing process flow , except that **Site Visits and personal intoraction with the private employers** will be done by the Marketing Gro up.

PROCESS NAME : MANAGE CONTRIBUTIONS
SUBPROCESS NAME : PRIVATE SECTOR COMPLIANCE ENFORCEMENT ("TO-BE")

| PERFORMED BY | PROCESS |
|---|---|
| REMITTANCE NOTIFICATION<br><br>ACCOUNT MANAGEMENT ANALYST<br><br>ACCOUNT MONITORING<br><br>ACCOUNT MANAGEMENT ANALYST |  |

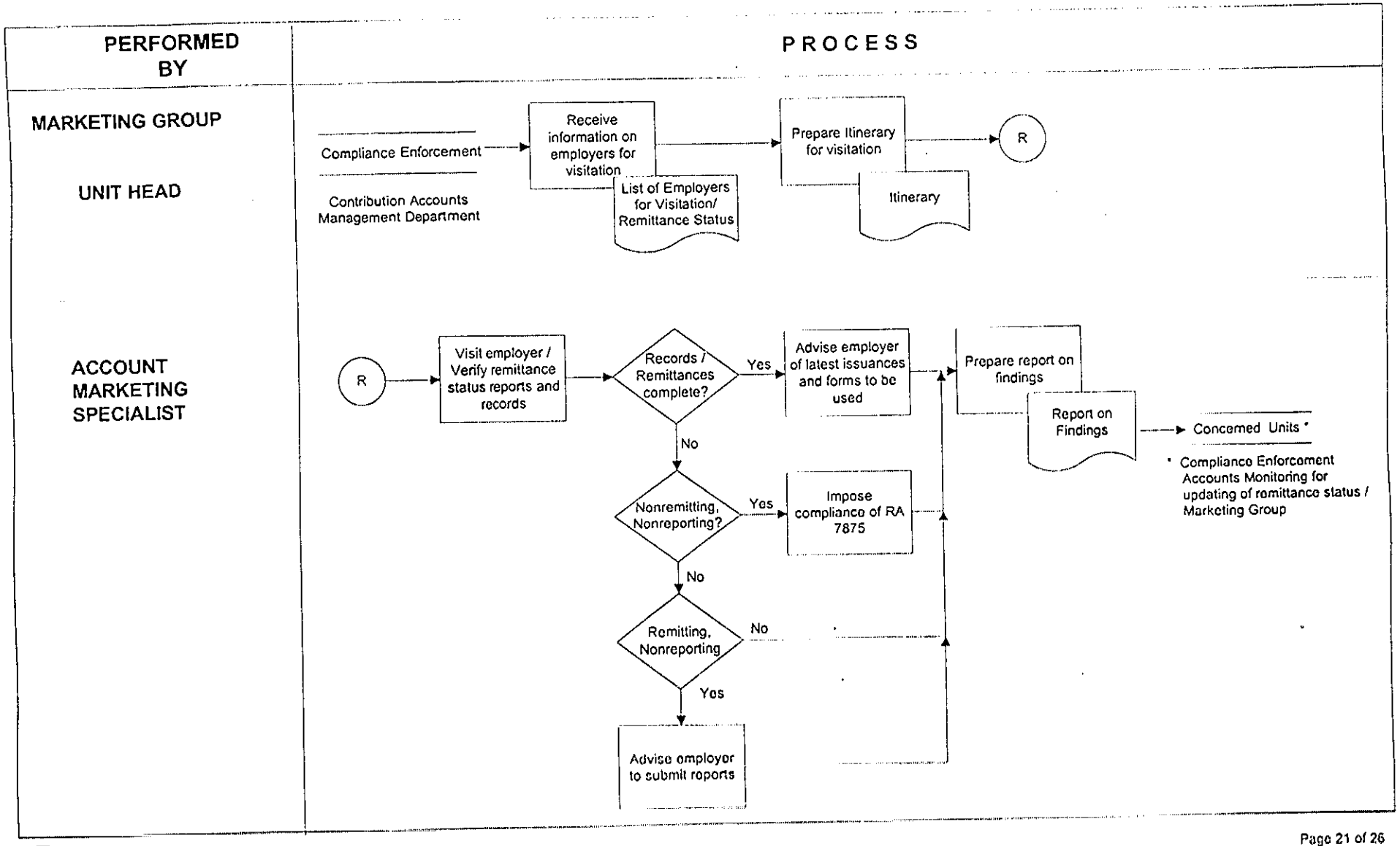




PHILIPPINE HEALTH INSURANCE CORPORATION

175

PROCESS NAME : MANAGE CONTRIBUTIONS
SUBPROCESS NAME : PRIVATE SECTOR SITE VISITATION ("TO BE")

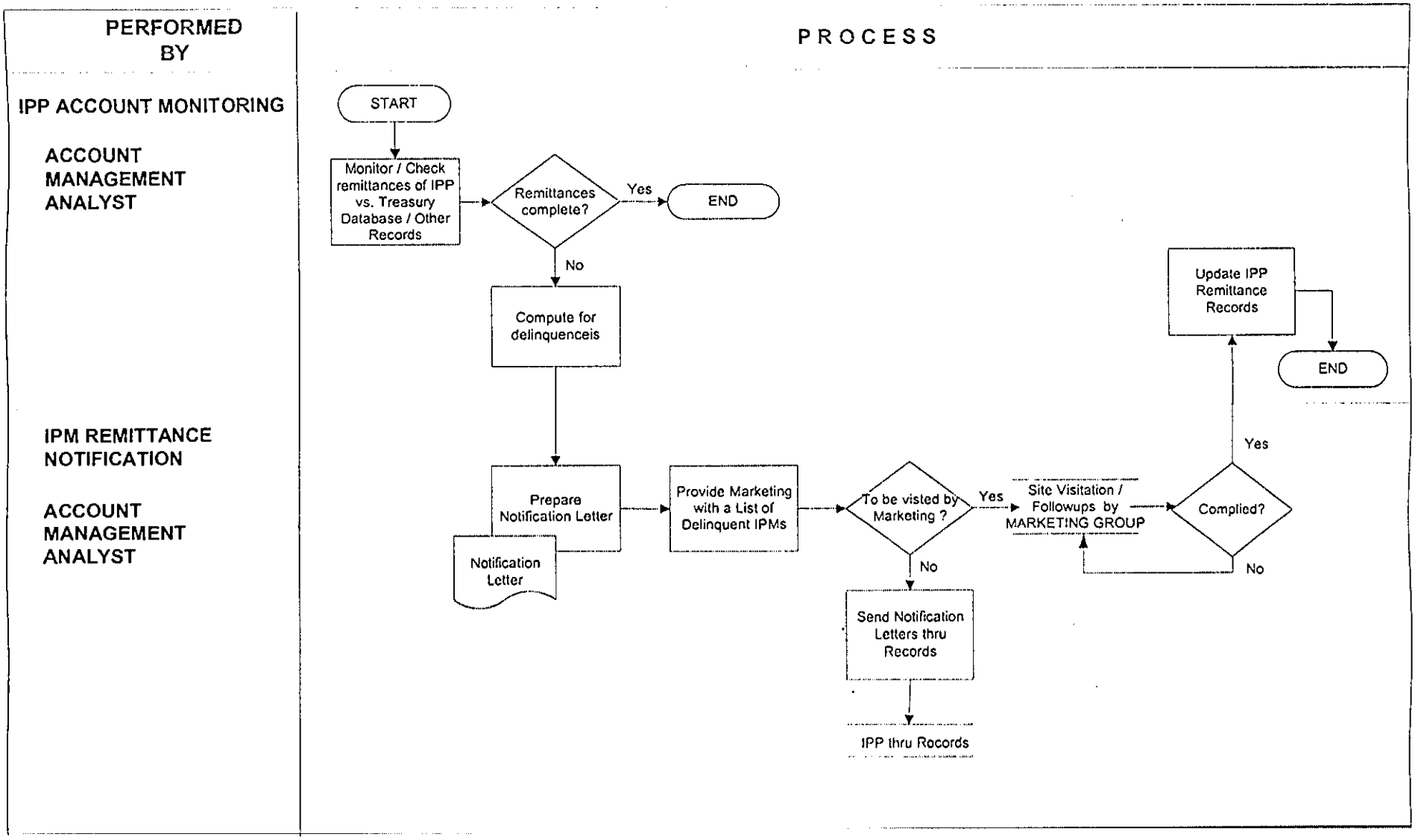





PHILIPPINE HEALTH INSURANCE CORPORATION

179

PROCESS NAME : MANAGE CONTRIBUTIONS
SUBPROCESS NAME : INDIVIDUALLY-PAYING MEMBER (IPM) COMPLIANCE ENFORCEMENT ("TO BE")



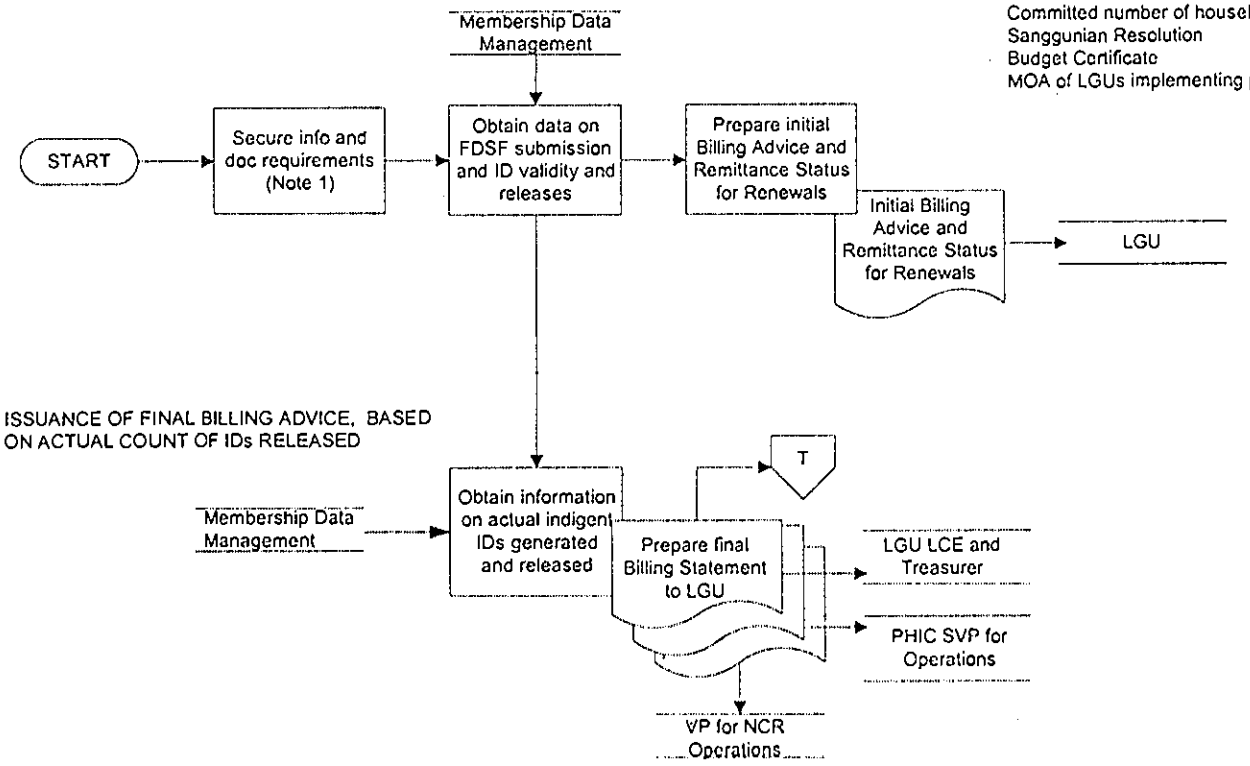



PHILIPPINE HEALTH INSURANCE CORPORATION

180

PROCESS NAME : MANAGE CONTRIBUTIONS
SUBPROCESS NAME : BILLING AND COLLECTION OF INDIGENT PREMIUM ACCOUNTS ("TO BE")
ISSUANCE OF INITIAL AND FINAL BILLING STATEMENTS

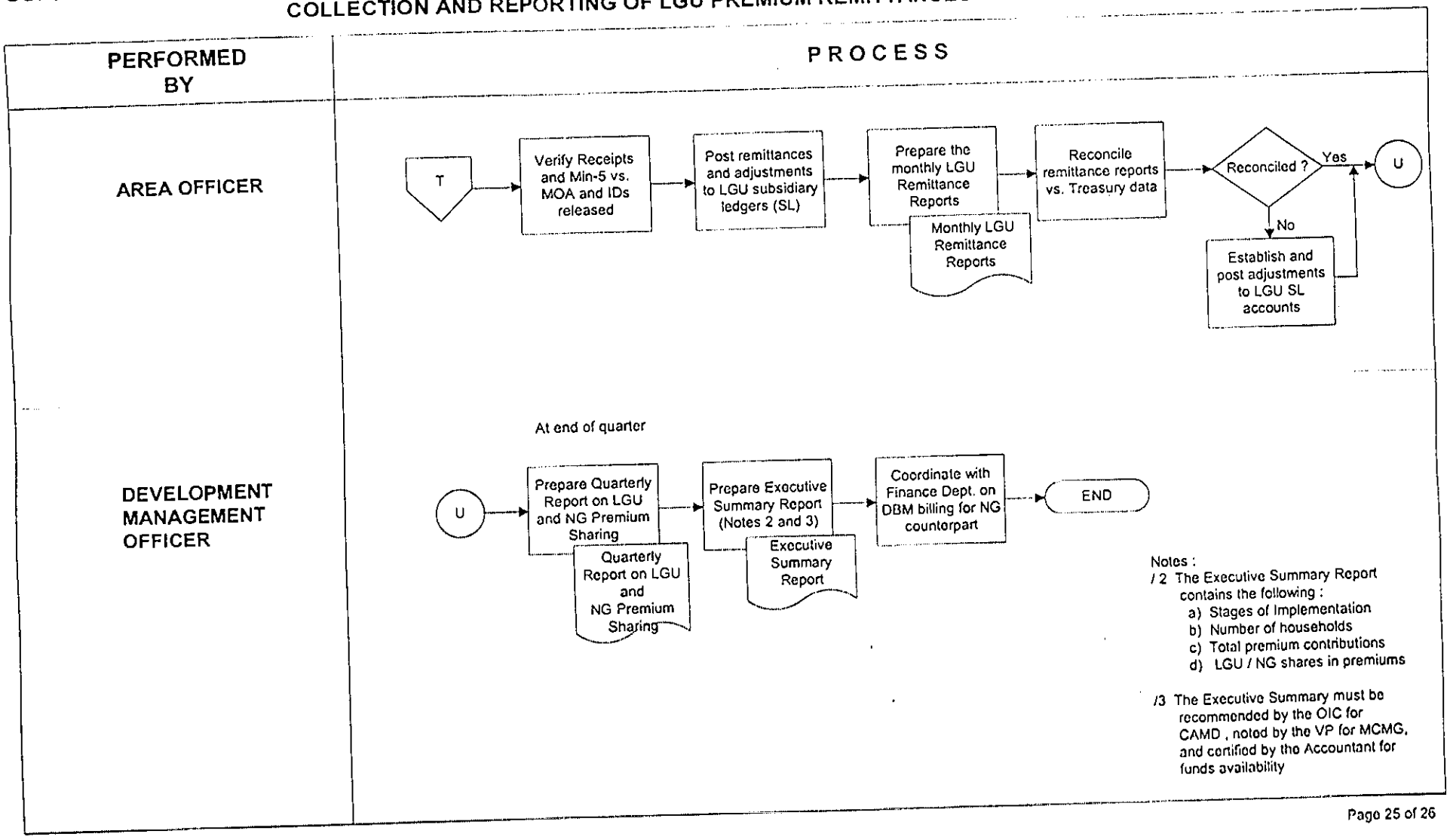
| PERFORMED BY | PROCESS |
|---|---|
| ACCOUNT MARKETING SPECIALIST - MARKETING GROUP | ISSUANCE OF INITIAL BILLING ADVICE, BASED ON PRELIMINARY COUNT OF HOUSEHOLDS |
| AREA OFFICER NCR | ISSUANCE OF FINAL BILLING ADVICE, BASED ON ACTUAL COUNT OF IDs RELEASED |






PHILIPPINE HEALTH INSURANCE CORPORATION

PROCESS NAME : MANAGE CONTRIBUTIONS
SUBPROCESS NAME : BILLING AND COLLECTION OF INDIGENT PREMIUM ACCOUNTS
COLLECTION AND REPORTING OF LGU PREMIUM REMITTANCES



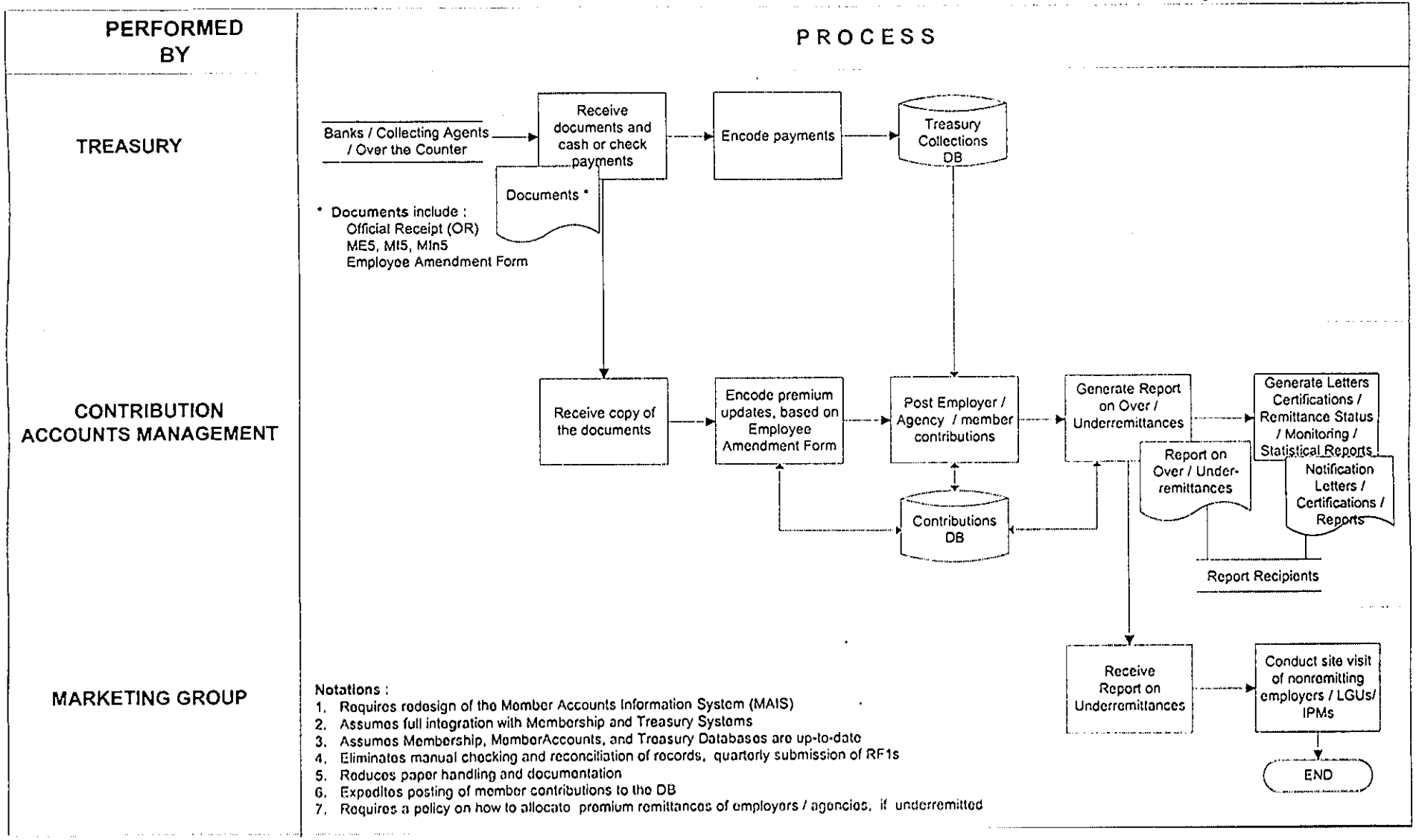



PHILIPPINE HEALTH INSURANCE CORPORATION

152

PROCESS NAME : MANAGE CONTRIBUTIONS
SUBPROCESS NAME : REMITTANCE ACCOUNT MONITORING AND ENFORCEMENT - ALL SECTORS ("TO BE")

Long-Term / Conceptual Diagram






PHILIPPINE HEALTH INSURANCE CORPORATION

# MANAGE CONTRIBUTIONS

# PROCEDURAL NARRATIVES

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| 4 | Private Sector Encoding of Notification and Compliance to Notification | 6 |
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| No | PARTICULARS | Page |
|---|---|---|
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| Process Name | Manage Contribution | Version Number | 1.0 |
|---|---|---|---|
| Sub Process Name | Processing of Remittance Reports Submitted thru Drop Boxes and Mails | Prepared by/Date | Susan R. |
| Subject | Narrative Procedures | Approved by/Date | |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| CAMD, CENTRAL RECEIVING MANAGEMENT DIVISION | 1. PROCESS REMITTANCE REPORTS SUBMITTED THROUGH DROP BOXES AND MAILS |
| RECEIVING CLERK | 1.1 Collect and retrieve remittance reports from drop boxes. Receive remittance reports from the Central Records Division. |
| RECEIVING CLERK | 1.2 Sort, count, stamp the receipt date, and arrange remittance reports by area |
| SCREENER1 | 1.3 Screen documents |
| ENCODER | 1.4 Encode employer data. Generate prooflist. |
| UNIT HEAD | 1.5 Validate and proofread encoded data<br>1.5.1 If the encoded data are correct, proceed to Step 5.<br>1.5.2 Otherwise, go back to Step 1.4 |
| SCREENER II | 1.5 Generate Acknowledgment Letters (Exhibit 1) for good (no deficiency) remittance reports |
| RELEASING CLERK | 1.6 Generate Summary of Batched Reports (Transmittal List). |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| CAMD, CENTRAL RECEIVING MANAGEMENT DIVISION | 1. PROCESS REMITTANCE REPORTS SUBMITTED BY WALK-IN CLIENTS |
| RECEIVING CLERK | 1.1 Receive remittance reports received from walk-in members / employers. Screen for completeness of documentary requirements.<br><br>1.1.1 If supporting documents are not complete, issue and attach Documentary Request Checklist (Exhibit 4) to deficient reports.<br><br>1.1.1.1 If deficiencies are not major, proceed to Step 1.1.2.<br><br>1.1.1.2 Otherwise, return reports with major deficiencies (incomplete) to the client.<br><br>1.1.2 If documents are complete, stamp the date of receipt, sort per area, count per transaction, and batch per 25 reports. |
| ENCODER | 1.2 Encode employer data. Generate Prooflist. |
| UNIT HEAD | 1.3 Review encoded data.<br><br>1.3.1 If encoded data are correct, proceed to Step 1.4.<br><br>1.3.2 Otherwise, go back to Step 1.2. |
| SCREENER II | 1.4 Generate Acknowledgment Letters (Exhibit 1) for good (no deficiency) remittance reports. |
| RELEASING CLERK | 1.5 Prepare Summary of Batched Reports for release to the appropriate CAMD Division. |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| MEMBERS ACCOUNTS DIVISION – PRIVATE SECTOR | **1. RECEIVE AND SCREEN PRIVATE REMITTANCE REPORTS** |
| UNIT HEAD, SCREENING | 1.1 Receive private remittance reports from different areas forwarded by the Central Receiving Mgt. Division for processing.<br><br>1.2 Check the number of documents received against the transmittal and remittance report releasing form from CRMD.<br><br>1.3 File the transmittal list and the releasing form.<br><br>1.4 Assign control number for easy tracking of documents.<br><br>1.5 Distribute workload to screeners for screening. |
| SCREENER | **2. RECEIVE AND SCREEN PRIVATE REMITTANCE REPORTS**<br><br>2.1 Check if documents are complete.<br><br>2.1.1 Check if all the necessary information required in the ME-5s (Exhibit 2) and RF-1s (Exhibit 3) are properly filled up.<br><br>2.1.2 Reconcile the amount reflected in the RF-1 with the amount in ME-5.<br><br>2.1.3 Calculate for underpayment or overpayment, if any.<br><br>2.2 Attach Documentary Request Checklist (Exhibit 4). Indicate the status of the report as to whether "Good" or "Deficient". Indicate the over- or underpayment.<br><br>2.2.1 If good :<br>2.2.1.1 Sort the reports by area, year, and quarter.<br><br>2.2.1.2 Bundle the reports in batches of 50.<br><br>2.2.1.3 Forward the batched reports to the Unit Head for review prior to |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| SCREENER | release to DMD.<br><br>2.2.2 If deficient, forward the documents to the Account Examiner for adjustment. Proceed to Step 3.<br><br>*Note* : Documents are considered "Good reports" if the information needed for database update are complete while documents are considered "deficient" if important information necessary for database update are missing. Deficient reports will be forwarded to the Account Examiner for adjustment. |
| ACCOUNT EXAMINER | **3. CHECK, VERIFY, EXAMINE, AND ADJUST**<br><br>3.1 Check, verify, examine, and adjust deficient documents (if applicable).<br><br>3.1.1 Recompute underpayment or overpayment indicated in the checklist.<br><br>3.1.2 Validate the deficiency discovered by the screeners.<br><br>3.1.2.1 If reports can be adjusted, calculate for the adjusted amount. Forward adjusted remittance reports and supporting documents to the Unit Head for final review.<br><br>3.1.2.2 If the deficient report cannot be adjusted, forward to Compliance Monitoring for encoding of deficiencies and notification.<br><br>**Note** : Adjustments are also done for remittance reports returned by the Private Sector Data Management Division to the Private Sector Accounts Management Division due to deficiencies subsequently found. |
| UNIT HEAD, SCREENING | **4. REVIEW AND RELEASE**<br><br>4.1 Review adjustments effected by the Account Examiner. |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| UNIT HEAD, SCREENING | 4.2 Prepare Transmittal List.<br>4.3 Release to Data Management Division for encoding and updating |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| COMPLIANCE MONITORING | |
| ENCODER | **1. RECEIVE DOCUMENTS FROM NCR AND PRO SECTIONS (for Centrally Remitting)** |
| | **2. ENCODE, SORT, AND SCREEN** |
| | 2.1 Encode remittance report deficiencies using the Premium Compliance System (PCS). |
| UNIT HEAD | 2.2 Counter-check deficiencies indicated on the Documentary Request Checklist (Exhibit 4) |
| | 2.3 Review encoded deficiencies. |
| ENCODER | **3. ENDORSE REPORTS WITH UNDER-REMITTANCES TO COMPLIANCE ENFORCEMENT FOR APPROPRIATE ACTION** |
| | 3.1 Attach a duplicate copy of the Documentary Request Checklist to the deficient reports. |
| | 3.2 Forward to Compliance Enforcement for appropriate action. |
| ENCODER | **4. PREPARE ACKNOWLEDGMENT AND NOTIFICATION LETTERS** |
| | 4.1 If the deficiencies are not major, generate Acknowledgement and Notification Letters (Exhibit 5). |
| | 4.2 Forward to Division Head for review and signature |
| DIVISION HEAD (OIC) | 4.3 Review and sign the Acknowledgment and Notification Letters. |
| | 4.4 Forward to Central Records for mailing to the intended recipients. |
| CENTRAL RECORDS | **5. MAIL NOTIFICATION LETTERS TO EMPLOYERS / PROS (FOR EMPLOYERS UNDER THE PROS).** |
| ACCOUNT EXAMINER | **6. RECEIVE AND REVIEW COMPLIANCE REPORT IN RESPONSE TO NOTIFICATION** |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| ACCOUNT EXAMINER | 6.1 Review compliance letter / report.<br><br>6.1.1 If complied, forward the documents to Data Management for encoding<br><br>6.1.2 If still deficient, send another letter to the employer reiterating the deficiency. |
| ENCODER | **7. UPDATE, SORT, AND RELEASE TO DATA MANAGEMENT FOR ENCODING**<br><br>7.1 Update documents using the Premium Compliance System.<br><br>7.2 Sort the documents by area.<br><br>7.3 Release the documents to Private Sector Data Management for employer profile encoding. |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| ACCOUNT MONITORING<br><br>ACCOUNT MANAGEMENT ANALYST | **1. RECEIVE AND REVIEW DEFICIENT DOCUMENTS**<br><br>1.1 Receive remittance reports with Documentary Request Checklist (Exhibit 4).<br><br>**2. PREPARE REMITTANCE STATUS REPORTS**<br><br>2.1 Prepare remittance status reports.<br><br>2.1.1 Check records available from existing systems, such as, Transmittal List System, Employer Posting Module, Premium Compliance System, Mailed/Drop Box files, Treasury, databases of remittances received in diskette format - to determine the completeness or irregularity in submitting RF1/Employer report.<br><br>2.1.2 Review and evaluate the remittance status report.<br><br>2.1.2.1 If the employers records are complete, endorse the report for Remittance Notification (Step 3)<br><br>2.1.2.2 If the employers records are not complete, endorse the report for reporting status confirmation<br><br>(Process : Confirmation and Certification of Premium Remittances for Private Employers) |
| REMITTANCE NOTIFICATION<br><br>ACCOUNT MANAGEMENT ANALYST | **3. NOTIFY DELINQUENT EMPLOYERS**<br><br>3.1 Prepare Billing Letter to notify delinquent employers with underremittances, unreported remittances, or no remittances.<br><br>3.2 Assign a Control number to the letter and send to the delinquent employers through mail.<br><br>3.3 Prepare and maintain a Monitoring List of delinquent employers.<br><br>3.4 Follow-up employers for compliance |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| ACCOUNT MANAGEMENT ANALYST | 3.4.1 If the employer complies within 30 days, prepare a Compliance Report and forward the report to Account Monitoring<br><br>3.4.2 If the employer does not comply within 30 days :<br><br>3.4.2 1 Prepare a 2nd Demand Letter.<br><br>3.4.2.2 Conduct site visit of delinquent employers. Deliver the 2nd Demand Letter.<br><br>(Procedure : Site Visitation of Delinquent Employers)<br><br>• If the employer complies within 15 days, prepare a Compliance Report. Forward to Account Monitoring<br><br>• If not, endorse to Legal for appropriate action |
| ACCOUNT MONITORING | **4. Update Compliance** |
| ACCOUNT MANAGEMENT ANALYST | 4.1 Update compliance reports, using PCS |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| REMITTANCE COMPLIANCE ENFORCEMENT<br><br>UNIT HEAD | **1. SCHEDULE ITINERARY FOR EMPLOYER VISITATION.**<br><br>1.1 Receive List of Employers for site visit, together with the 2nd Demand Letters and Remittance Status Report (Exhibit 6)<br><br>1.2 Assign site visit work to Marketing Specialist. |
| MARKETING SPECIALIST | **2. CONDUCT SITE VISIT**<br><br>2.1 Meet with employer and discuss remittance status report<br><br>2.1.1 If verification shows that remittances are complete, inform employer of latest Philhealth issuances and forms to use.<br><br>2.1.2 If employer is nonremitting and nonreporting, require employer to comply with RA7875,<br><br>2.1.3 If employer is underremitting, discuss and assist resolve employer problem with settlement of arrearages.<br><br>2.1.4 If employer is remitting but not reporting, advise employer to submit the required reports.<br><br>2.2 Prepare Travel Report.<br><br>2.2.1 Include all critical incidents encountered during the site visit.<br><br>2.2.2 Submit to the Unit Head. |
| UNIT HEAD | **3. REVIEW AND COLLATE TRAVEL REPORTS**<br><br>3.1 Review and collate all Travel Reports submitted by the Marketing Specialists<br><br>3.2 Encode after travel reports and critical incidents to maintain a mini database of visited employers for monitoring and reporting |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| UNIT HEAD | 3.3 Prepare incident, statistics, urgent concerns and accomplishment reports.<br><br>3.4 Evaluate and endorse reports to the Section Chief for final review and possible comments. |
| SECTION HEAD | **4. PERFORM FINAL REVIEW OF TRAVEL REPORTS AND CRITICAL INCIDENTS**<br><br>4.1 Review reports submitted by the Unit Head.<br><br>4.2 Discuss travel reports, accomplishments, and urgent concerns with the Marketing Specialist. |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| PRIVATE SECTOR DATA MANAGEMENT | **1. RECEIVE REMITTANCE REPORTS FROM PRIVATE SECTOR MEMBER ACCOUNTS.** |
| RECEIVING STAFF | 1.1 Receive documents<br>1.2 Check completeness of received documents vis a vis the transmittal list<br>1.3 Check documents for deficiencies.<br>1.3.1 If with deficiencies, return the documents to the Private Sector Member Accounts Division (Procedure : Private Sector Screening and Account Examination)<br>1.3.2 If documents are not deficient, proceed to the next step.<br>1.4 Stamp documents according to date of receipt and distribute to respective screeners per area.<br>1.5 Keep / file transmittal list for record purposes.<br>1.6 Forward documents to the Data Encoder. |
| DATA ENCODER | **2. ENCODE AND POST**<br>2.1 Encode / post ME-5 using MAIS.<br>2.2 Generate document control numbers, Document Control Slips (Exhibit 7), and Batch Lists (Exhibit 8). |
| CLERK | **3. PACK DOCUMENTS IN ENVELOPES**<br>3.1 Attach Document Control Slips and Batch Lists to the document.<br>3.2 Insert in envelopes. |
| DOCUMENT REVIEWER | **4. REVIEW AND EDIT ENCODED REPORTS**<br>4.1 Review reports vis a vis control slips, reports vis a vis batch list.<br>4.2 Edit erroneous entry; then, generate a new Control Slip and / or Batch Lists to be attached to |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| | remittance reports for release to the Service Bureau. |
| | 4.3 Forward problem reports back to Private Sector Member Accounts (Procedure: Private Sector Screening and Account Examination) |

| Job / Unit Responsible | Activity / Task |
|---|---|
| PREMIUM ACCOUNTING DIVISION<br><br>ACCOUNT MANAGEMENT ANALYST I | 1. RECEIVE AND EVALUATE REQUEST<br><br>1.1 Receive and evaluate request for the issuance of premium remittance certification from clients (employer / employees) to be used for varied purposes, such as, application for business permit, bidding, etc.<br><br>1.2 Verify client premium remittance records, based on the Contribution and Treasury databases. Check with the concerned client, as necessary. |
| ACCOUNT MANAGEMENT ANALYST | 2. PREPARE SUMMARY OF REMITTANCES AND ISSUE CERTIFICATION<br><br>2.1 Prepare a Summary of Remittance Transactions to determine remittance compliance status.<br><br>2.1.1 If the client records are complete and without delinquencies, issue a Certification of Premium Remittances<br><br>2.1.2 If remittance records are incomplete and unpaid contributions are established, advise the client to settle their delinquencies before the issuance of the certification.<br><br>2.2 Follow-up compliance with the client.<br><br>2.2.1 If the client settles the delinquent accounts, issue the Certification of Premium Remittances.<br><br>2.2.2 If the client persists in his delinquency :<br><br>2.2.2.1 Itemize premium remittances.<br><br>2.2.2.2 Prepare a Summary of Premium Payments.<br><br>2.2.2.3 Issue the Summary of Premium Payments to the requesting employer / member |

| Job / Unit Responsible | Activity / Task |
|---|---|
| ACCOUNT MANAGEMENT ANALYST | 2.2.2.4 Forward a copy to the concerned Premium Accounting units for appropriate action. |

| Job / Unit Responsible | Activity / Task |
|---|---|
| PREMIUM ACCOUNTING DIVISION<br><br>SECTION HEAD | **1. RECEIVE REQUEST FOR REFUND / OFFSET.**<br><br>1.1 Receive and evaluate request for refund / offset from clients (employer / employees) . |
| ACCOUNT MANAGEMENT ANALYST I | **2. VERIFY PREMIUM REMITTANCES**<br><br>2.1 Verify client premium remittance records, based on the Contribution and Treasury databases. Check with the concerned client, as necessary.<br><br>2.2 Prepare a Summary of Remittance Transactions to determine overpayment. |
| ACCOUNT MANAGEMENT ANALYST II | **3 EVALUATE REMITTANCE STATUS**<br><br>3.1 Evaluate the remittance status report.<br><br>3.2 Submit report to Section Head. |
| SECTION HEAD | **4. ISSUE REQUEST FOR REFUND / NOTIFICATION OF NO BASIS FOR REFUND / OFFSET**<br><br>4.1 Receive remittance status evaluation report.<br><br>4.2 Review remittance status evaluation.<br><br>4.2.1 If overpayment was established, send written advise to Treasury to refund the client.<br><br>4.2.2 If there is no basis to offset or refund premium contributions, notify the client that there is no record of overremittance for refund or offset or of payments made to SSS |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| PREMIUM ACCOUNTING DIVISION - RECONCILIATION | 1. RECEIVE AND EVALUATE REMITTANCE STATUS REPORTS FOR RECONCILIATION |
| ACCOUNT MANAGEMENT ANALYST | 1.1 Receive and evaluate remittance status reports from Accounts Monitoring / Compliance Enforcement units. |
| | 2. RECONCILE CONTRIBUTIONS AND TREASURY RECORDS |
| | 2.1 Record information (employer name, address, SSS #, bank branch, validation date, PBR #, Reconciliation #, month of coverage, and amount) from employer reports in Excel format for reconciliation purposes. |
| | 2.2 Match posted employer reports from Contributions against the RF-2 Loader system printouts (Treasury Reports). |
| | 2.2.1 If the transactions reconcile, write the date of reconciliation on the file to indicate that the transaction is complete. |
| | 2.2.2 if the transactions do not match, evaluate both remittance reports to determine where the error lies. |
| | 2.2.2.1 For Treasury-related errors, inform the Treasury Dept. (through a memorandum) of corrections / adjustments to be made. |
| | 2.2.2.2 For employer-related errors, inquire from employer on correct data or information. |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| ELECTRONIC DATA AND INFORMATION MANAGEMENT DIVISION<br><br>RECEIVING STAFF | **1. RECEIVE AND SCREEN DOCUMENTS**<br><br>1.1 Receive the diskette, together with the ME-5s.<br><br>1.2 Load the diskette for checking and editing.<br><br>1.3 Perform integrity checking and initial screening of report. Match the ME-5 data with the electronic file of transactions.<br><br>1.1.1 If there is a discrepancy between the ME5 and control data contained in the electronic files, reject diskette and return to the employer.<br><br>1.1.2 If no discrepancy is found, stamp the report, as received for processing. |
| DATA CONTROLLER | **2. EDIT AND ADJUST ELECTRONIC DATA**<br><br>2.1 Review the text file content and format of the report. Edit the file, as necessary.<br><br>2.2 Load good files to an MsAccess DB. |
| ACCOUNT MANAGEMENT ANALYST | **3. VALIDATE REPORTS**<br><br>3.1 Validate the transactions against the existing databases using MAIS (Members Accounts Information System), EPM (Employer Posting Module)., and RF Loader System of Treasury.<br><br>3.1.1 If reports are found to be deficient :<br><br>3.1.1.1 Notify the employer through a letter about the errors and indicate the computer amount receivable and / or collectible.<br><br>3.1.1.2 Enter the notified employer in the Mailing List System (MLS) for monitoring purposes.<br><br>3.1.2 If reports are not deficient, |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| ACCOUNT MANAGEMENT ANALYST | 3.1.2.1 Tag the report as reconciled.<br><br>3.1.2.2 Keep data on file until loaded to the permanent database.<br><br>3.2 Monitor compliance by employers of deficiencies.<br><br>3.2.1 If there is no response from the employer within 20 days, send a follow-up notice.<br><br>3.2.2 If there is no response after 3 notices, prepare an endorsement letter to Remittance Compliance and Enforcement Section of the Premium Accounting Division, together with all pertinent documents for appropriate action. |
| COMPUTER OPERATOR | **4. LOAD GOOD REPORTS TO DATABASE**<br><br>4,1 Load good reports to the database.<br><br>4,2 Monitor the load process. Note system errors and rejected data.<br><br>4.3 Review compilation of data transactions rejected by the system. Determine the cause of the erroneous entry.<br><br>4.4 Refer the data errors to the concerned groups, such as, Membership for member data errors |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| PUBLIC SECTOR DATA MGT. DIVISION | **1. RECEIVE REMITTANCE REPORTS FROM CENTROL RECEIVING** |
| RECEIVING STAFF | 1.1 Check completeness of the received documents vis a vis the transmittal list<br>1.2 Stamp documents according to date of receipt and distribute to respective screeners per area.<br>1.3 Keep / file transmittal list for record purposes. |
| ACCOUNT EXAMINER | **2. SCREEN REPORTS**<br>2.1 Check reports for completeness of documentary requirements and correctness of computations.<br>2.1.1 If deficient, prepare Notification Letters either to the owning PRO or directly to the employer. Proceed to Step 3.<br>2.1.2 If not deficient, proceed to next step.<br>2.2 Post information to index cards. Proceed to Step 5. |
| UNIT HEAD | **3. REVIEW REPORTS AND NOTIFICATION LETTERS**<br>3.1 Review processed reports. Segregate good from deficient documents.<br>3.2 For deficient documents, review Notification Letters, then, forward to OIC-PSDMD for signature.<br>3.3 Forward "Good" documents to Data Quality Control. |
| DIVISION HEAD | **4. REVIEW AND SIGN NOTIFICATION LETTERS**<br>4.1 Review deficient documents with Notification Letters.<br>4.2 Sign Notification Letters.<br>4.3 Release Notification Letters to agencies or PROs through Records. |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| DATA ENCODER | **5. ENCODE EMPLOYER PROFILE, BASED ON ME-5**<br>5.1 Encode and / post ME-5 (Exhibit 2) to the database, using MAIS.<br>5.2 Generate document control numbers, Document Control Slips (Exhibit 7), and Batch Lists (Exhibit 8). |
| DATA CONTROLLER | **6. REVIEW ENCODED EMPLOYER PROFILE**<br>6.1 Review reports vis a vis control slips and batch list.<br>6.2 Edit erroneous entry; then, generate a new batch list.<br>6.3 Attach edited Batch List and Control Slip to remittance reports for release to Data Entry. |
| DATA ENCODER | **7. ENCODE MEMBER CONTRIBUTIONS**<br>7.1 Encode and update member's monthly contribution based on employer's submitted reports. |
| DATA CONTROLLER | **8. REVIEW ENCODED MEMBER CONTRIBUTIONS**<br>8.1 Review and edit posted monthly member contributions.<br>8.2 Forward processed NCR reports to Data Quality Control Unit for editing; then, turn over to Records Section.<br>8.3 Forward PRO reports to Records Section of CAMD for safekeeping. |
| | **OTHER TASKS** |
| ACCOUNT MANAGEMENT ANALYST | **9. CONFIRMATION OF PREMIUM REMITTANCE**<br>9.1 Receive confirmation request from agencies and COA.<br>9.2 Verify remittances vs.the contribution database, treasury database, index cards (Exhibit 10), and transmittal lists (Exhibit 11). |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| ACCOUNT MANAGEMENT ANALYST | 9.3 Prepare confirmation letter to requesting party.<br><br>9.4 In case of incomplete reports, send confirmation letter to agency.<br><br>10. REQUEST FOR CONFIRMATION OF REMITTANCE FOR REFUND<br><br>10.1 Verify remittances (given the period coverage) thru treasury and contribution databases, employer reports, index cards and transmittal list.<br><br>10.2 Prepare endorsement letter to Treasury for processing of refund.<br><br>11. VALIDATE VS. TREASURY BANK REPORTS<br><br>11.1 Validate encoded remittance vis a vis Treasury Bank Reports<br><br>11.2 Prepare List of non-remitting / non-reporting agencies and banks. |

| Job / Unit Responsible | Activity / Task |
|---|---|
| INDIGENT PROGRAM<br><br>AREA OFFICER, NCR | **1. SECURE / EVALUATE DATA GATHERED**<br><br>1.1 Obtain from the Marketing Group, information, such as, income class, sharing scheme, number of committed households. Secure documents such as Sanggunian Resolution, Budget certificate, MOA of LGUs implementing the Program.<br><br>1.2 Coordinate with Membership Data Management Department – Indigent members (MDMD-IM) on Family Data Survey Forms (FDSFs) submission and validation, ID validity,and releases.<br><br>**2. PREPARE BILLING ADVICE (ESTIMATES)**<br><br>2.1 Prepare initial billing advice (estimates) and status of remittances for renewal of LGU enrolled members, based on committed number of households.<br><br>2.2 Endorse Billing Advice to the Marketing Group for submission to the concerned LGU.<br><br>**3. PREPARE FINAL BILLING STATEMENT**<br><br>3.1 Obtain information from MDMD-IM on the actual number of IDs generated and released.<br><br>3.2 Prepare and send final Billing Statement to the LGU-LCE & Treasurer.<br><br>3.3 Furnish the PHIC SVP for Operations and VP and AVP Operations with a copy of the final billing statement.<br><br>**4. VERIFY LGU REMITTANCES vs. MOA**<br><br>4.1 Review and verify LGU remittance, based on the Min5 (Exhibit 9) vs. the signed Memorandum of Agreement (MOA) and the number of IDs released.<br><br>4.2 Post remittances to the subsidiary ledger of the LGU concerned. |

| Job / Unit Responsible | Activity / Task |
|---|---|
| AREA OFFICER, NCR | **5. CONSOLIDATE MONTHLY MONITORING REPORTS**<br><br>5.1 At the end of the month, prepare the LGU Monitoring Report, Report on LGU remittances, Status of LGU Remittances, List of New Enrollees and Summary of Billing Statement.<br><br>(Note : The report takes account of the LGUs' number of qualified households, sharing scheme. Amount of total LGU premium counterpart for the year and the outstanding balances/excess payment of the previous year (renewal.)<br><br>5.2 Furnish the VP MCMG and OIC-CAMD with a copy of the report<br><br>**6. RECONCILE**<br><br>6.1 Reconcile the consolidated Monthly Summary of LGU Remittances for all PROs with Treasury reports that include payment details (amount, place and date of payment)<br><br>6.1.1 If unreconciled, compute for and post the adjustment to the LGU subsidiary ledger.<br><br>6.1.2 If reconciled, proceed to the next step.<br><br>**7. POST / RECORD UPDATED DATA OF LGU REMITTANCES**<br><br>7.1 Prepare, compute and post the National Government (NG) and Local Government Unit (LGU) share in the insurance premium, based on the reconciled monthly Report of LGU Remittances, |
| DEVELOPMENT MANAGEMENT OFFICER | **8. PREPARE QUARTERLY REPORT ON LGU AND NG PREMIUM SHARING**<br><br>8.1 At the end of the quarter, consolidate the reconciled monthly report of LGU remittances.<br><br>**9. PREPARE AN EXECUTIVE SUMMARY REPORT ( FOR DBM PURPOSES)** |

| Job / Unit Responsible | Activity / Task |
|---|---|
| DEVELOPMENT MANAGEMENT OFFICER | 9.1 Prepare an Executive Summary Report indicating the Stages of Implementation, Number of Households, Total Premium Contributions Share, Total LGU Remittances and NG Counterpart.<br><br>9.2 Route the Executive Summary to the following officers for notation and approval :<br><br>9.2.1 OIC for CAMD – for the recommending approval<br><br>9.2.2 VP for MCMG - for notation and reference<br><br>9.2.3 Accountant - for certification of funds availability<br><br>**10 COORDINATE / FOLLOW-UP FOR THE RELEASE OF NG PREMIUM COUNTERPART**<br><br>10.1 Coordinate with Finance Department for the issuance of the DBM Billing Statement for the release of the NG premium counterpart (nationwide). |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| ACCOUNT MONITORING<br><br>ACCOUNT MANAGEMENT ANALYST | **1. RECEIVE AND REVIEW DEFICIENT DOCUMENTS**<br><br>1.1 Receive remittance reports with Documentary Request Checklist (Exhibit 4).<br><br>**2. PREPARE REMITTANCE STATUS REPORTS**<br><br>2.1 Prepare remittance status reports.<br><br>2.1.1 Check records available from existing systems, such as, Transmittal List System, Employer Posting Module, Premium Compliance System, Mailed/Drop Box files, Treasury, databases of remittances received in diskette format - to determine the completeness or irregularity in submitting RF1/Employer report.<br><br>2.1.2 Review and evaluate the remittance status report.<br><br>2.1.2.1 If the employers records are complete, endorse the report for Remittance Notification (Step 3)<br><br>2.1.2.2 If the employers records are not complete, endorse the report for reporting status confirmation<br><br>(Process : Confirmation and Certification of Premium Remittances for Private Employers) |
| REMITTANCE NOTIFICATION<br><br>ACCOUNT MANAGEMENT ANALYST | **3. NOTIFY DELINQUENT EMPLOYERS**<br><br>3.1 Prepare Billing Letter to notify delinquent employers with underremittances, unreported remittances, or no remittances.<br><br>3.2 Assign a Control number to the letter and send to the delinquent employers through mail.<br><br>3.3 Prepare and maintain a Monitoring List of delinquent employers.<br><br>3.4 Follow-up employers for compliance |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| ACCOUNT MANAGEMENT ANALYST | 3.4.1 If the employer complies within 30 days, prepare a Compliance Report and forward the report to Account Monitoring<br><br>3.4.2 If the employer does not comply within 30 days :<br><br>3.4.2 1 Prepare a 2nd Demand Letter.<br><br>3.4.2.2 Conduct site visit of delinquent employers. Deliver the 2nd Demand Letter.<br><br>(Procedure : SITE VISITATION OF DELINQUENT EMPLOYERS TO BE DONE BY THE MARKETING GROUP)<br><br>• If the employer complies within 15 days, prepare a Compliance Report. Forward to Account Monitoring<br><br>• If not, endorse to Legal for appropriate action |
| ACCOUNT MONITORING | **4. Update Compliance** |
| ACCOUNT MANAGEMENT ANALYST | 4.1 Update compliance reports, using PCS |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| MARKETING GROUP<br><br>UNIT HEAD | **1. SCHEDULE ITINERARY FOR EMPLOYER VISITATION.**<br><br>1.1 Receive List of Employers for site visit, together with the 2nd Demand Letters and Remittance Status Report.<br><br>1.2 Assign site visit work to Marketing Specialist. |
| MARKETING SPECIALIST | **2. CONDUCT SITE VISIT**<br><br>2.1 Meet with employer and discuss remittance status report<br><br>2.1.1 If verification shows that remittances are complete, inform employer of latest Philhealth issuances and forms to use.<br><br>2.1.2 If employer is nonremitting and nonreporting, require employer to comply with RA7875,<br><br>2.1.3 If employer is underremitting, discuss and assist resolve employer problem with settlement of arrearages.<br><br>2.1.4 If employer is remitting but not reporting, advise employer to submit the required reports.<br><br>2.2 Prepare Travel Report.<br><br>2.2.1 Include all critical incidents encountered during the site visit.<br><br>2.2.2 Submit to the Unit Head. |
| UNIT HEAD | **3. REVIEW AND COLLATE TRAVEL REPORTS**<br><br>3.1 Review and collate all Travel Reports submitted by the Marketing Specialists<br><br>3.2 Encode after travel reports and critical incidents to maintain a mini database of visited employers for monitoring and reporting |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| UNIT HEAD | 3.3 Prepare incident, statistics, urgent concerns and accomplishment reports.<br><br>3.4 Evaluate and endorse reports to the Section Chief for final review and possible comments. |
| SECTION HEAD | **4. PERFORM FINAL REVIEW OF TRAVEL REPORTS AND CRITICAL INCIDENTS**<br><br>4.1 Review reports submitted by the Unit Head.<br><br>4.2 Discuss travel reports, accomplishments, and urgent concerns with the Marketing Specialist.<br><br>4.3 Inform CAMD Remittance Compliance Enforcement about the results of the site visit. |



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| Job/Unit Responsible | Activity/ Task |
|---|---|
| IPM ACCOUNT MONITORING<br><br>ACCOUNT MANAGEMENT ANALYST | **1. MONITOR PREMIUM REMITTANCES OF INDIVIDUALLY PAYING MEMBERS (IPMs).**<br><br>1.1 Check IPM records available from the existing Treasury and other records.<br><br>1.2 Review and evaluate the remittance status of IPMs.<br><br>1.2.1 If the IPM records are complete, no subsequent action is required. End process.<br><br>1.2.2 If the employers records are not complete, compute for delinquencies. |
| IPM REMITTANCE NOTIFICATION<br><br>ACCOUNT MANAGEMENT ANALYST | **2. NOTIFY DELINQUENT EMPLOYERS**<br><br>2.1 Prepare Notification Letter to notify IPMs with payment defaults. Assign control number.<br><br>2.2 Prepare a List of IPMs with payment defaults.<br><br>2.3 Furnish Marketing with a copy of the list.<br><br>2.3.1 If the member will be visited by Marketing, forward the Notification Letter to Marketing<br><br>(Procedure : SITE VISITATION OF DELINQUENT EMPLOYERS TO BE DONE BY THE MARKETING GROUP)<br><br>2.3.2 If the member will not be visited by Marketing, send the Notification Letter through mail. |
| IPM ACCOUNT MONITORING<br><br>ACCOUNT MANAGEMENT ANALYST | **3. MONITOR AND UPDATE COMPLIANCE**<br><br>3.1 Monitor compliance by the IPM.<br><br>3.2 Update IPM remittance records if IPM complies; otherwise, continue with the monitoring and notification process (Steps 1 and 2 above). |



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| Job/Unit Responsible | Activity/ Task |
|---|---|
| MARKETING GROUP<br><br>UNIT HEAD | **1. SCHEDULE ITINERARY FOR IPM / IPM GROUP VISITATION.**<br><br>1.1 Receive List of IPMs / IPM Groups for site visit, together with the Notification Letters for IPMs with payment defauts.<br><br>(Note : The Marketing Group has the option to select whom and which group to visit)<br><br>1.2 Assign site visit work to the Marketing Specialist in charge of the account |
| MARKETING SPECIALIST (IN CHARGE OF ACCOUNT) | **2. CONDUCT SITE VISIT**<br><br>2.1 Meet with IPMS / IPM Groups and discuss the remittance status report<br><br>2.3 Encourage IPMs to remit unpaid premiums / non-Philhealth members of IPM Groups to participate in the National Health Insurance Program (RA 7875).<br><br>2.2 Prepare Travel Report.<br><br>2.2.1 Include all critical incidents encountered during the site visit.<br><br>2.2.2 Submit to the Unit Head. |
| UNIT HEAD | **3. REVIEW AND COLLATE TRAVEL REPORTS**<br><br>3.1 Review and collate all Travel Reports submitted by the Marketing Specialists<br><br>3.2 Encode after travel reports and critical incidents to maintain a mini database of visited IPMs / IPM Groups for monitoring and reporting<br><br>3.3 Prepare incident, statistics, urgent concerns and accomplishment reports.<br><br>3.4 Evaluate and endorse reports to the Section Chief for final review and possible comments. |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| SECTION HEAD | **4. PERFORM FINAL REVIEW OF TRAVEL REPORTS AND CRITICAL INCIDENTS**<br><br>4.1 Review reports submitted by the Unit Head.<br><br>4.2 Discuss travel reports, accomplishments, and urgent concerns with the Marketing Specialist.<br><br>4.3 Inform CAMD Accounts Monitoring and Remittance Notification (for IPM) about the results of the site visit. |

| Job / Unit Responsible | Activity / Task |
|---|---|
| MARKETING GROUP<br>MARKETING ACCOUNT SPECIALIST | **1. SECURE / EVALUATE DATA GATHERED**<br><br>1.1 Obtain information, such as, income class, sharing scheme, number of committed households. Secure documents such as Sanggunian Resolution, Budget certificate, MOA of LGUs implementing the Program.<br><br>1.2 Collate Family Data Survey Forms (FDSFs) submission and validation, ID validity,and releases.<br><br>**2. PREPARE BILLING ADVICE (ESTIMATES)**<br><br>2.1 Prepare initial billing advice (estimates) and status of remittances for renewal of LGU enrolled members, based on committed number of households<br><br>2.2 Submit Billing Advice to the concerned LGU. |
| CONTRIBUTION ACCOUNTS MANAGEMENT GROUP<br><br>INDIGENT PROGRAM<br><br>AREA OFFICER | **3. PREPARE FINAL BILLING STATEMENT**<br><br>3.1 Obtain information from MDMD-IM on the actual number of IDs generated and released.<br><br>3.2 Prepare and send final Billing Statement to the LGU-LCE & Treasurer.<br><br>3.3 Furnish the PHIC SVP for Operations and VP and AVP Operations with a copy of the final billing statement.<br><br>**4. VERIFY LGU REMITTANCES vs. MOA**<br><br>4.1 Review and verify LGU remittance, based on the Min5 (Exhibit 9) vs. the signed Memorandum of Agreement (MOA) and the number of IDs released.<br><br>4.2 Post remittances to the subsidiary ledger of the LGU concerned.<br><br>**5. CONSOLIDATE MONTHLY MONITORING REPORTS** |

| Job / Unit Responsible | Activity / Task |
|---|---|
| AREA OFFICER | 5.1 At the end of the month, prepare the LGU Monitoring Report, Report on LGU remittances, Status of LGU Remittances, List of New Enrollees and Summary of Billing Statement.<br><br>(Note : The report takes account of the LGUs' number of qualified households, sharing scheme. Amount of total LGU premium counterpart for the year and the outstanding balances/excess payment of the previous year (renewal.)<br><br>5.2 Furnish the VP MCMG and OIC-CAMD with a copy of the report<br><br>**6. RECONCILE**<br><br>6.1 Reconcile the consolidated Monthly Summary of LGU Remittances for all PROs with Treasury reports that include payment details (amount, place and date of payment)<br><br>6.1.1 If unreconciled, compute for and post the adjustment to the LGU subsidiary ledger.<br><br>6.1.2 If reconciled, proceed to the next step.<br><br>**7. POST / RECORD UPDATED DATA OF LGU REMITTANCES**<br><br>7.1 Prepare, compute and post the National Government (NG) and Local Government Unit (LGU) share in the insurance premium, based on the reconciled monthly Report of LGU Remittances. |
| DEVELOPMENT MANAGEMENT OFFICER | **8. PREPARE QUARTERLY REPORT ON LGU AND NG PREMIUM SHARING**<br><br>8.1 At the end of the quarter, consolidate the reconciled monthly report of LGU remittances.<br><br>**9. PREPARE AN EXECUTIVE SUMMARY REPORT ( FOR DBM PURPOSES)**<br><br>9.1 Prepare an Executive Summary Report indicating the Stages of Implementation, Number of Households, Total Premium Contributions Share, Total LGU Remittances and NG Counterpart. |

| Job / Unit Responsible | Activity / Task |
|---|---|
| DEVELOPMENT MANAGEMENT OFFICER | 9.2 Route the Executive Summary to the following officers for notation and approval :<br><br>9.2.1 OIC for CAMD – for the recommending approval<br><br>9.2.2 VP for MCMG - for notation and reference<br><br>9.2.3 Accountant - for certification of funds availability<br><br>**10 COORDINATE / FOLLOW-UP FOR THE RELEASE OF NG PREMIUM COUNTERPART**<br><br>10.1 Coordinate with Finance Department for the issuance of the DBM Billing Statement for the release of the NG premium counterpart (nationwide). |

# MANAGE CONTRIBUTIONS

## FORMS

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| 1 | Acknowledgment Letter for Receipt of Remittance Reports |
| 2 | ME-5 |
| 3 | RF1 |
| 4 | Documentary Request Checklist |
| 5 | Acknowledgment and Notification Letter |
| 6 | Remittance Status Report Form |
| 7 | Document Control Slip |
| 8 | Batch File Listing |
| 9 | Min5 |
| 10 | Index Card |
| 11 | Transmittal List (Public Sector) |

# EXHIBIT 1

## Acknowledgment Letter for Receipt of Remittance Reports

*Republic of the Philippines*
**PHILIPPINE HEALTH INSURANCE CORPORATION**
12th Floor, 709 City State Centre, Shaw Boulevard, Brgy. Oranbo, Pasig City
Direct Line: 637-2664 Trunk Line: 637-99-99 local 1201, 1202

_____

_____

_____

_____

_____

Dear Sir / Madam:

We hereby acknowledge receipt of your Remittance Report for the period _____ together with the validated Contribution Payment Return (ME-5).

We thank you for your continued support to National Health Insurance Program.

Very truly yours,

**MS. ANA CORETA D. FADERA**
OIC, Public Sector Data Management Division

EXHIBIT 2

ME5 – Contribution Payment Return
Employed Sector

**ME-5** EMPLOYED SECTOR
(Formerly M - 5)

*Republic of the Philippines*
**PHILIPPINE HEALTH INSURANCE CORPORATION**
**CONTRIBUTIONS PAYMENT RETURN**

**1 PAYOR'S COPY**

PLEASE READ INSTRUCTIONS AT THE REVERSE SIDE BEFORE ACCOMPLISHING THIS FORM

EMPLOYER'S NAME

PHILHEALTH EMPLOYER NO. (PEN) and/or SSS No./TIN

MEMBER REFERENCE
- ☐ GOVERNMENT SECTOR
- ☐ PRIVATE SECTOR
- ☐ HOUSEHOLD EMPLOYER
- ☐ OTHERS _____

MAILING ADDRESS INCLUDING ZIP CODE

TELEPHONE NO.

FORM OF PAYMENT
☐ CASH ☐ CHECK _____ *Bank/Check No./Date* ☐ MONEY ORDER _____ *Post Office/M.O. No./Date*

☐ SUBJECT TO PENALTY | PENALTY REFERENCE NO. & DATE:

TOTAL AMOUNT REMITTED (IN WORDS)

CERTIFIED CORRECT

*Signature Over Printed Name* *Official Designation* *Date*

| APPLICABLE PERIOD | | AMOUNT |
|---|---|---|
| MONTH | YEAR | |
| | | |
| | | |
| | | |
| | | |
| ADD: UNDER PAYMENT | | |
| ADD: PENALTY/INTEREST | | |
| LESS: OVER PAYMENT | | |
| TOTAL REMITTANCE | | |

TO BE FILLED UP BY BANK TELLER
BANK _____ BRANCH _____ TELLER'S SIGNATURE _____

INSTRUCTIONS TO ACB:
THIS FORM MUST BE MACHINE VALIDATED TO BE CONSIDERED AN OFFICIAL RECEIPT. IN THE ABSENCE OF MACHINE VALIDATION, OR IN CASE OF OFF-LINE TRANSACTION, REMITTANCE CAN BE ACCEPTED, BUT SAME MUST BE RECEIVED BY ISSUING THE BANK'S OFFICIAL RECEIPT INDICATING THEREIN THAT THE PAYMENT IS FOR THE ACCOUNT OF THE PHILHEALTH MEMBER WITH THE FOLLOWING DATA PROPERLY FILLED UP:

BANK OR NO. _____ DATE _____

RECONCILIATION NO. 200804532

(THIS IS YOUR RECEIPT WHEN VALIDATED)

EXHIBIT 3

RF1 – Employers Quarterly Remittance Report

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION

# RF-1
REVISED JAN 2002

## EMPLOYER'S QUARTERLY REMITTANCE REPORT

**FOR PHILHEALTH USE**

Date Screened: Action Taken:
By:
Signature Over Printed Name

Date Received: Action Taken:
By:
Signature Over Printed Name

**1** PHILHEALTH NO. ☐☐-☐☐☐☐☐☐☐☐☐☐-☐
EMPLOYER TIN ☐☐☐-☐☐☐-☐☐☐-☐☐☐

**2** COMPLETE EMPLOYER NAME _____
COMPLETE MAILING ADDRESS _____
_____ TELEPHONE NO. _____

**3** EMPLOYER TYPE
☐ REGULAR
☐ Private
☐ Government
☐ HOUSEHOLD

EMPLOYER'S SSS NO. ☐☐-☐☐☐☐☐☐☐-☐
EMPLOYER'S SSS / GSIS POLICY NO. ☐☐☐☐☐☐☐☐☐☐☐☐

**4** TYPE OF REPORT
☐ REGULAR RF-1
☐ ADDITION TO PREVIOUS RF-1
☐ DEDUCTION TO PREVIOUS RF-1

**5** APPLICABLE QUART
☐ QUARTER ENDING MAR 20
☐ QUARTER ENDING JUN 20
☐ QUARTER ENDING SEP 20
☐ QUARTER ENDING DEC 20

**3** NAME OF EMPLOYEE/S

| | SURNAME | GIVEN NAME | MI | 7 PhilHealth ID No./SSS ID No./ GSIS Policy No. | 8 MONTHLY COMPENSATION BRACKET 1st Month | 2nd Month | 3rd Month | 9 NHIP PREMIUM CONTRIBUTIONS 1st Month PS | 1st Month ES | 2nd Month PS | 2nd Month ES | 3rd Month PS | 3rd Month ES | 10 REMARKS S-Separated, NE-No Earnings, NH-New 1st Month | 2nd Month | 3rd Month | DATE EFFECTIVE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | | | | | |
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| 14 | | | | | | | | | | | | | | | | | |
| 15 | | | | | | | | | | | | | | | | | |

**11** ME - 5 SUMMARY OF CONTRIBUTION PAYMENTS

| MONTH/ QUARTER | TOTAL CONTRIBUTION | ME-5 RECONCILIATION NO. | DATE PAID | NO. OF EMPLOYEES |
|---|---|---|---|---|
| 1st Month | | | | |
| 2nd Month | | | | |
| 3rd Month | | | | |

**12** SUBTOTAL (PS + ES)
(To be accomplished on every page)

GRAND TOTAL (PS + ES)
(To be accomplished on the last page)

**13** CERTIFIED CORRECT:
SIGNATURE OVER PRINTED NAME
OFFICIAL DESIGNATION
DATE

PLEASE READ INSTRUCTIONS (FOR EACH NUMBERED BOX) AT THE BACK BEFORE ACCOMPLISHING THIS FORM

**14** PAGE _____ OF _____ PA

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EXHIBIT 4

Documentary Request Checklist

Doc. Control # _____

☐ GOOD ☐ MAJOR ☐ VERIF

Employer's Name _____
Employer's Address _____
PEN/SSS/TIN # _____

☑ Inconsistent Employer's Name/Address _____

☐ No ME5/RF-1 ☐ Unreadable ME5/RF-1 _____

☐ Inconsistent/No Employer's SSS#/PEN _____

☐ No Bank Validation _____

☐ Missing Pages – lacking RF-1 _____

☐ No Month Coverage _____

☐ No Monthly Compensation _____

☐ Underpayment (due to non-compliance)

| MONTH | AMOUNT |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

☐ Underpayment (for notification/_____)

| MONTH | AMOUNT |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

TOTAL _____

OTHERS: _____

____ # of RF-1 Amt. RF-1 _____
____ # of ME5 ____ # of Employee/s
____ # of OR Amt. ME5 _____

Screened by: _____ Date: _____

# EXHIBIT 5

## Acknowledgment and Notification Letter

*Republic of the Philippines*
PHILIPPINE HEALTH INSURANCE CORPORATION
**Contribution Accounts Department**
12th Floor, CityState Center Bldg., 709 Shaw Blvd., Brgy. Oranbo, Pasig City
Tel. No. 637-9999, local 1201, 1202

_____

_____

_____

_____

_____

Dear Sir / Madam:

This is to acknowledge receipt of your remittance report for the period from _____ to _____. However, upon thorough evaluation of said report, the following deficiencies and/or errors have been noted by our examiner:

- ☐ no bank validation M-5/O.R.
- ☐ no attached PBR/M-5/ME-5
- ☐ no attached Employer's Remittance List (RF-1)
- ☐ missing page(s)/lacking RF-1 of _____
- ☐ amount / month coverage specified in RF-1 not tally with that reflected in M-5
- ☐ others, _____

_____

To facilitate proper posting of your remittance report, please submit the following necessary document/report:

- ☐ complete and clear copy of Remittance List Form (RF-1) in the amount of _____ for the month of _____, page _____
- ☐ copy of M-5/ME-5 duly validated by PhilHealth accredited Bank
- ☐ others, _____

Further, to ensure immediate posting and processing of your employee's PhilHealth Contribution, remittance forms should be properly accomplished and submitted within 15 days after applicable quarter as stated under PhilHealth Circular No. 17 and 42 s. 1998. Otherwise, your remittance report will be considered deficient and will be returned back to your office for necessary adjustment or compliance.

Moreover, any deficiency in remittance report might prejudice your employee's availment of Medicare benefits. Thus, attached herewith are _____ for your guidance.

We sincerely hope for your kind consideration and utmost attention.

Thank you.

Very truly yours,

**Ms. ANA CORETA D. FADERA**
***Officer In-Charge***
**Public Sector Data Management Division**

# EXHIBIT 6

## Remittance Status Report Form

EMPLOYER NAME:

ADDRESS:

TEL NO.

CONTACT PERSON:

TIN NO.:

PHILHEALTH NO.

AGENCY TYPE:

| BANK BRANCH | VALIDATION DATE | PBR / OR / RECON # | MONTH COVERAGE | AMOUNT | | TOTAL | REMARKS | DATE RECONCILED |
|---|---|---|---|---|---|---|---|---|
| | | | | PS | ES | | | |
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Prepared By:

Certified Correct:

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EXHIBIT 7

Document Control Slip

PHILIPPINE HEALTH INSURANCE CORPORATION
CONTRIBUTION ACCOUNTS DEPARTMENT
DOCUMENT CONTROL SLIP

DOC. CONTROL NO: C21126021901567
FILE NUMBER : 20159299112602132430

MUNICIPAL GOVERNMENT OF HADJI PANGLIMA TAHIL

BANGAS HADJI PANGLIMA TAHIL SULU

**DEFICIENCY LIST**

- [ ] Inconsistent Employer's Name/Address
- [ ] Incorrect/No Employer SSS/PEN/TIN
- [ ] Lacking/Missing RF1 Pages/copies of MF-5
- [ ] Unreadable MF-5/RF1/Bank validation
- [ ] No Bank Validation
- [ ] Month Coverage in RF1/MF-5 does not fa
- [ ] Underpayment Amount
- [ ] Overpayment Amount
- [ ] Others:

Philippine Health I

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# EXHIBIT 8

## Batch File Listing

FILE NUMBER: 20159299112602132134

| NOTIF | ENTRY | REPORT PERIOD | CONTROL NO | EMPLOYER NAME | REF PAGE | MEMBER COUNT | MF-5 COPIES | PBR COPIE | OR COPIES |
|---|---|---|---|---|---|---|---|---|---|
| | | 04/2012 - 06/2012 | C211260219 00043 | TUKURAN WATER DISTRICT | 1 | 4 | 3 | 0 | 0 |
| | | 04/2012 - 06/2012 | C211260219 00047 | DINAS MUNICIPAL HOSPITAL | 1 | 10 | 3 | 0 | 0 |
| | | 04/2012 - 06/2012 | C211260219 00050 | NATIONAL FOOD AUTHORITY REGION IX | 3 | 47 | 3 | 0 | 0 |
| | | 01/2012 - 06/2012 | C211260219 00056 | PIO. NATIONAL IRRIGATION ADMINISTRATION | 2 | 17 | 3 | 0 | 0 |
| | | 04/2012 - 06/2012 | C211260219 00059 | MUNICIPALITY OF VINCENZO SAGUN | 5 | 63 | 1 | 0 | 0 |
| | | 04/2012 - 06/2012 | C211260219 00062 | LOCAL GOVERNMENT OF MAHAYAG | 9 | 100 | 3 | 0 | 0 |
| | | 04/2012 - 06/2012 | C211260219 00064 | MUNICIPALITY OF JOSEFINA | 4 | 56 | 2 | 0 | 0 |
| | | 04/2012 - 06/2012 | C211260219 00074 | DEPARTMENT OF PUBLIC WORKS AND HIGHWAYS - SUB-DISTRICT OFFICE | 1 | 11 | 1 | 0 | 0 |
| | | 04/2012 - 06/2012 | C211260219 00077 | KUMALARANG WATER DISTRICT | 1 | 4 | 3 | 0 | 0 |
| | | 04/2012 - 06/2012 | C211260219 00083 | BAYCO NATIONAL HIGH SCHOOL | 5 | 43 | 3 | 0 | 0 |
| | | 04/2012 - 06/2012 | C211260219 00089 | PHILIPPINE CROP INSURANCE CORPORATION | 1 | 14 | 3 | 0 | 0 |
| | | 04/2012 - 06/2012 | C211260219 00096 | NATIONAL STATISTICS OFFICE PAGADIAN CITY | 2 | 59 | 4 | 0 | 0 |
| | | 04/2012 - 06/2012 | C211260219 00102 | GOVERNMENT SERVICE INSURANCE SYSTEM | 1 | 11 | 3 | 0 | 0 |
| | | 04/2012 - 06/2012 | C211260219 00106 | MUNICIPALITY OF LABANGAN | 8 | 117 | 3 | 0 | 0 |
| | | 01/2012 - 03/2012 | C211260219 00112 | DEPARTMENT OF PUBLIC WORKS AND HIGHWAY-1ST ENGINEERING DISTRICT | 5 | 17 | 4 | 0 | 0 |
| | | 04/2012 - 06/2012 | C211260219 00126 | DEPARTMENT OF PUBLIC WORKS AND HIGHWAY-1ST ENGINEERING DISTRICT | 6 | 26 | 4 | 0 | 0 |
| | | 03/2012 - 04/2012 | C211260219 00140 | GUIRADAN AND RURAL CREDIT GUARANTEE CORPORATION | 2 | 15 | 3 | 0 | 0 |
| | | 04/2012 - 06/2012 | C211260219 00145 | ZAMBOANGA DEL SUR PROVINCIAL HOSPITAL | 9 | 118 | 3 | 0 | 0 |
| | | 04/2012 - 06/2012 | C211260219 00152 | NATIONAL IRRIGATION ADMINISTRATION | 1 | 2 | 2 | 0 | 0 |
| | | 04/2012 - 06/2012 | C211260219 00160 | LOCAL GOVERNMENT UNIT-MAIPOSAURIG | 7 | 104 | 3 | 0 | 0 |
| | | 04/2012 - 06/2012 | C211260219 00168 | PAGADIAN CITY WATER DISTRICT | 5 | 43 | 3 | 0 | 0 |
| | | 04/2012 - 06/2012 | C211260219 00180 | DEPARTMENT OF THE INTERIOR AND LOCAL GOVERNMENT - PAGADIAN CITY | 2 | 5 | 2 | 0 | 0 |
| | | 03/2012 - 05/2012 | C211260219 00188 | DEPARTMENT OF PUBLIC WORKS AND HIGHWAYS - SUB DISTRICT OFFICE | 1 | 4 | 1 | 0 | 0 |
| | | 01/2012 - 03/2012 | C211260219 00215 | CITY GOVERNMENT OF PAGADIAN CITY | 24 | 511 | 3 | 0 | 0 |
| | | 01/2012 - 03/2012 | C211260219 00221 | CITY GOVERNMENT OF PAGADIAN CITY | 15 | 245 | 3 | 0 | 0 |
| | | 02/2012 - 03/2012 | C211260219 00241 | AGRICULTURAL TRADING INSTITUTE REGIONAL TRADING CENTER | 1 | 11 | 1 | 0 | 0 |

Date printed :
Time printed :
Printed by :

# PHILIPPINE HEALTH INSURANCE CORPORATION
Contribution Accounts Department

## BATCH FILE LISTING
Government Sector Reports

FILE NUMBER: 20159299112602132134

| NOTIF | ENTRY | REPORT PERIOD | CONTROL NO | EMPLOYER NAME | RF1 PAGE | MEMBER COUNT | ME-5 COPIES | PBR COPIE | OR COPIES |
|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | 04/2012 - 06/2012 | C2112/021300257 | OLUTANGA MUNICIPAL HOSPITAL | 2 | 20 | 4 | 0 | 0 |
| ☐ | ☐ | 01/2012 - 03/2012 | C2112/021300266 | OLUTANGA MUNICIPAL HOSPITAL | 2 | 21 | 3 | 0 | 0 |
| ☐ | ☐ | 04/2012 - 06/2012 | C2112/021300288 | KATIPUNAN NATIONAL AGRICULTURAL SCHOOL | 3 | 25 | 3 | 0 | 0 |
| ☐ | ☐ | 01/2012 - 03/2012 | C2112/021300300 | KATIPUNAN NATIONAL AGRICULTURAL SCHOOL | 3 | 25 | 3 | 0 | 0 |
| | | | | TOTAL | 142 | 1,091 | 85 | 0 | 0 |

Total reports30

IMPORTANT:TO BE SIGNED PER DIVISION/SECTION PRIOR TO TURN OVER TO NEXT DIVISION/SECTION.

| | RECEIVING REPORTS | SCREENING | NOTIFICATION | RELEASE FOR DATA ENTRY | DATA ENTRY/SB | RETURNED BY SB | VERIFICATION/VALIDATION |
|---|---|---|---|---|---|---|---|
| Number of Reports Received | | | | | | | |
| Date Received | | | | | | | |
| No. of Reports Turnover/Transmitted | | | | | | | |
| Date Turnover/Transmitted | | | | | | | |
| Printed Name & Signature | | | | | | | |

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# EXHIBIT 9

## Min5 – Contribution Payment Form
## Indigent Sector

**MIn-5** INDIGENT SECTOR
(Formerly M - 5)

*Republic of the Philippines*
PHILIPPINE HEALTH INSURANCE CORPORATION
CONTRIBUTIONS PAYMENT RETURN

**1 Payor's Copy**

PLEASE READ INSTRUCTIONS AT THE REVERSE SIDE BEFORE ACCOMPLISHING THIS FORM

PHILHEALTH EMPLOYER NO. (PEN)

PAYOR'S NAME

ZIP CODE

MAILING ADDRESS

FORM OF PAYMENT

☐ CASH ☐ CHECK _____ *Bank/Check No./Date* ☐ MONEY ORDER _____ *Post Office/M.O. No./Date*

TOTAL AMOUNT REMITTED (IN WORDS)

CERTIFIED CORRECT

Signature Over Printed Name | Official Designation | Date

TO BE FILLED UP BY BANK TELLER

BANK | BRANCH | TELLER'S SIGNATURE

REFERENCE

☐ BARANGAY PREMIUM COUNTERPART
☐ MUNICIPAL/CITY PREMIUM COUNTERPART
☐ PROVINCIAL PREMIUM COUNTERPART
☐ PREMIUM DONOR FOR

NAME OF LGU _____ (BARANGAY/MUNICIPALITY/CITY/PROVINCE)

BILLING STATEMENT NO. | Date

AMOUNT REMITTED IN FIGURES P _____

INSTRUCTIONS TO ACO

THIS FORM MUST BE MACHINE VALIDATED TO BE CONSIDERED AN OFFICIAL RECEIPT. IN THE ABSENCE OF MACHINE VALIDATION, OR IN CASE OF OFF-LINE TRANSACTION, REMITTANCE CAN BE ACCEPTED, BUT SAME MUST BE RECEIVED BY ISSUING THE BANK'S OFFICIAL RECEIPT INDICATING THEREIN THAT THE PAYMENT IS FOR THE ACCOUNT OF THE PHILHEALTH MEMBER WITH THE FOLLOWING DATA PROPERLY FILLED UP:

BANK OR NO. | DATE

RECORDATION NO.

C 0021448

(THIS IS YOUR RECEIPT WHEN VALIDATED)

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# EXHIBIT 10

## INDEX CARD – PUBLIC SECTOR

EMPLOYER'S NAME :

ADDRESS : TIN : ____-____-____-____

TEL No. : PEN: ____-____-____

| Recon. No./ O.R.No. | Check No. | Validation | Month/Year Coverage | AMOUNT PAID | | | No. of Members | Remarks | Date Screened |
|---|---|---|---|---|---|---|---|---|---|
| | | Date/Time | | PS | ES | Total | | | |
| | | | | | | | | | |
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# EXHIBIT 11

## TRANSMITTAL LIST (PUBLIC SECTOR)

Public Sector Data Management Division
DOCUMENT CONTROL UNIT
TRANSMITTAL LIST

Box 4.010

| LOPE UMBER | REGION | BATCH ID NUMBER | | EMPLOYER COUNT | EMPLOYEE COUNT | RF1 | ME5 | PBR | OR | REMARKS |
|---|---|---|---|---|---|---|---|---|---|---|
| 55 | Reg 1 | A1602 ACA 06 | 0000001 | 3 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 56 | Reg 3 | A1602 [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | 2 | 1 | [illegible] | |
| | | A1601 ACA [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 57 | REG 4A | A1601 ACA 03 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| [illegible] | REG 4B | A1601 ACA [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| | | A1601 ACA [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| [illegible] | Reg 5 | A1601 ACA 10 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| | | A1601 ACA 10 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| [illegible] 10 | REG 6 | A1602 ACA 11 | [illegible] | 15 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| | | A1601 ACA 11 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| [illegible] 61 | Reg 9 | A1602 ACA 14 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| [illegible] 62 | REG 11 | A1602 ACA 16 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| [illegible] 63 | REG 12 | A1602 ACA 17 | [illegible] | 15 | [illegible] | 27 | [illegible] | [illegible] | 2 | |
| | | A1602 ACA 17 | 02 1999 | 5 | [illegible] | 109 | 25 | [illegible] | [illegible] | |
| | | A1602 ACA 17 | [illegible] | 1 | [illegible] | 210 | 8 | [illegible] | 2 | |
| [illegible] 64 | REG 12 | A1602 ACA 17 | 03 1999 | 33 | 1928 | 70 | 33 | 9 | [illegible] | |
| | | A1601 MA 17 | 05 1999 | 50 | 447 | 67 | 59 | 14 | [illegible] | |
| | | | TOTAL | [illegible] | [illegible] | [illegible] | 464 | 128 | [illegible] | |

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# *MANAGE CONTRIBUTIONS*

# EXISTING POLICIES

1. The Premium Contribution of members shall have been remitted when the following conditions have been met:

   1.1 Employed Sector

   1.1.1 Employees have been automatically deducted from their salary, wage or earnings their Premium Contribution counterpart on a monthly basis.

   1.1.2 Employers have remitted the Employees Premium Contribution counterpart plus the employer counterpart on or before the tenth ($10^{th}$) calendar day following the month for which the payment is due and applicable.

   1.1.3 In case wherein the employee has separated from the company, the employer counterpart has been paid by the employer, while the employee counterpart has been collected and paid by another company where the employee is employed or the employee paid as an Individually Paying Member.

   1.1.4 The Premium Contributions have been remitted to any accredited collecting and/or depository banks or offices.

   1.1.5 The Premium Contribution payments have been validated by any accredited collecting and/or depository banks or offices.

   1.2 Self-employed Sector

   1.2.1 Members have paid at least three (3) months or one quarter Premium Contribution to any accredited collecting and/or depository banks or offices.

   1.3 Indigent Sector

   1.3.1 The LGU premium subsidies have been paid in accordance with the pertinent provisions of the MOA entered into by and between the Corporation and the LGU concerned.

   1.3.2 A premium donor who may either be a government agency, a local/foreign private entity/organization, charitable organization, cooperative or an individual, under the partial subsidy scheme has paid their subsidy in accordance with the pertinent provisions of the MOA entered into by and between the Corporation and the premium donor concerned.

2. The Premium Contribution Remittance shall have been validated when the following conditions have been met:

   2.1 Employed

2.1.1 Employers have submitted quarterly remittance reports to the Corporation not later than the fifteenth (15th) calendar day of the month after the applicable quarter. (Employer's Quarterly Remittance Report Form - RRF1)

2.1.2 Employers have submitted machine-validated Contribution Payment Return Form (ME5).

2.1.3 Accredited Collecting/Depository Banks and offices have submitted RF2s and copies of machine validated ME5s.

2.2 Self-employed

2.2.1 Members have submitted machine validated MI5.

2.2.2 Members have submitted machine printed receipts.

2.2.3 Members have submitted Government or bank receipts.

2.2.4 Accredited Collecting/Depository Banks and offices have submitted RF2s and copies of machine validated MI5s.

2.3 Indigent Sector

2.3.1 LGUs have submitted machine validated M1n5s and ORs.

2.3.2 Accredited Collecting/Depository Banks and offices have submitted RF2 and copies of machine validated M1n5s.

3. The Premium Contribution shall be in accordance with the prescribed premium schedule set by the Corporation.

3.1 Employed

3.1.1 50% of Premium Contribution as Employee counterpart.

3.1.2 50% of Premium Contribution as Employer counterpart.

3.1.3 Employer's counterpart was not recovered from the employee.

3.1.4 If an underpayment was incurred due to insufficient payment for non-compliance to the prescribed schedule, employers have remitted the balance.

3.2 Self-employed

3.2.1 As determined by the Corporation.

3.3 Indigent Sector

3.3.1 National Government subsidy as determined by the Corporation.

3.3.2 Local Government subsidy as determined by the Corporation.

3.3.3 Partial donor subsidy as determined by the Corporation.

4. Philhealth shall retain the policy of no retroactive payments on missed previous quarter/s except for self-employed members who have established sufficient regularity of contributions. In such case, the member is given a one-month grace period immediately after the missed quarter to settle his obligation.

5. Responsibilities for Premium Contribution Remittance and Validation include the following:

| Office | Responsibilities |
|---|---|
| Central Receiving Division | • Receive the following documents :<br>o Employer's Quarterly Remittance Reports (RF1)<br>o Self-employed machine validated (M1-5), Official Receipts, or Bank receipts.<br>o LGU machine validated (M1n-5) |
| Member Account Examination and Validation | • Screen Remittance Reports<br>• Inspect, review and validate Remittance Reports |
| Premium Accounts Division | • Post Quarterly Remittance Reports<br>• Bill non-remitting and under-remitting employers / LGUs / Donors<br>• Monitor compliance with premium remittances and reporting requirements<br>• Reconcile employer and member submitted documents with bank remittances with Treasury |

# MANAGE HEALTHCARE PROVIDER RELATIONS

## PROCESS FLOWS

## Table of Contents


| No | PARTICULARS | Page |
|---|---|---|
| 1 | Health Finance Policy Services | 1 |
| 2 | Benefits Development | 2 |
| 3 | Screening of Application for Accreditation | 3 |
| 4 | Pre-Survey Activities / Actual Conduct of Survey | 4 |
| 5 | Deliberation and Approval of Accreditation | 5 |
| 6 | PRO – Accreditation of Hospitals (Initial) | 7 |
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| 13 | Clinical Practice Guidelines Appraisal and Dissemination / MRC Development | 18 |
| 14 | Development / Enhancement of Relative Value Scale (RVS) 2001 | 20 |
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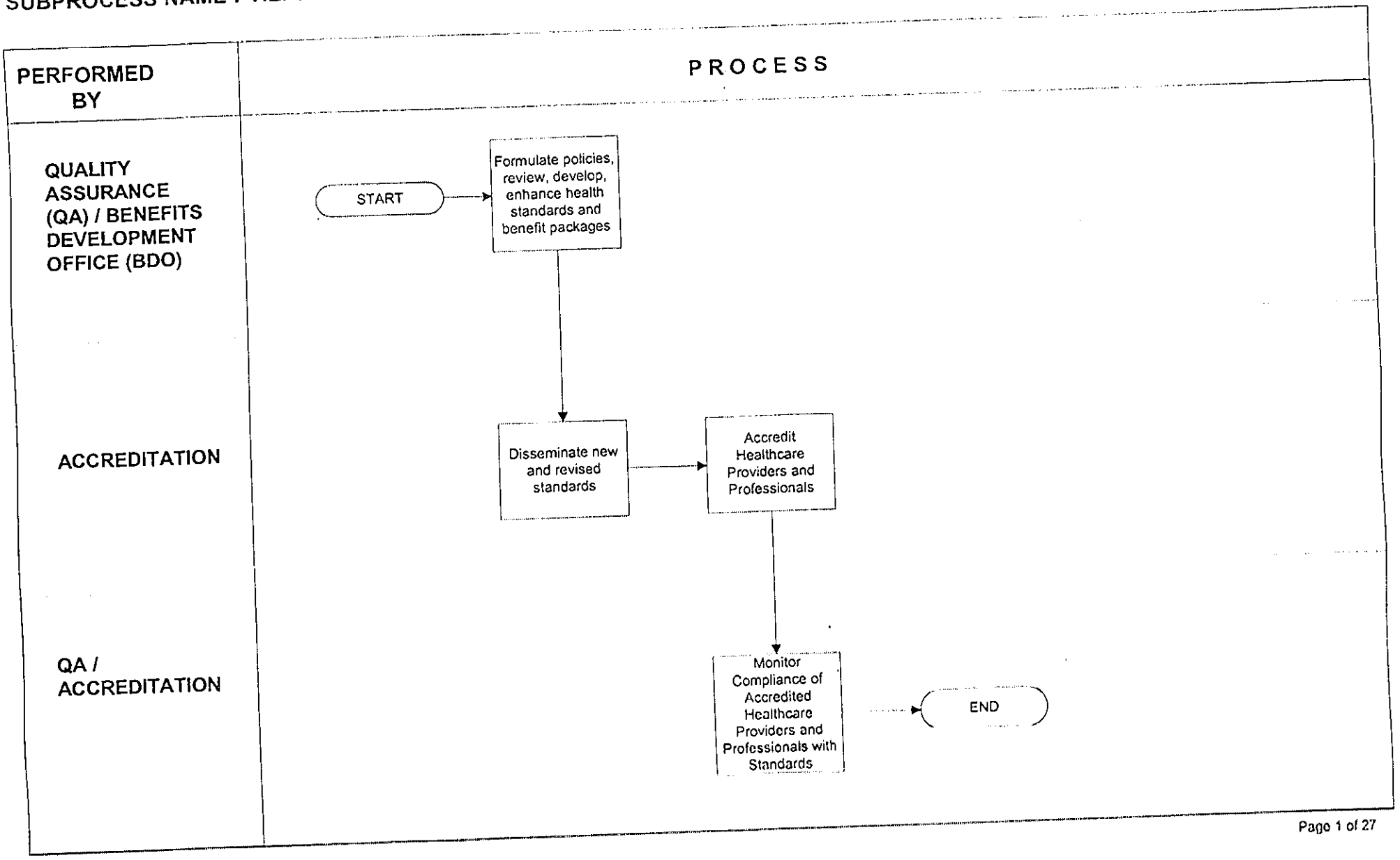
| No | PARTICULARS | Page |
|---|---|---|
| 16 | Drug Price Reference Index (DPRI) Study | 23 |
| 17 | ICD-10 Compliance Monitoring | 24 |
| 18 | ICD-10 Proficiency Examnation | 25 |
| 19 | ICD-10 Referencing System – Time and Motion Study | 26 |

PROCESS NAME : MANAGE HEALTHCARE PROVIDER RELATIONS
SUBPROCESS NAME : HEALTH FINANCE POLICY SERVICES






PHILIPPINE HEALTH INSURANCE CORPORATION

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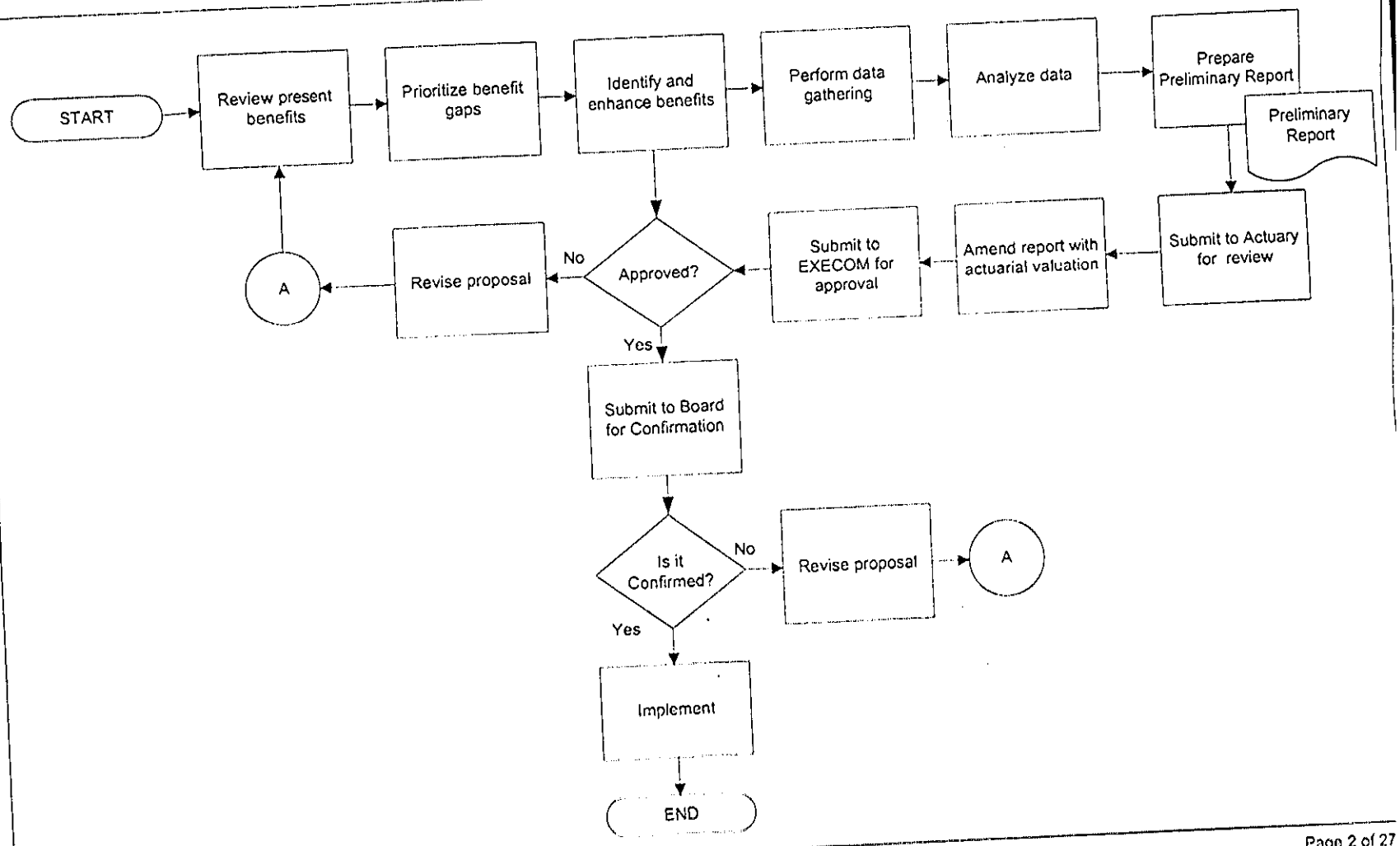
| PERFORMED BY | PROCESS |
|---|---|
| BENEFIT DEVELOPMENT OFFICE STAFF |  |

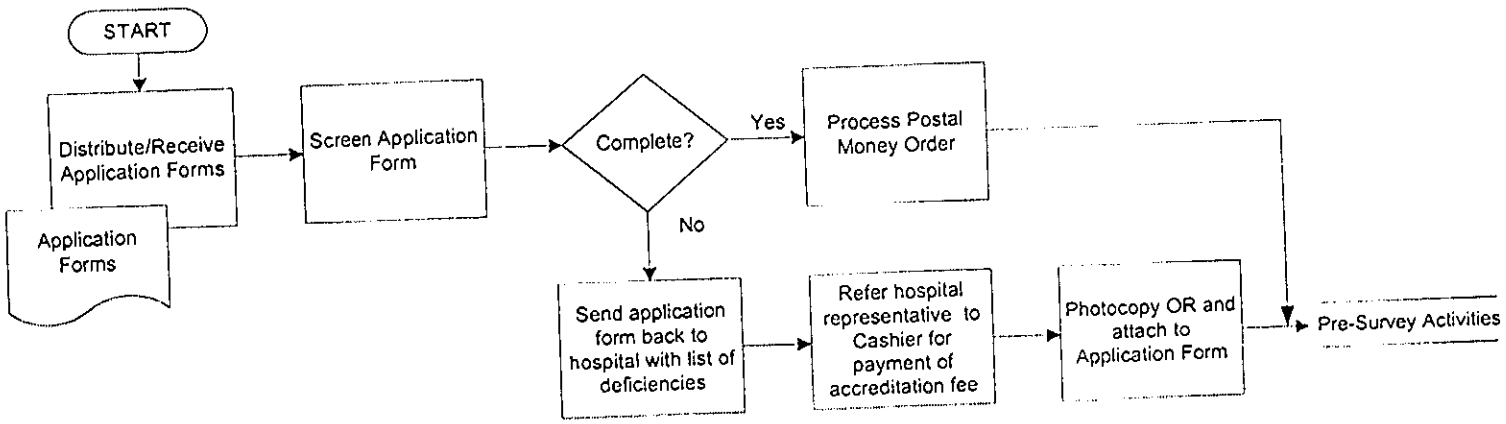






252

PROCESS NAME : MANAGE HEALTHCARE PROVIDER RELATIONS
SUBPROCESS NAME : SCREENING OF APPLICATION FOR ACCREDITATION

| PERFORMED BY | PROCESS |
|---|---|
| PROJECT ASSISTANT |  |





PHILIPPINE HEALTH INSURANCE CORPORATION

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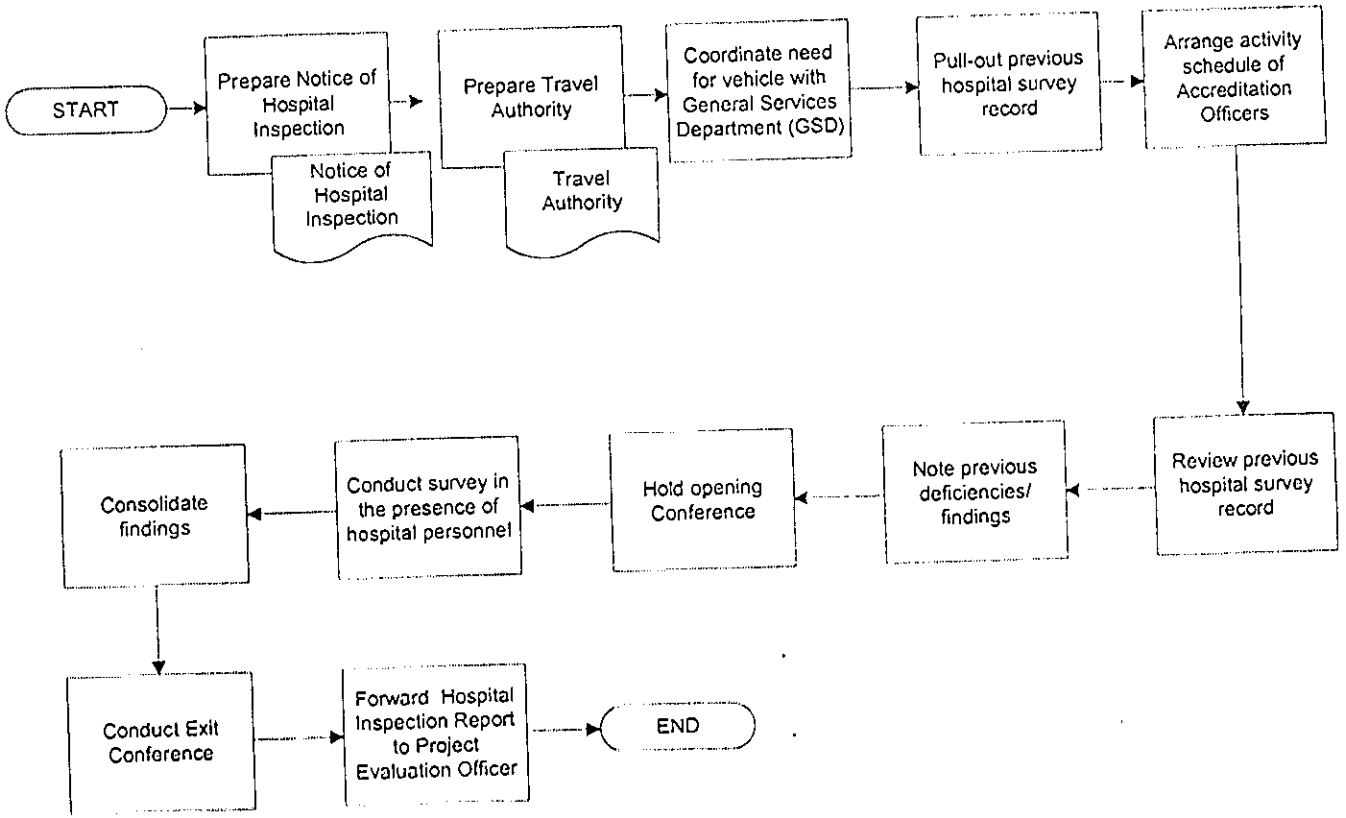
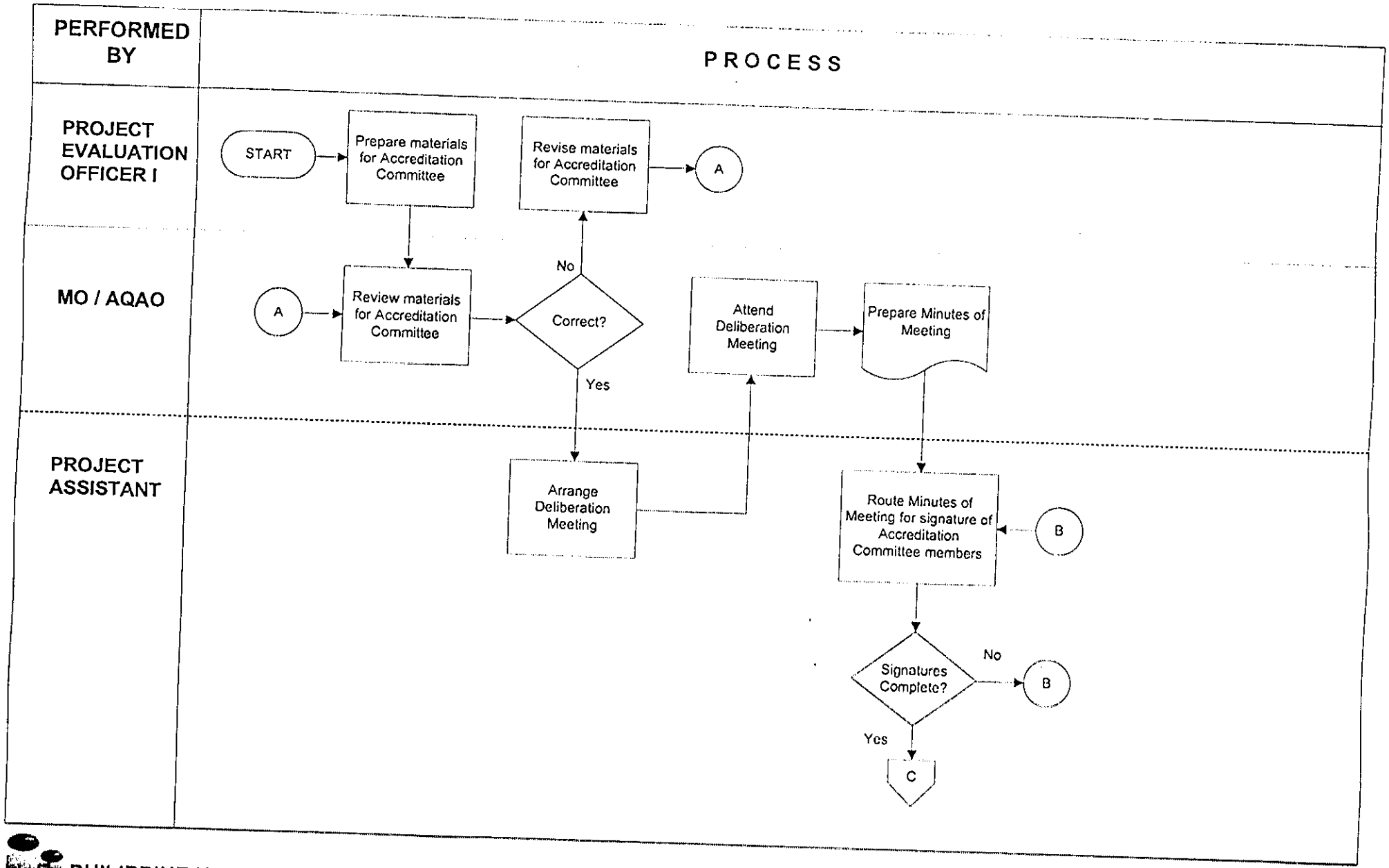
| PERFORMED BY | PROCESS |
|---|---|
| PROJECT ASSISTANT | |
| ACCREDITATION OFFICERS (MOs/ AQAOs/PEO IIs) | |



PROCESS NAME : MANAGE HEALTHCARE PROVIDER RELATIONS
SUBPROCESS NAME : DELIBERATION AND APPROVAL OF ACCREDITATION



| PERFORMED BY | PROCESS |
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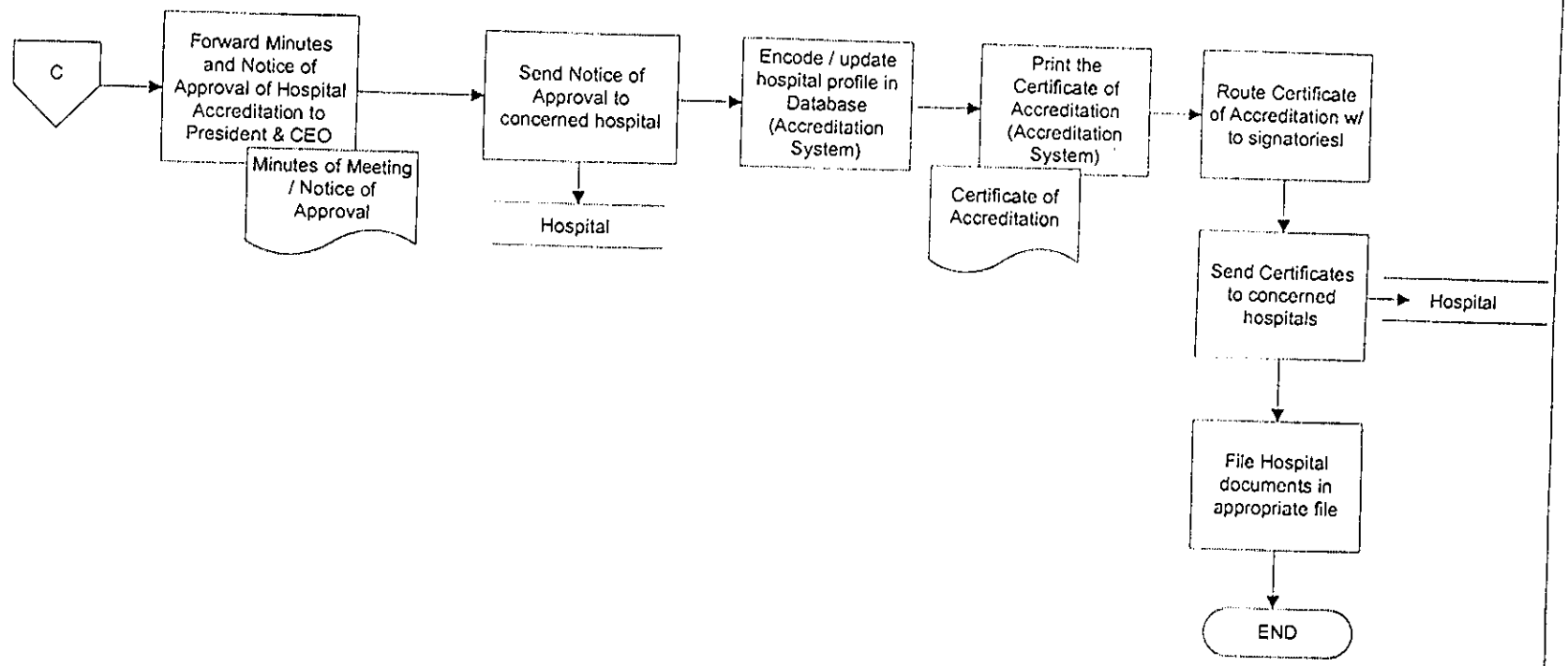
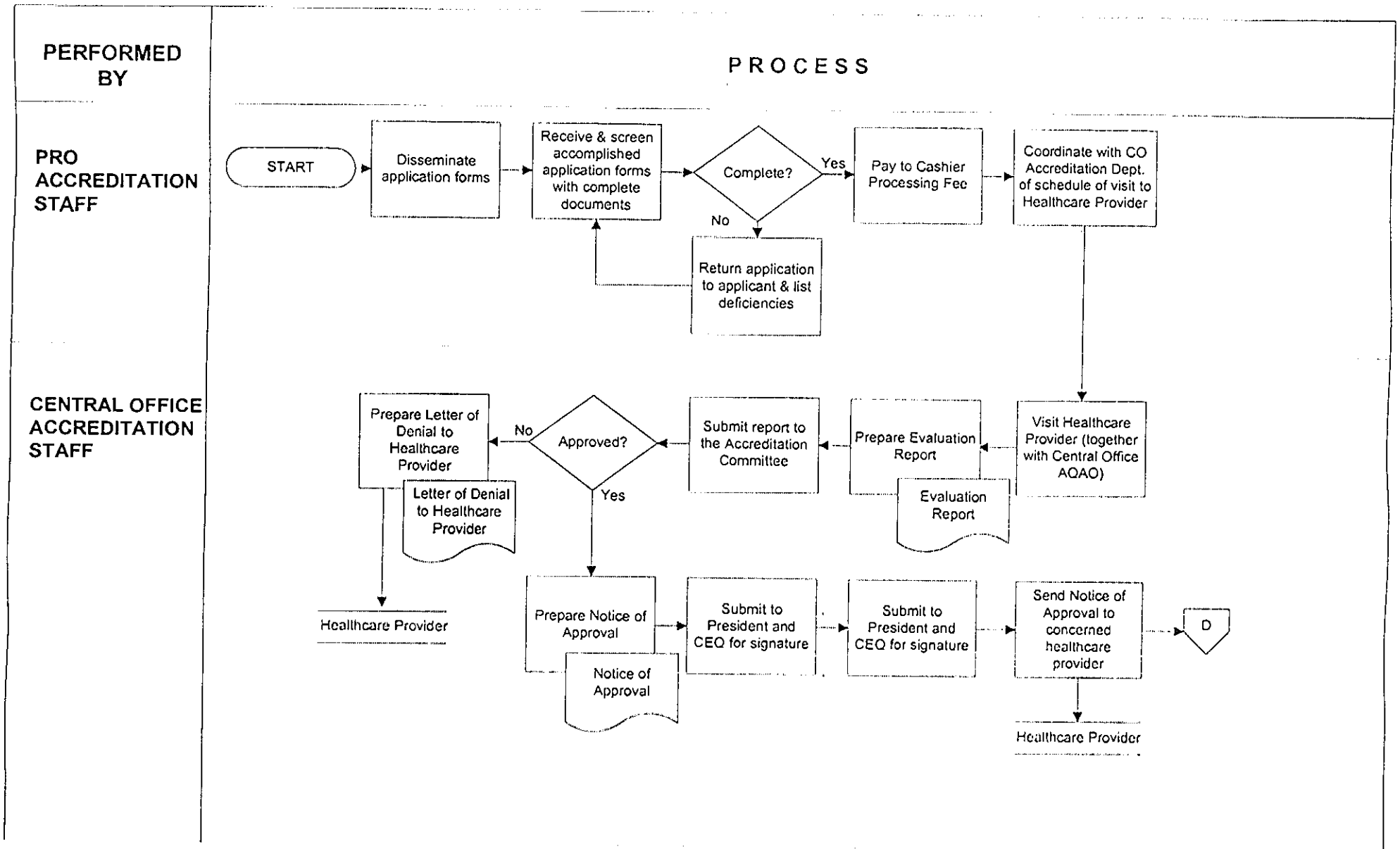





256


PERFORMED BY
PROCESS
PRO ACCREDITATION STAFF
CENTRAL OFFICE ACCREDITATION STAFF
START
Disseminate application forms
Receive & screen accomplished application forms with complete documents
Complete?
Yes
No
Return application to applicant & list deficiencies
Pay to Cashier Processing Fee
Coordinate with CO Accreditation Dept. of schedule of visit to Healthcare Provider
Visit Healthcare Provider (together with Central Office AQAO)
Prepare Evaluation Report
Evaluation Report
Submit report to the Accreditation Committee
Approved?
No
Yes
Prepare Letter of Denial to Healthcare Provider
Letter of Denial to Healthcare Provider
Healthcare Provider
Prepare Notice of Approval
Notice of Approval
Submit to President and CEO for signature
Submit to President and CEO for signature
Send Notice of Approval to concerned healthcare provider
Healthcare Provider
D



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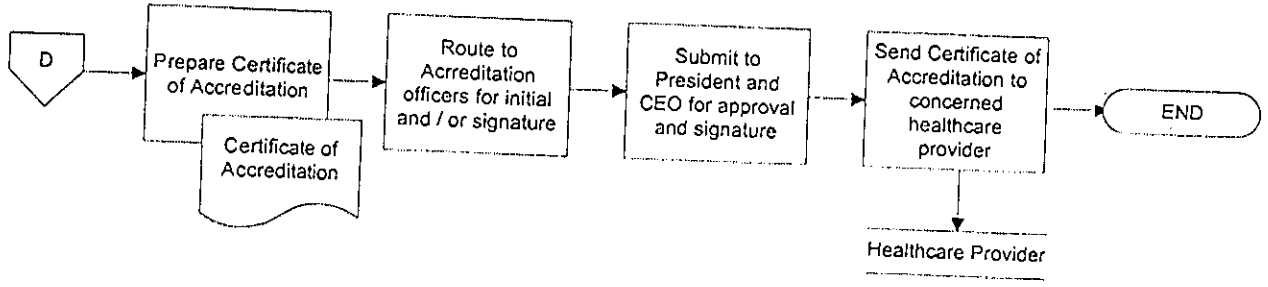
| PERFORMED BY | PROCESS |
|---|---|
| CENTRAL OFFICE ACCREDITATION STAFF |  |

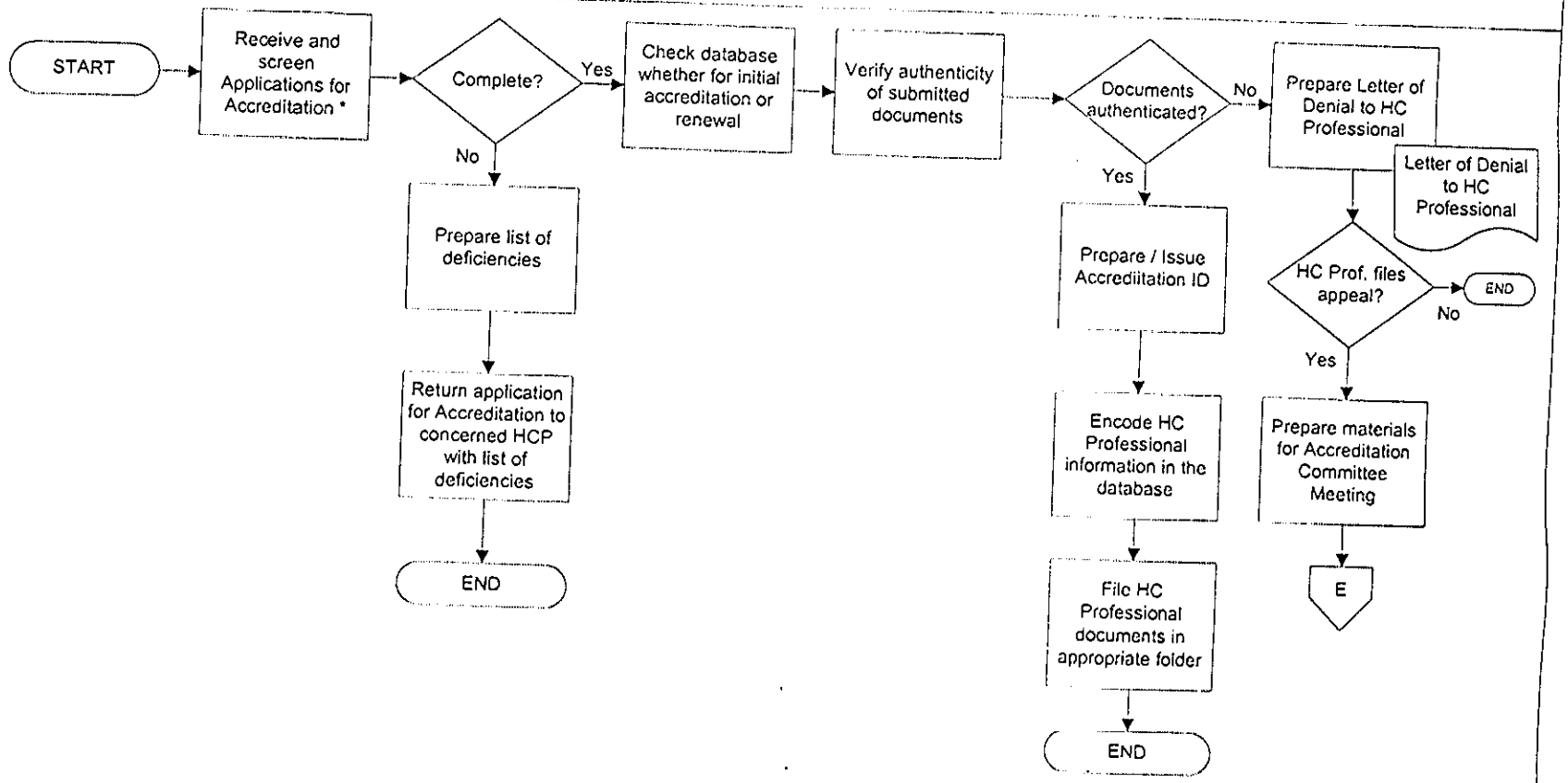




PHILIPPINE HEALTH INSURANCE CORPORATION

SUBPROCESS NAME : ACCREDITATION OF HEALTHCARE PROFESSIONALS

| PERFORMED BY | PROCESS |
|---|---|
| PROJECT ASSISTANT | |




* Pls. refer to Exhibit 3 - Forms (Manage Healthcare Provider Relations for a sample of the Application Form



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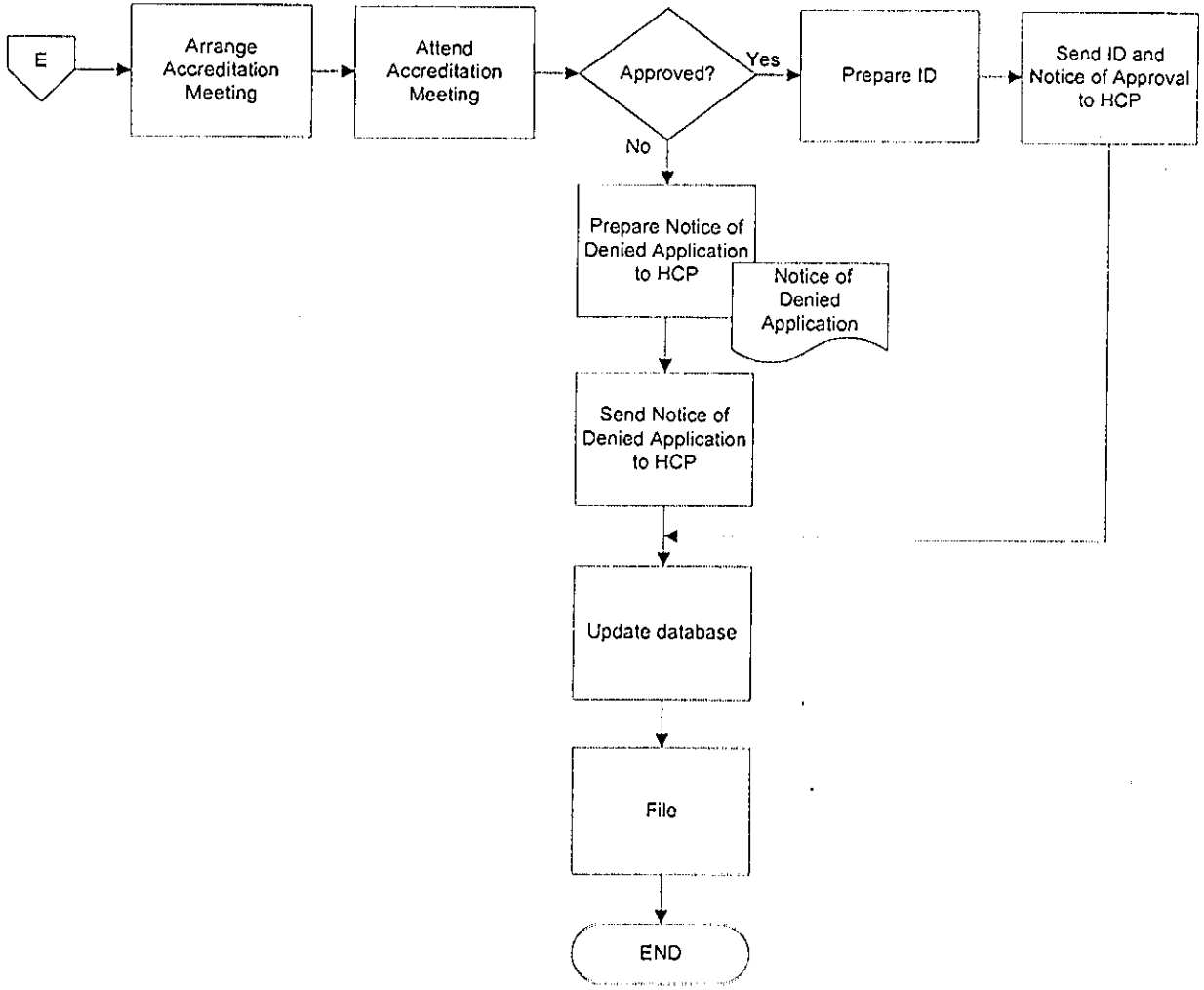
| PERFORMED BY | PROCESS |
|---|---|
| PROJECT ASSISTANT |  |





PHILIPPINE HEALTH INSURANCE CORPORATION

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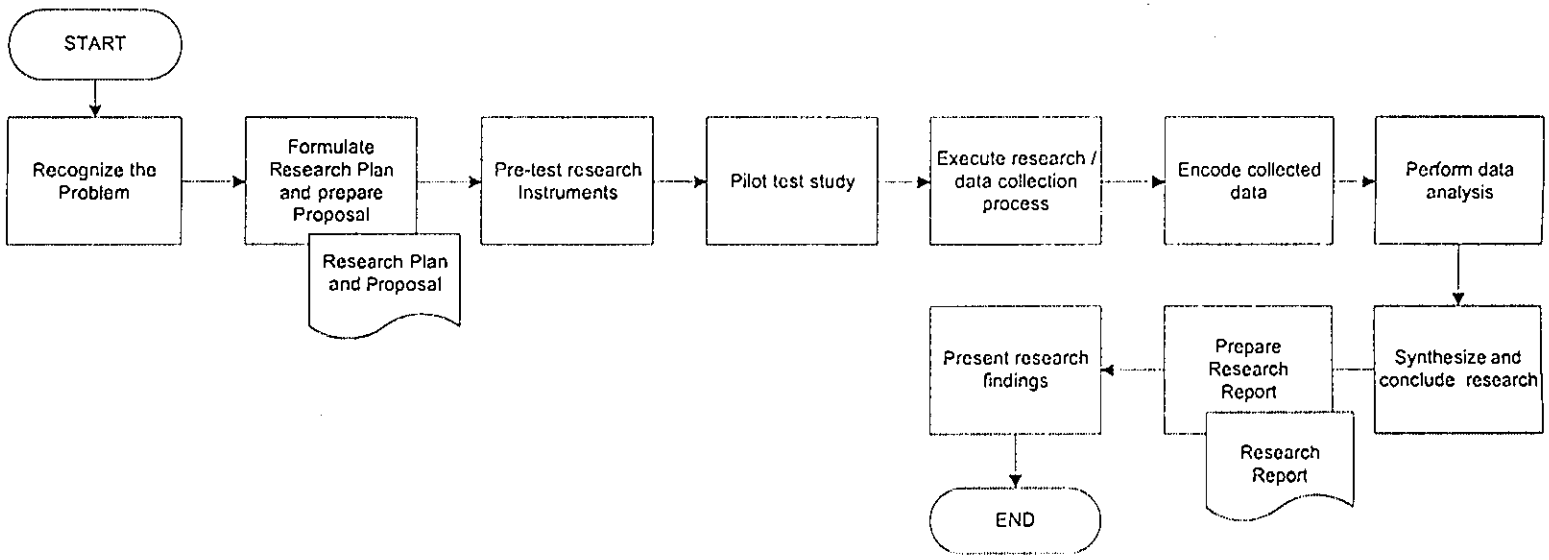
PROCESS NAME : MANAGE HEALTH PROVIDERS RELATIONS
SUBPROCESS NAME : UTILIZATION RESEARCH

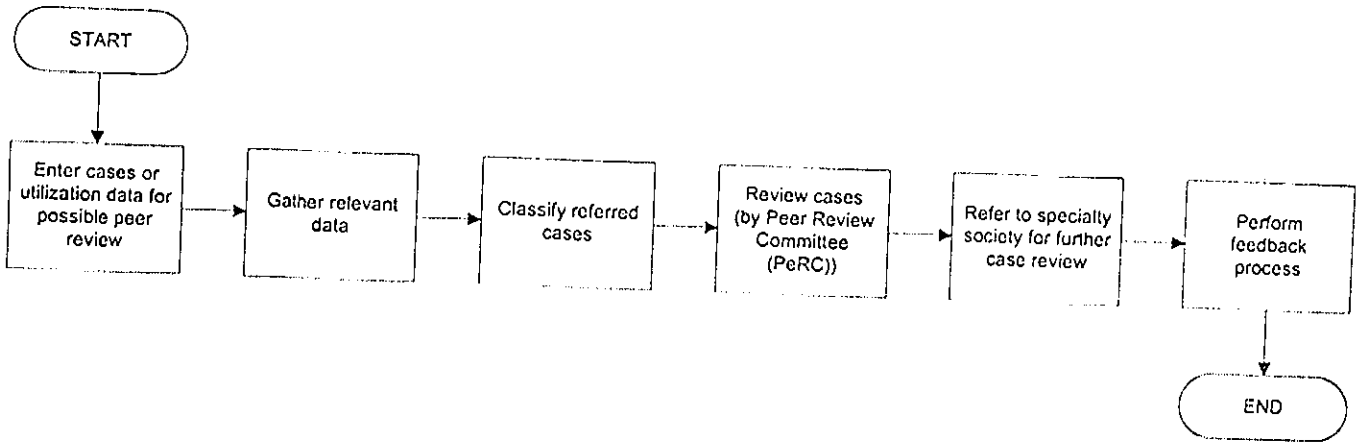
| PERFORMED BY | PROCESS |
|---|---|
| RESEARCHER / RESEARCH ASSISTANT |  |





PHILIPPINE HEALTH INSURANCE CORPORATION

PROCESS NAME : MANAGE HEALTHCARE PROVIDER RELATIONS
SUBPROCESS NAME : PEER REVIEW

| PERFORMED BY | PROCESS |
|---|---|
| URAID Secretary / Peer Review Secretariat / Medical Informatics |  |





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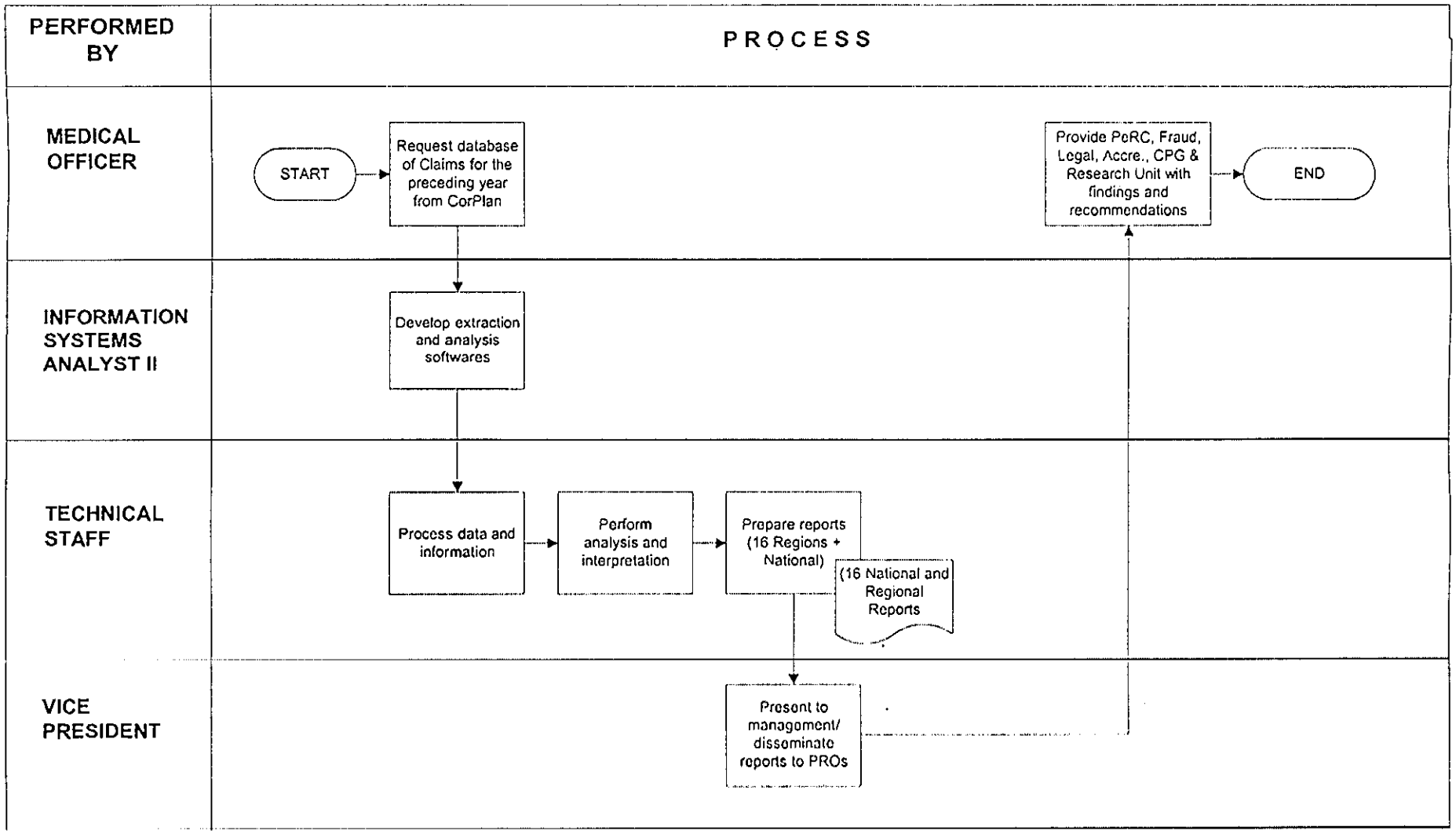
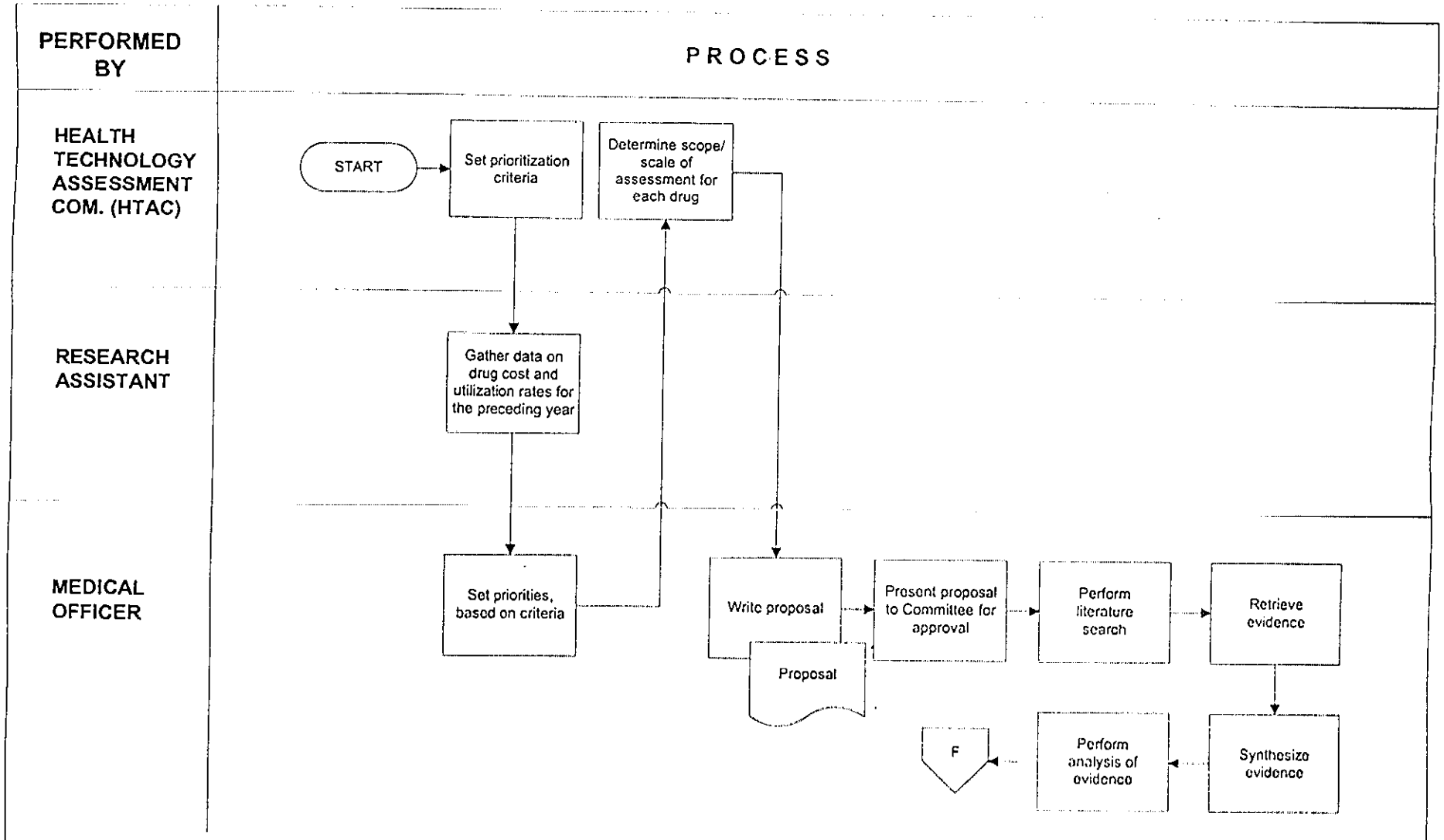
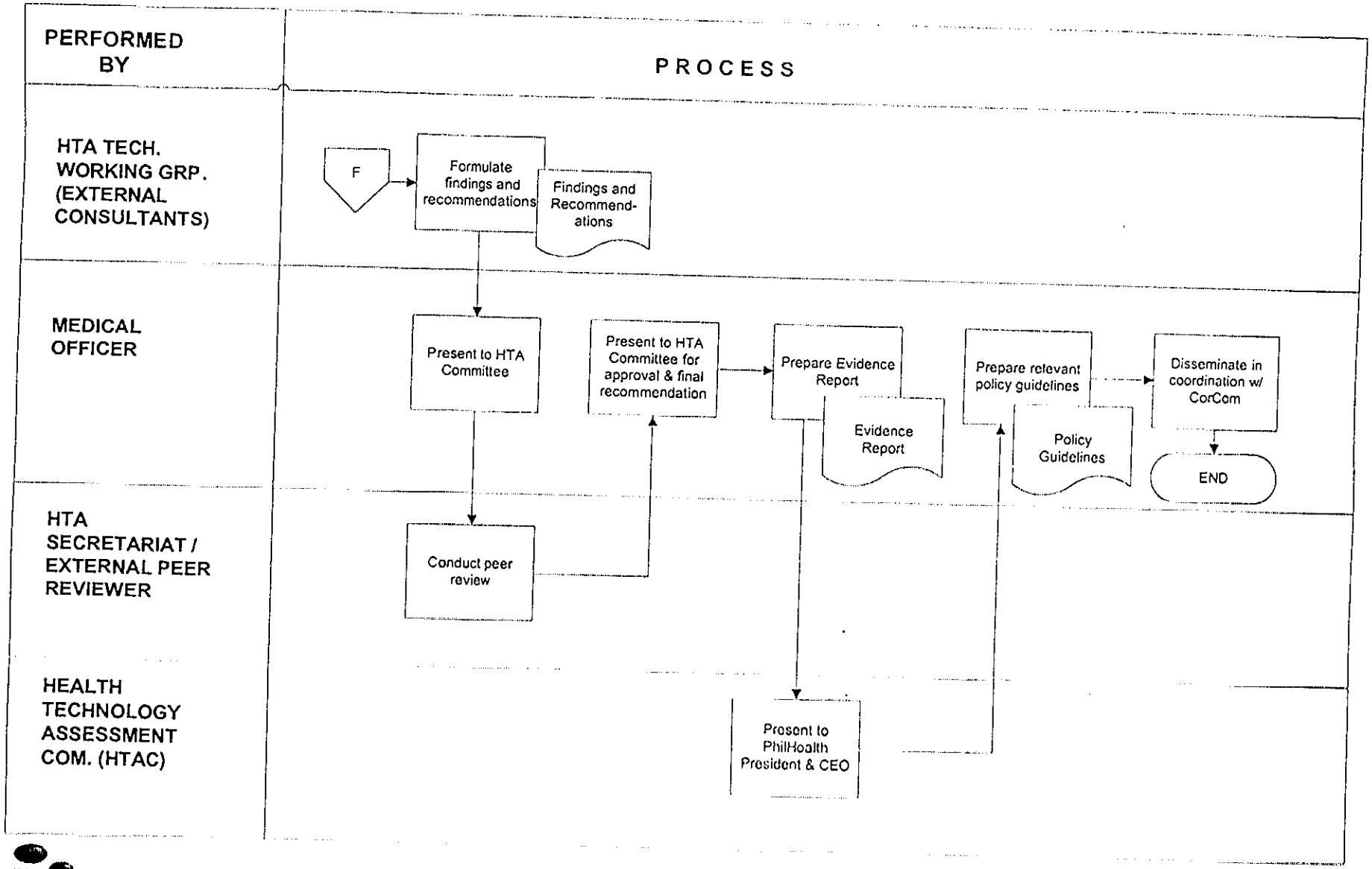
PROCESS NAME : MANAGE HEALTHCARE PROVIDER RELATIONS
SUBPROCESS NAME : UTILIZATION REVIEW OF CLAIMS



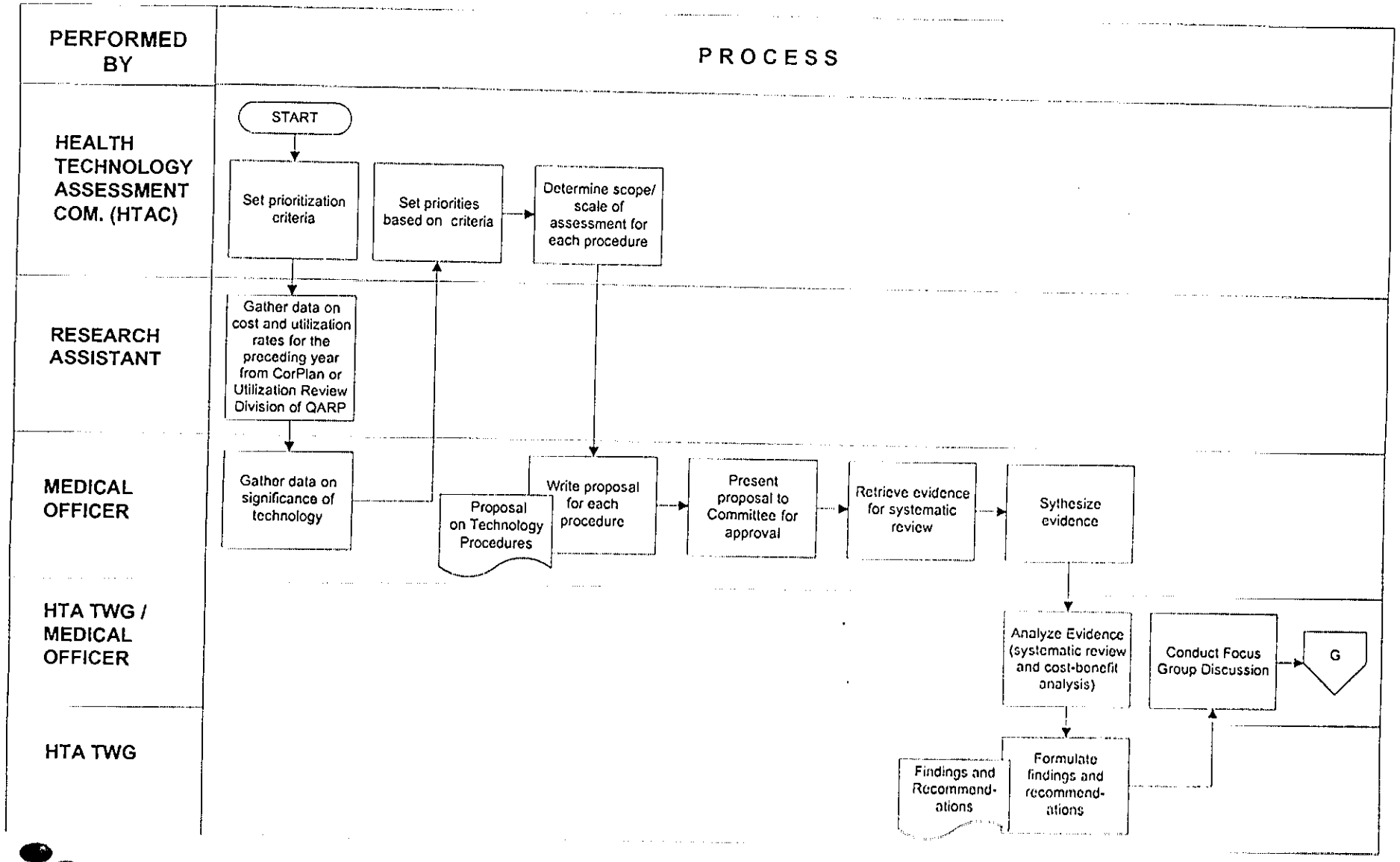
PROCESS NAME : MANAGE HEALTHCARE PROVIDER RELATIONS
SUBPROCESS NAME : CONDUCT OF TECHNOLOGY ASSESSMENT ON DRUGS (Non-PNDF)



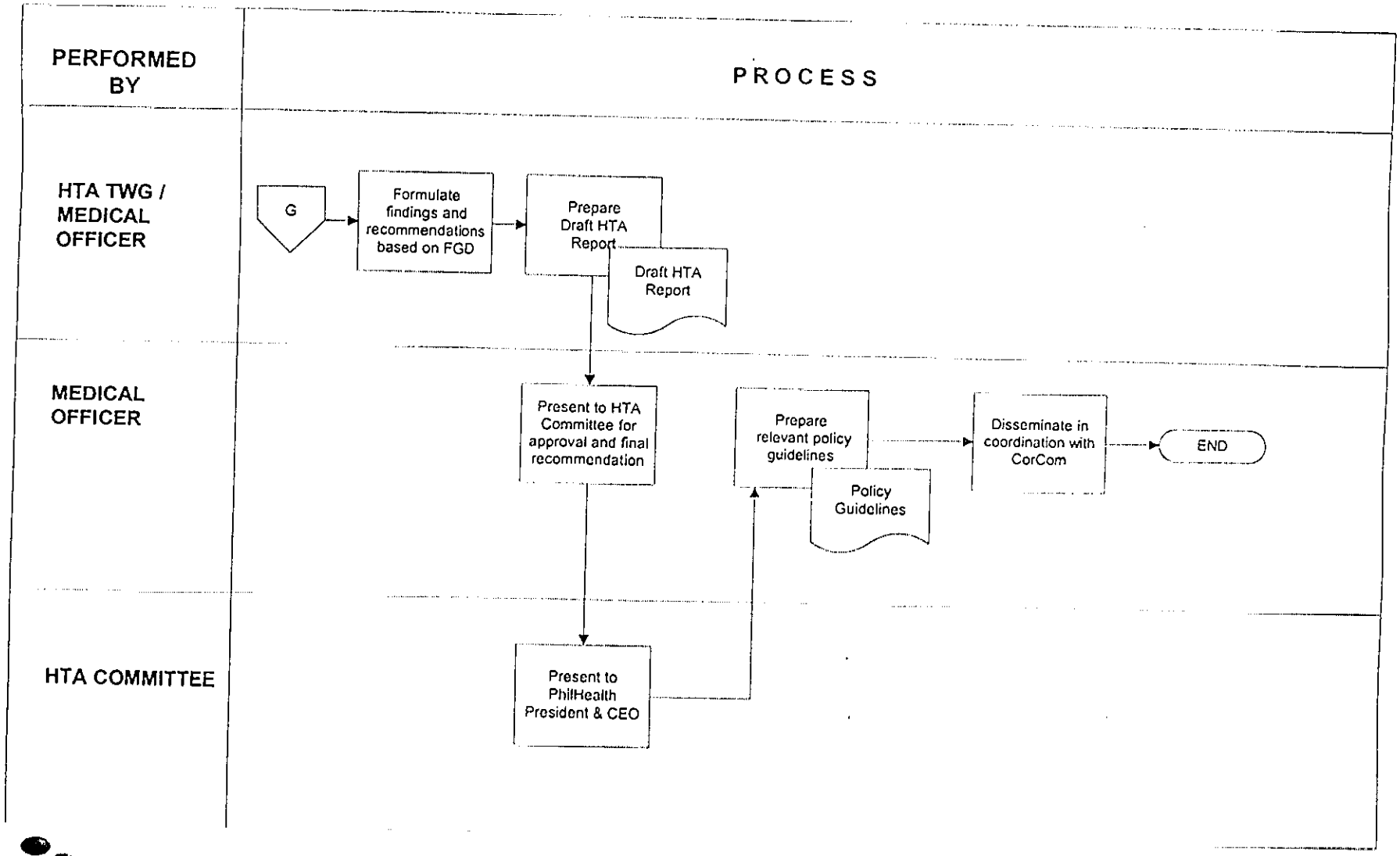
PROCESS NAME : MANAGE HEALTHCARE PROVIDER RELATIONS
SUBPROCESS NAME : CONDUCT TECHNOLOGY ASSESSMENT ON DRUGS (Non-PNDF)



PROCESS NAME : MANAGE HEALTHCARE PROVIDER RELATIONS
SUBPROCESS NAME : CONDUCT OF TECHNOLOGY ASSESSMENT ON PROCEDURES



PROCESS NAME : MANAGE HEALTHCARE PROVIDER RELATIONS
SUBPROCESS NAME : CONDUCT OF TECHNOLOGY ASSESSMENT ON PROCEDURES



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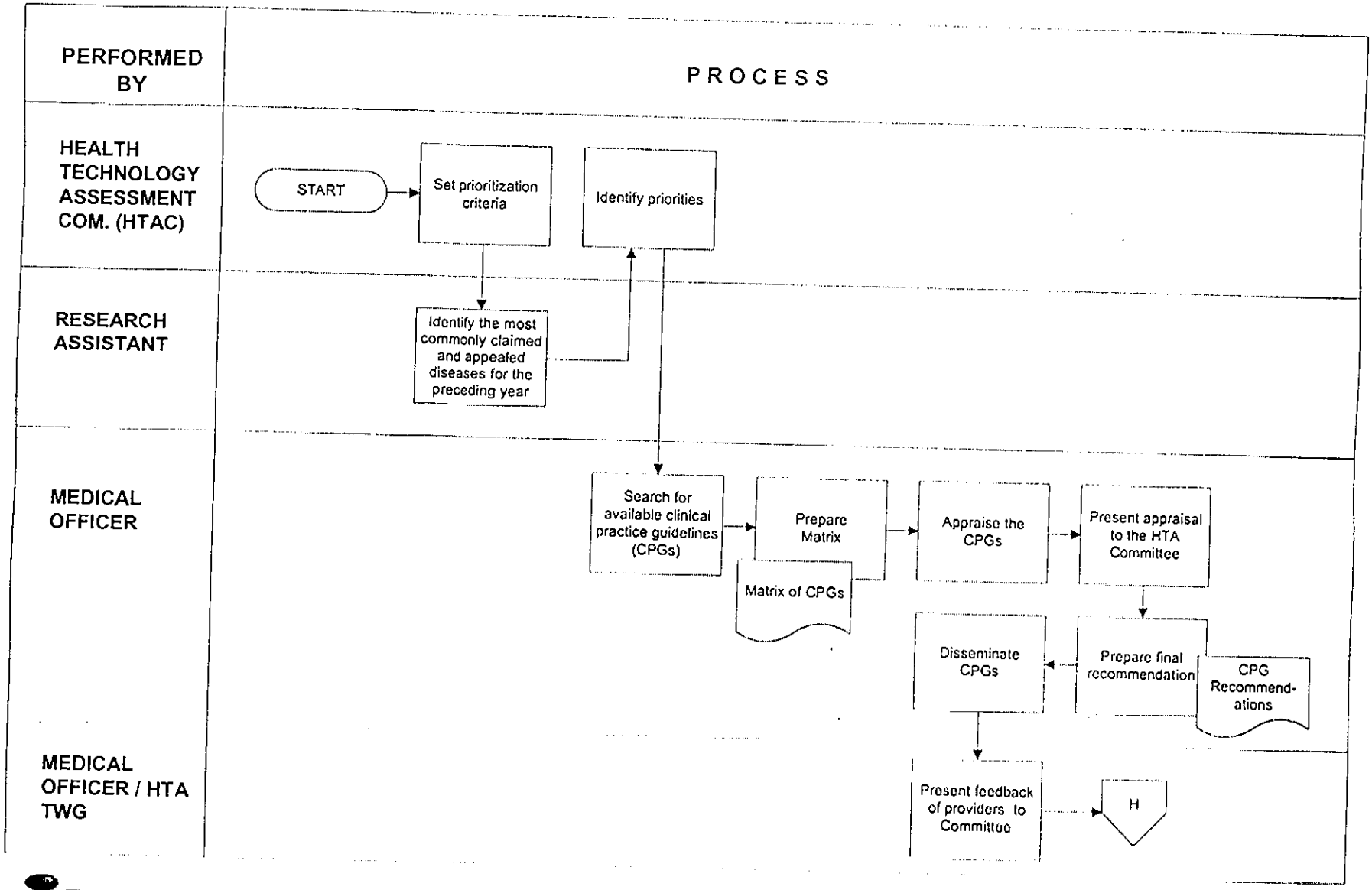
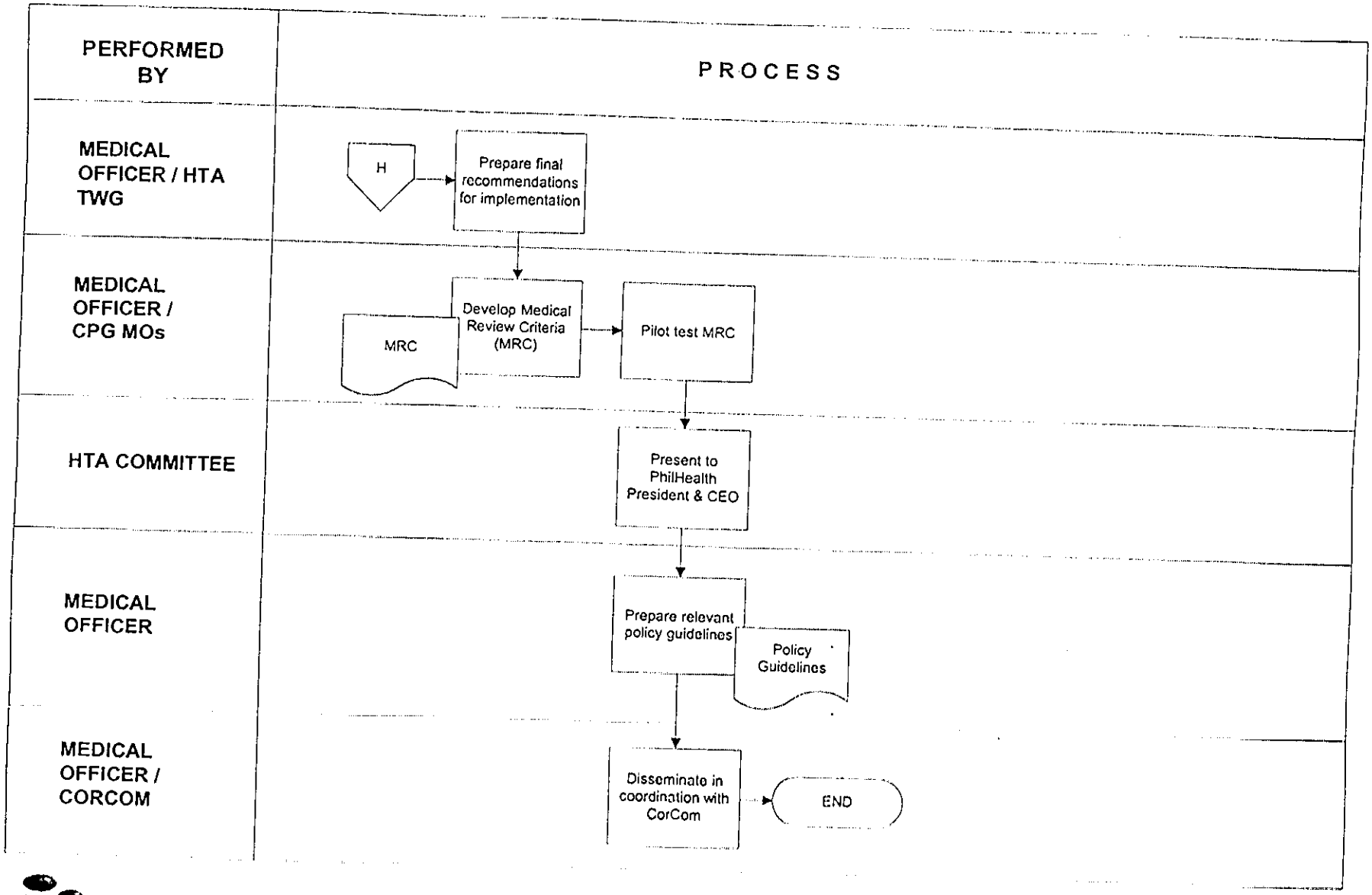
PROCESS NAME : MANAGE HEALTH PROVIDER RELATIONS
SUBPROCESS NAME : CLINICAL PRACTICE GUIDELINES APPRAISAL AND DISSEMINATION / MRC DEVELOPMENT



PROCESS NAME : MANAGE HEALTH PROVIDER RELATIONS
SUBPROCESS NAME : CLINICAL PRACTICE GUIDELINES APPRAISAL AND DISSEMINATION / MRC DEVELOPMENT



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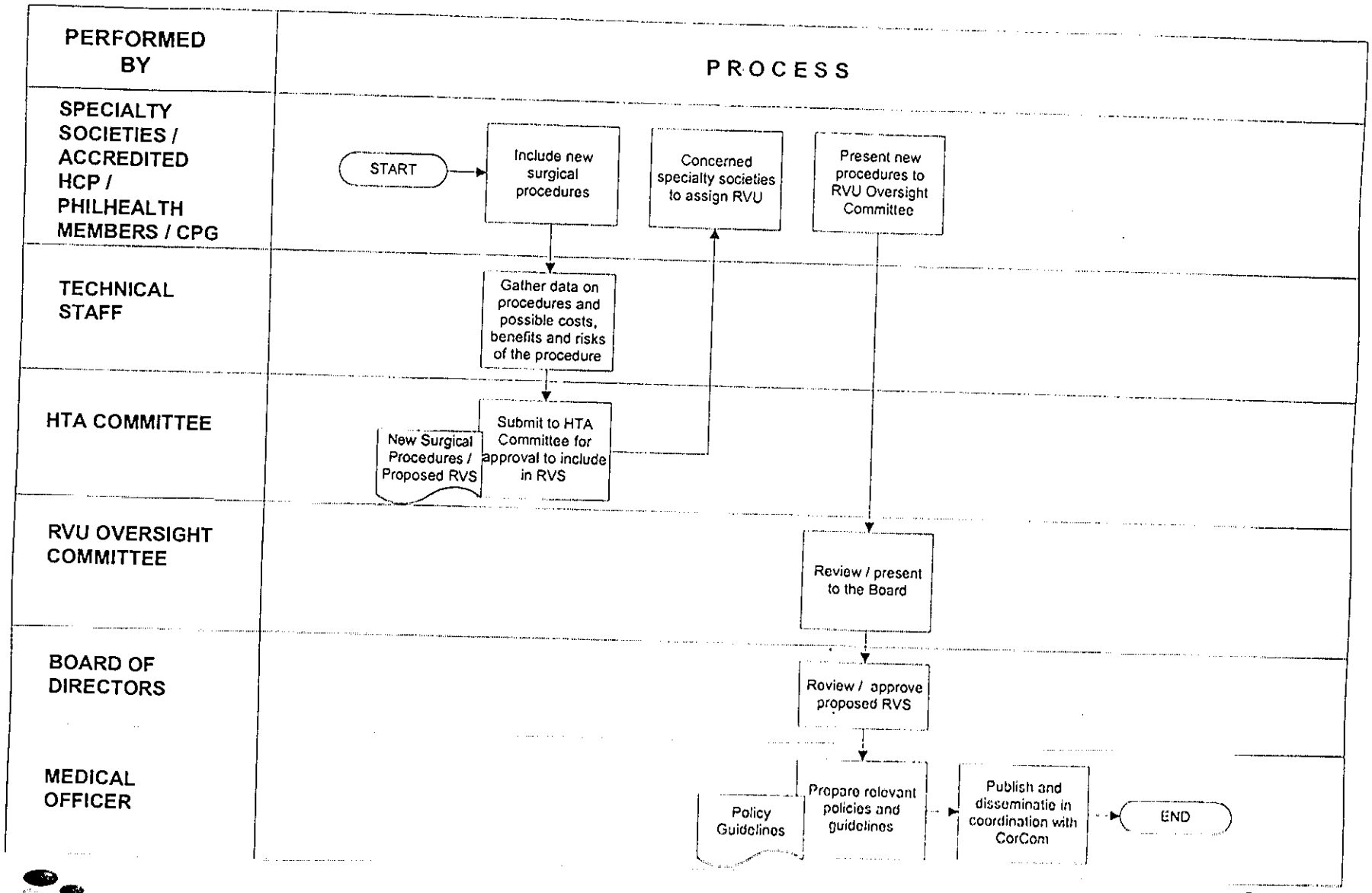
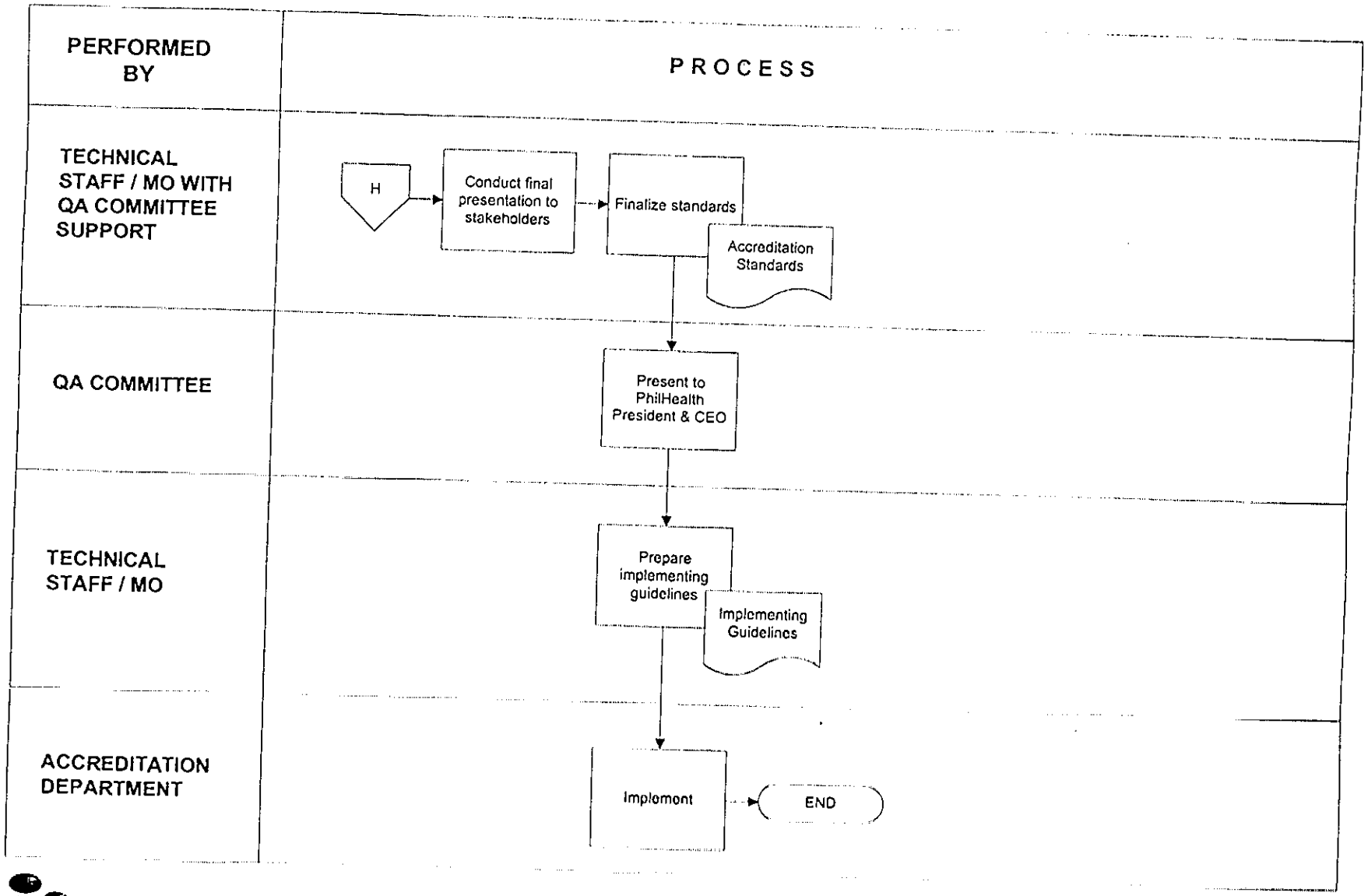
PROCESS NAME : MANAGE HEALTHCARE PROVIDER RELATIONS
SUBPROCESS NAME : DEVELOPMENT / ENHANCEMENT OF RELATIVE VALUE SCALE (RVS) 2001



PROCESS NAME : MANAGE HEALTHCARE PROVIDER RELATIONS
SUBPROCESS NAME : DEVELOPMENT / ENHANCEMENT OF ACCREDITATION STANDARDS FOR HEALTH CARE PROVIDERS: INSTITUTIONS AND PROFESSIONALS



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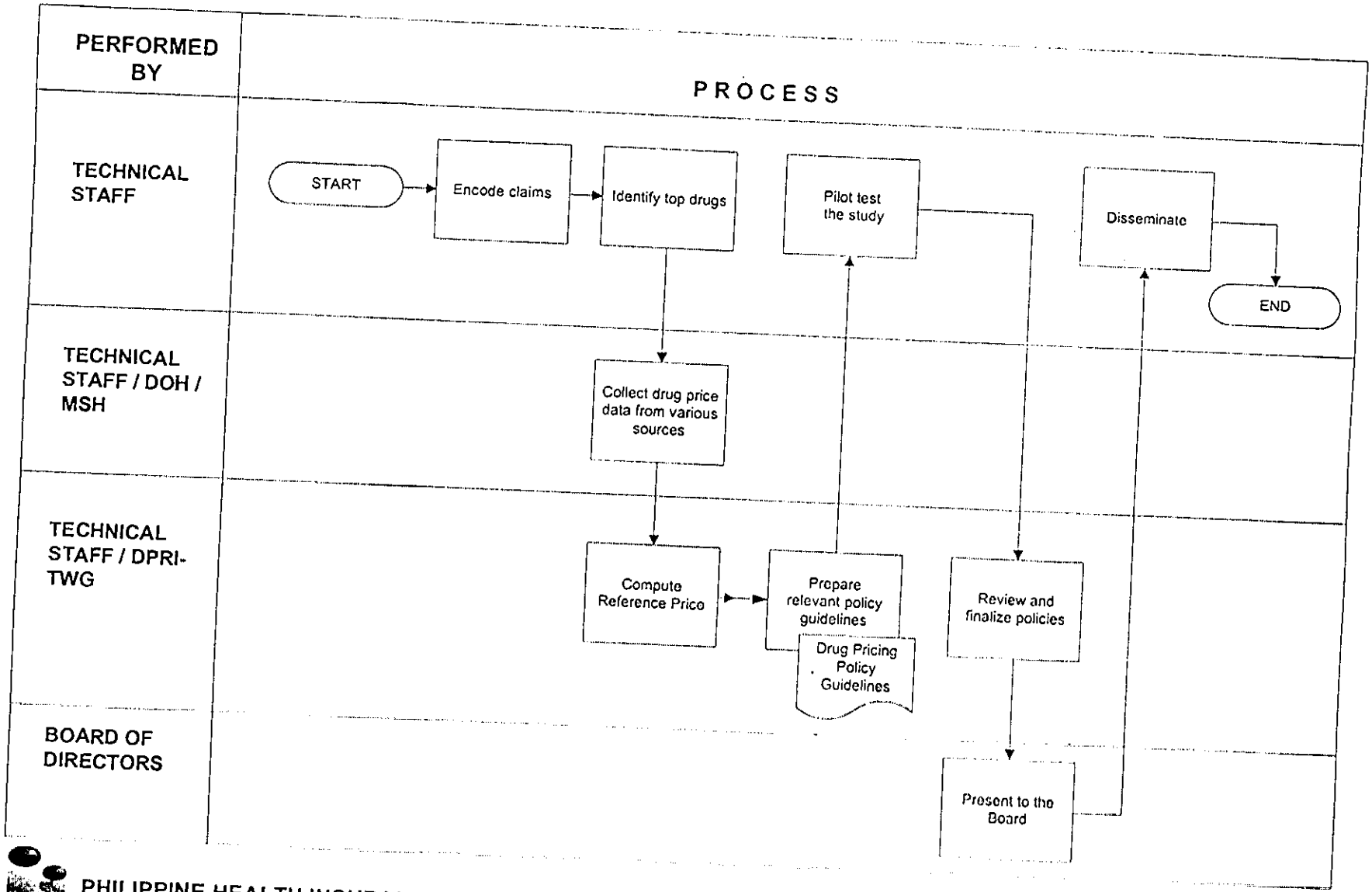
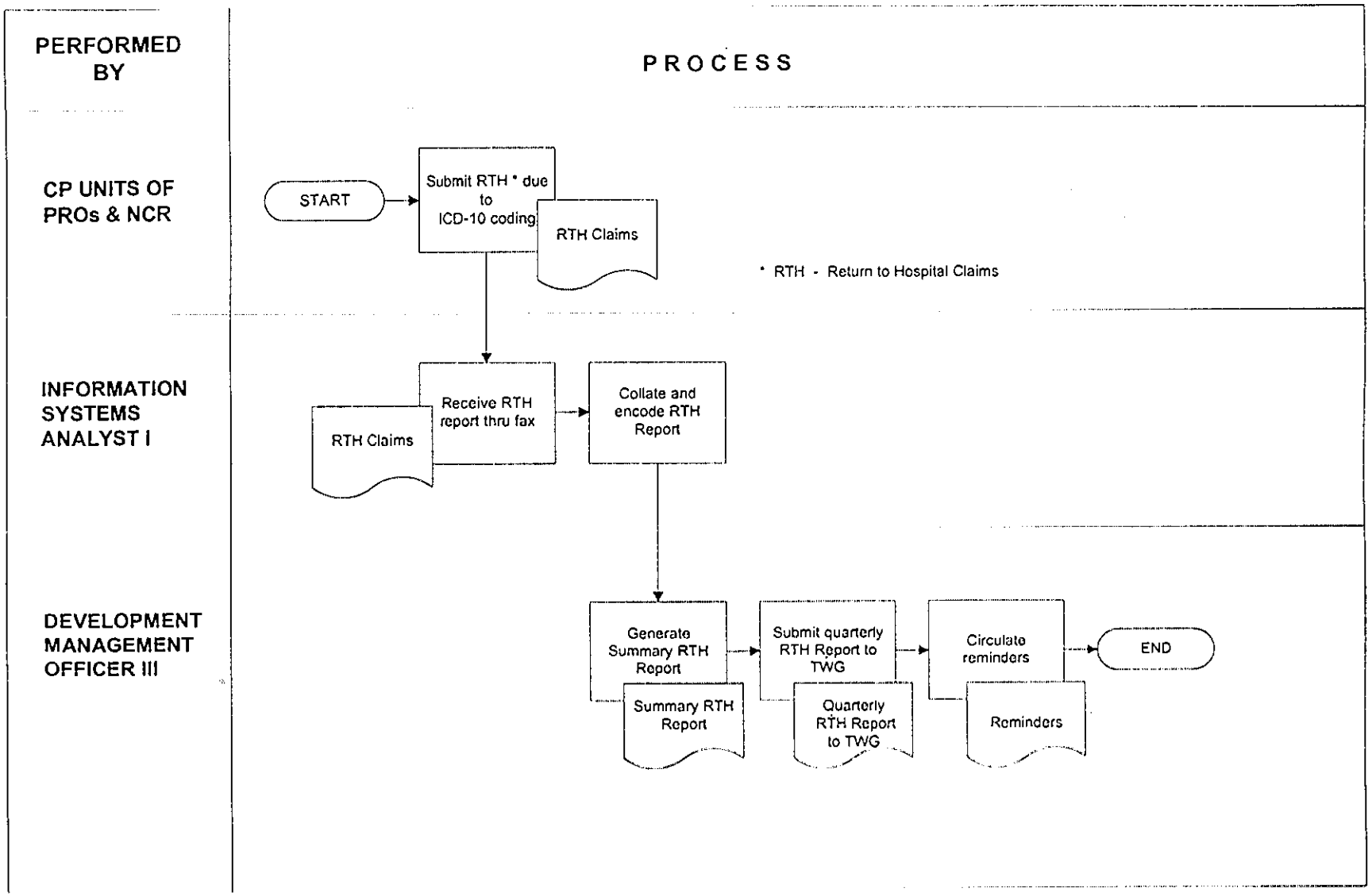
PROCESS NAME : MANAGE HEALTHCARE PROVIDER RELATIONS
SUBPROCESS NAME : DRUG PRICE REFERENCE INDEX (DPRI) STUDY



PROCESS NAME : MANAGE HEALTHCARE PROVIDER RELATIONS
SUBPROCESS NAME : ICD-10 COMPLIANCE MONITORING






PHILIPPINE HEALTH INSURANCE CORPORATION

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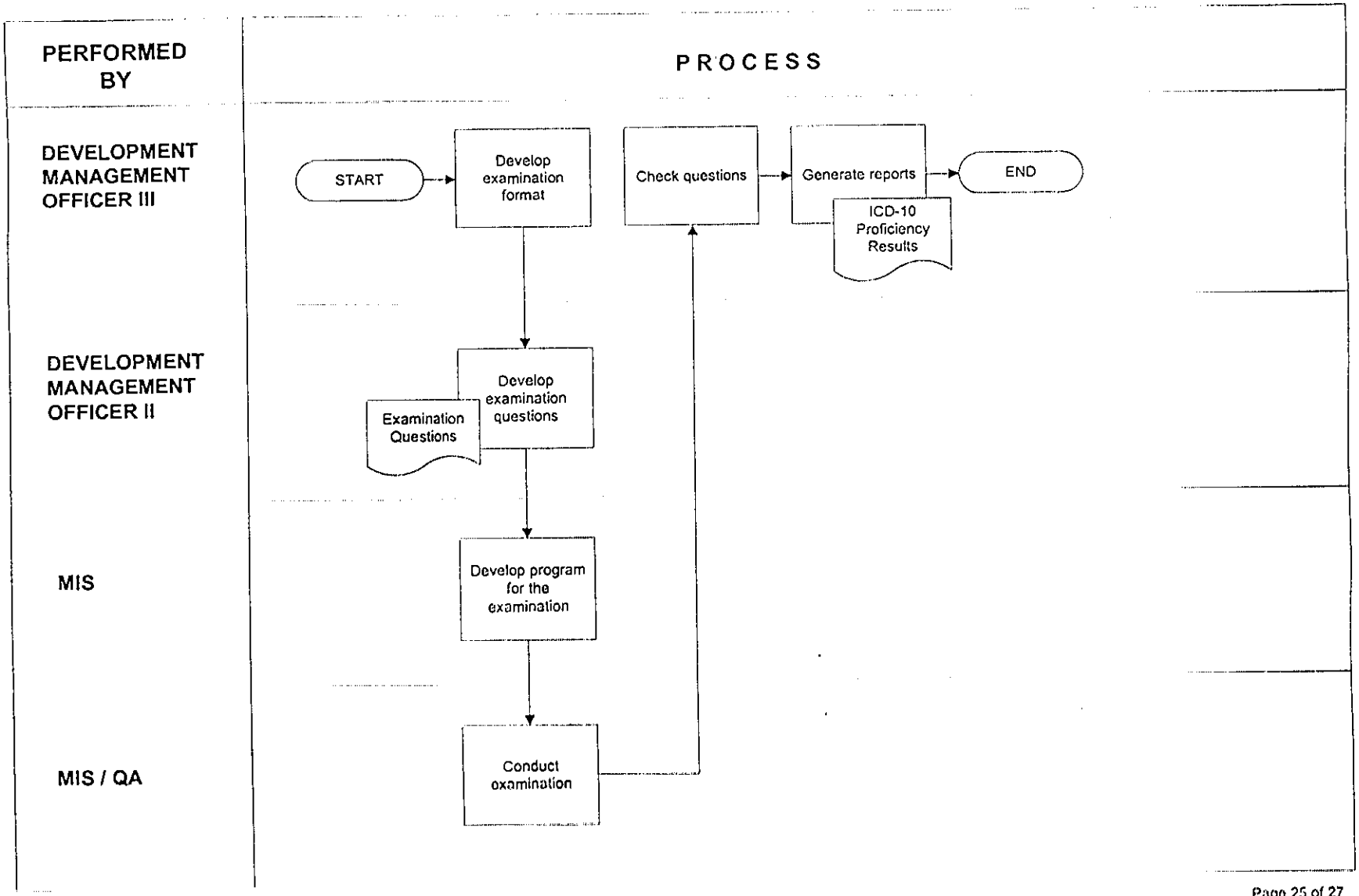
PROCESS NAME : MANAGE HEALTHCARE PROVIDER RELATIONS
SUBPROCESS NAME : ICD-10 PROFICIENCY EXAMINATIONS






PHILIPPINE HEALTH INSURANCE CORPORATION

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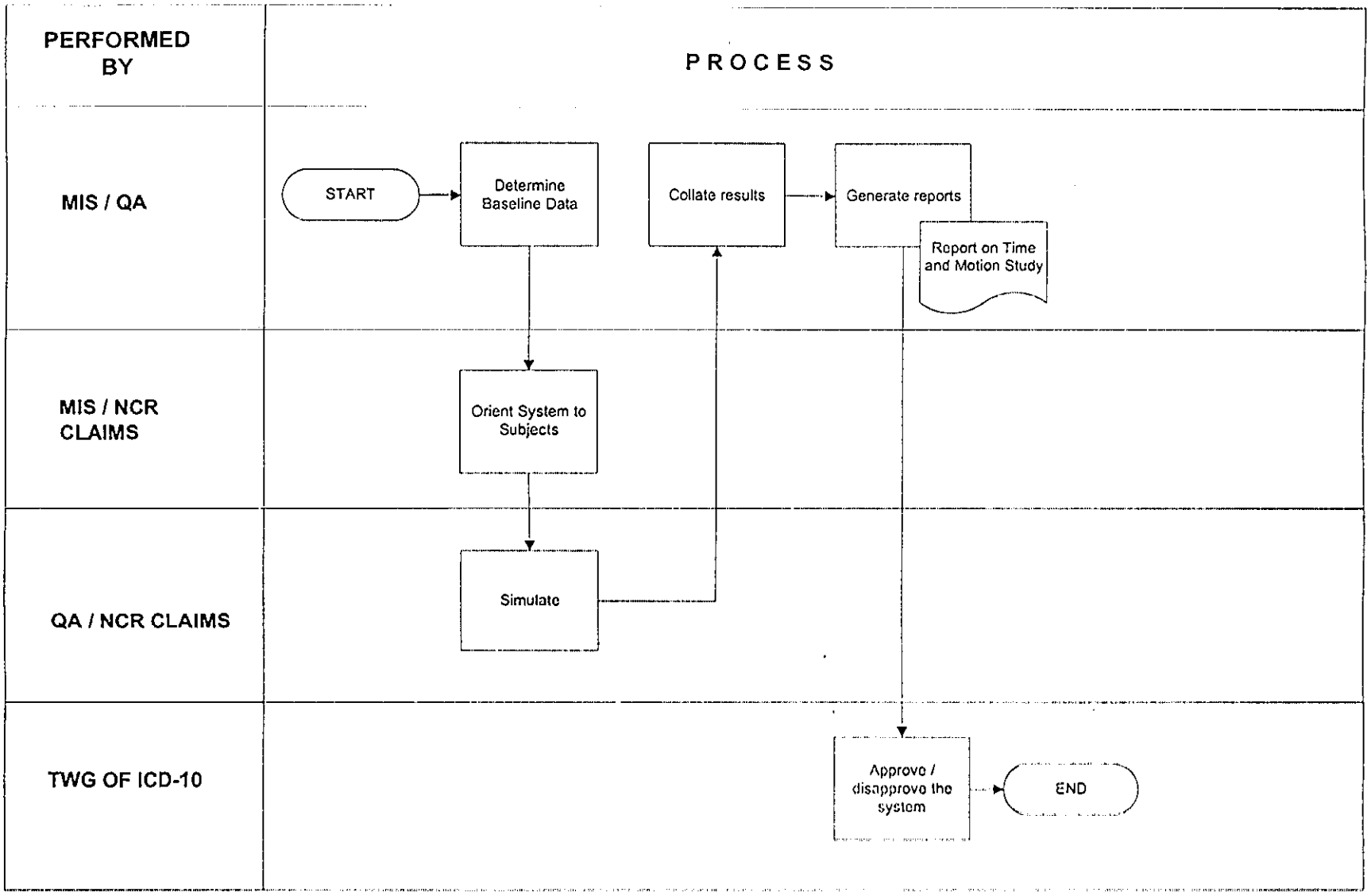
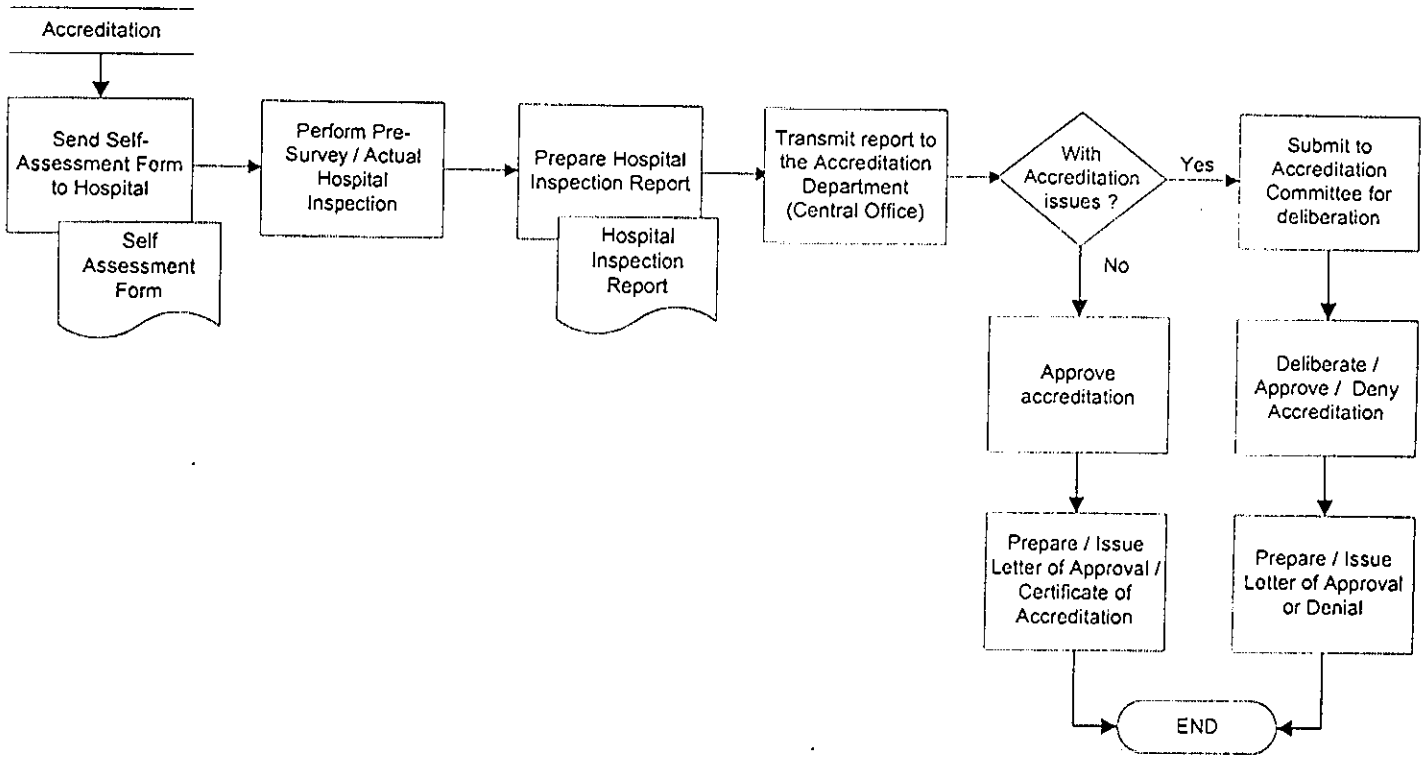
PROCESS NAME : MANAGE HEALTHCARE PROVIDER RELATIONS
SUBPROCESS NAME : ICD-10 REFERENCING SYSTEM TIME AND MOTION STUDY






PHILIPPINE HEALTH INSURANCE CORPORATION

| PERFORMED BY | PROCESS |
|---|---|
| ACCREDITATION | |




Note :

1. Initial accreditation will continue to take effect until revoked.
2. As a procedure, the Accreditation Group will monitor the hospitals due for renewal of accreditation. Hospitals due for renewal of accreditation will be required to accomplish a Self- Assessment Form. Accreditation will, thereafter, conduct the actual hospital inspection to verify compliance with accreditation standards.
3. If hospitals due for renewal of accreditation are deficient in certain areas, submit the hospital to the Accreditation Committee for deliberation; otherwise, the Head of the Accreditation Department will be authorized to approve renewal of hospital accreditation.

# MANAGE HEALTHCARE PROVIDER RELATIONS

## PROCEDURAL DIAGRAMS

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| No | PARTICULARS | Page |
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| 1 | Screening of Applications for Accreditation | 1 |
| 2 | Pre-Survey Activities / Conduct of Actual Survey | 2 |
| 3 | Deliberation and Approval of Accreditation | 4 |
| 4 | Accreditation of RHU | 7 |
| 5 | Post Accreditation Monitoring | 9 |

| Process Name | Manage Healthcare Provider Relations | Version Number | 1.0 |
|---|---|---|---|
| Sub Process Name | Screening of Application for Accreditation | Prepared by/Date | Susan R. |
| Subject | Narrative Procedures | Approved by/Date | |

| Job/Unit Responsible | Activity/ Task |
|---|---|
| ACCREDITATION DEPARTMENT<br><br>PROJECT ASSISTANT | 1. REPRODUCE AND DISTRIBUTE HOSPITAL APPLICATION FORMS<br><br>1.1 Reproduce the application forms (Exhibit 1)<br><br>1.2 Reproduce the guidelines for initial and / or renewal of hospital accreditation.<br><br>1.3 Prepare reminder letters of renewal of accreditation<br><br>1.4 Get the updated hospital addresses from the database.<br><br>1.5 Send the application forms to the hospitals. |
| PROJECT ASSISTANT | 2. VALIDATE DATA ENTRY AND CHECK COMPLETENESS OF DOCUMENTARY REQUIREMENTS SUBMITTED<br><br>2.1 Check if the application form is filled up properly and completely.<br><br>2.2 Check completeness of documentary requirements versus the checklist of requirements.<br><br>2.2.1 If the application form and / or documentary requirements are incomplete:<br><br>2.2.1.1 Send a letter to the hospital indicating the deficiencies.<br><br>2.2.1.2 Confirm receipt of deficiency letter by the hospital.<br><br>2.2.1.3 Follow up the hospital to comply with the deficiencies.<br><br>2,2.2. If the application form and documentary requirements are complete, refer the hospital representative to the cashier for the payment of the accreditation fee. |

| Job / Unit Responsible | Activity / Task |
|---|---|
| PROJECT ASSISTANT | **1. PRE-SURVEY ACTIVITIES**<br>1.1 Prepare Letter of Notice of Hospital Inspection.<br>1.2 Prepare the survey tool.<br>1.3 Prepare the survey plan.<br>1.4 Prepare the travel authority.<br>1.5 Coordinate with the General Services Department (GSD) on transportation arrangements.<br>1.6 Review previous hospital survey results and note deficiencies in a separate sheet.<br>1.7 Confirm schedule of hospital visit to make sure that the Hospital Director is present during the inspection |
| ACCREDITATION OFFICER | **2. CONDUCT HOSPITAL INSPECTION**<br>2.1 Open the Conference.<br>2.1.1 Introduce the team to the Hospital Director and other hospital officers and staff.<br>2.1.2 State the purpose of the visit.<br>2.1.3 Describe the steps / areas to be inspected,<br>2.1.4 Reiterate the documents that will be reviewed,<br>2.1.5 Agree on the time for the exit conference.<br>2.2 Review past survey records and new data.<br>2.3 Conduct the actual survey, with each Accreditation team member accompanied by the hospital personnel.<br>2.4 Consolidate hospital findings. |

| Job / Unit Responsible | Activity / Task |
|---|---|
| ACCREDITATION OFFICER | 2.5 Hold the Exit Conference.<br><br>2.5.1 Describe the findings, validate with the hospital staff, and solicit for recommendations on how they could address the findings.<br><br>2.5.2 Provide the hospital with a copy of the pre-formatted post-inspection report.<br><br>2.5.3 Request the Medical Director to sign the report.<br><br>**3. EVALUATE HOSPITAL INSPECTION FINDINGS.**<br><br>3.1 Review of hospital survey tool and inspection report (Exhibit 2).<br><br>3.2 Fill up the Hospital Evaluation Sheet.<br><br>3.3 Recommend the hospital for deliberation at the Accreditation Meeting. |

| Job / Unit Responsible | Activity / Task |
|---|---|
| ACCREDITATION DEPARTMENT<br><br>PROJECT EVALUATION OFFICER | **1. PREPARE MATERIALS FOR ACCREDITATION COMMITTEE DELIBERATIONS.**<br><br>1.1 Obtain copies of the Hospital Inspection Reports (Exhibit 2) prepared by the MOs / AQAOs.<br><br>1.2 Prepare a Matrix Summary of Inspection Reports containing issues and recommendations of the MOs / AQAOs.<br><br>1.3 Prepare the agenda and other materials for the Accreditation Committee meeting.<br><br>(Note : Deliberation of applications for initial or renewal of accreditation is done twice a month by the Accreditation Committee. The Accreditation Committee is chaired by the President & CEO of PhilHealth and is represented by concerned Philhealth offices and external agencies, as follows : DOH, PMA,PHA, PhilHealth- Legal, Claims, QARPDG and Accreditation.) |
| ACCREDITATION OFFICERS (MO / AQAO) | **2. REVIEW MATERIALS FOR ACCREDITATION COMMITTEE MEETING.** |
| PROJECT ASSISTANT | **3. COORDINATE ARRANGEMENTS FOR THE ACCREDITATION COMMITTEE MEETING** |
| ACCREDITATION COMMITTEE / ACCREDITATION OFFICERS | **4. CONDUCT DELIBERATION OF APPLICATION FOR INITIAL / RENEWAL OF ACCREDITATION**<br><br>4.1 Deliberate on the applications. Resolve accreditation issues.<br><br>4.2 Approve or deny the application for accreditation. |
| ACCREDITATION OFFICER | **5. PREPARE MINUTES OF ACCREDITATION COMMITTEE MEETING** |
| PROJECT ASSISTANT | **6. PERFORM POST-DELIBERATION ACTIVITIES** |

| Job / Unit Responsible | Activity / Task |
|---|---|
| PROJECT ASSISTANT | 6.1 Route the Minutes of Meeting to the Accreditation Committee members for signature.<br><br>6.2 For approved applications<br><br>6.2.1 Prepare the Notices of Approval of Accreditation.<br><br>6.2.2 Forward the Minutes of Meeting and Notices of Approval to the President for signature.<br><br>6.2.3 Send the Notices of Approval to the concerned hospitals.<br><br>6.2.4 Prepare the Certificates of Accreditation.<br><br>6.2.5 Forward the Certificates to the authorized signatories for signature.<br><br>6.2.6 Send the Certificates to the concerned hospitals<br><br>6.3 For denied applications :<br><br>6.3.1 Prepare the Letters of Denial.<br><br>6.3.2 Forward the Letters of Denial to the authorized signatory for signature.<br><br>6.3.3 Send the Letters to the concerned hospitals. |
| PROJECT ASSISTANT | **7. UPDATE HOSPITAL PROFILE DATA**<br><br>7.1 Encode / update the hospital profile in the Accreditation database.<br><br>7.2 Print out the Certificates of Accreditation.<br><br>7.3 Print out a List of Accredited Hospitals.<br><br>7.4 Extract the hospital profiles from the database.<br><br>7.5 Review the list of extracted file in terms of accuracy and completeness of data. |

| Job / Unit Responsible | Activity / Task |
|---|---|
| PROJECT ASSISTANT | 7.6 Forward data of newly-accredited hospital profiles to MIS |
| MIS STAFF | 8. **DOWNLOADING OF ACCREDITATION DATA** (THRU MIS DEPT.)<br>8.1 Forward the data to the regional offices. |

| Job / Unit Responsible | Activity / Task |
|---|---|
| ACCREDITATION DEPARTMENT EVALUATION DIVISION | **1. RECEIVE, VALIDATE, AND EVALUATE APPLICATIONS**<br><br>1.1 Receive and check on the correctness and completeness of the application forms and documentary requirements.<br><br>1.2 Validate and evaluate the authenticity of the documents. Check if the evaluation sheets are filled-up and signed by the evaluator.<br><br>**2. CONDUCT OCULAR INSPECTION**<br><br>2.1 Schedule the ocular inspection of the Regional Health Units (RHUs).<br><br>2.2 Perform ocular inspection of the RHU to check if its physical facility, manpower, equipment, and supplies conform with the accreditation standards.<br><br>2.3 Hold exit conference after inspection. Give feedback on inspection findings to the RHU Chief and other personnel.<br><br>**3. PREPARE FINAL EVALUATION REPORT**<br><br>3.1 Prepare final evaluation report. Recommend whether to accredit , defer, or deny accreditation.<br><br>3.2 Prepare the List of RHU for deliberation at the Accreditation Committee meeting and for approval by the Division Chief.<br><br>**4. DELIBERATE ON RHUs FOR ACCREDITATION**<br><br>4.1 Deliberate on the RHU application for accreditation. Recommend approval, denial. or deferment of accreditation.<br><br>4.2 Encode the approved applications of the RHUs.<br><br>4.3 Verify encoded data against the Masterlist to check for any error / correction.<br><br>**5. ISSUE LETTERS OF APPROVAL AND CERTIFICATIONS**<br><br>5.1 Draft and print the letters of approval, deferment |

| Job / Unit Responsible | Activity / Task |
|---|---|
| ACCREDITATION DEPARTMENT EVALUATION DIVISION | and denial of RHU accreditation.<br>5.2 Print the RHU Certificates of Accreditation.<br>5.3 Initial / sign the Letters of Approval and Certificates of Accreditation.<br>5.4 Forward the Letter of Approval and Certificates of Accreditation to the President & CEO for signature.<br>5.5 Prepare transmittal letters to the PROs. Attach the Letters of Approval and Certificates of Accreditation.<br>5.6 Forward the documents to the Records Section for mailing to the PROs. |

| Job / Unit Responsible | Activity / Task |
|---|---|
| ACCREDITATION DEPARTMENT MONITORING DIVISION | **1. IDENTIFY HOSPITALS FOR MONITORING.**<br>1.1 Review the hospital profile. Look at the following criteria:<br>1.1.1 2-3x with logbook deficiency in the past 3 years<br>1.1.2 DOH expired license / delayed issuance of DOH license<br>1.1.3 Hospital with expired ancillary services<br>1.1.4 Excess MBOR (>100) for 3 successive months within the year for the past and current years<br>1.1.5 Incompletely filled-up clinical charts<br>1.1.6 Significant findings from the PRO reports<br>1.1.7 Hospitals identified for monitoring by the Accreditation Committee<br>• Hospitals with recurrent deficiencies<br>• Referred to Legal<br>• With high service utilization<br>**2. PREPARE PRE-MONITORING EVALUATION REPORT**<br>2.1 Draft the hospital evaluation. Indicate the evaluation findings.<br>2.2 Discuss the findings with the team leader.<br>2.3 Present the findings to the Supervisor for approval.<br>**3. REQUEST FOR TRAVEL ORDER / SPECIAL ORDER**<br>3.1 Fill up the travel request for approval of the supervisor.<br>3.2 Prepare the travel authority. |

| Job / Unit Responsible | Activity / Task |
|---|---|
| ACCREDITATION DEPARTMENT MONITORING DIVISION | 3.3 Prepare the Special Order.<br>3.4 Coordinate for transportation arrangements.<br>**4. PERFORM ACTUAL HOSPITAL MONITORING ACTIVITIES**<br>5.1 Prepare the monitoring tool.<br>5.2 Conduct the pre-monitoring conference.<br>5.2.1 Meet with the Chief of the Hospital.<br>5.2.2 Define the purpose of the visit.<br>5.2.3 Indicate areas to be inspected.<br>5.2.4 Set the time of feedback.<br>5.2.5 Request the presence of the hospital chief/medical director, chief nurse, chief of ancillary services during the inspection.<br>5.2.6 Review of documents.<br>5.3 Visit to the different areas of the hospital.<br>5.4 Discuss findings within the team prior to the exit conference.<br>5.5 Hold the Exit Conference.<br>**6. PREPARE MONITORING REPORT**<br>6.1 Draft the Monitoring Report.<br>6.2 Give feedback to the Supervisor.<br>6.3 Refer findings to Legal or to the concerned department, as warranted. |

# MANAGE HEALTHCARE PROVIDER RELATIONS

## FORMS

## Table of Contents


| Exhibit No | PARTICULARS |
|---|---|
| 1 | Application for Accreditation – Hospitals |
| 2 | Hospital Inspection Report |
| 3 | Application for Accreditation – Healthcare Professionals |

# EXHIBIT 1

## Application for Accreditation - Hospitals

*Republic of the Philippines*
**PHILIPPINE HEALTH INSURANCE CORPORATION**
Citystate Centre 709 Shaw Boulevard, Pasig City
Healthline 637-0999 www.philhealth.gov.ph

PLAN 500

# CHECKLIST OF REQUIREMENTS FOR HOSPITAL ACCREDITATION FOR ( PRIMARY )

NAME OF HOSPITAL:_____

ADDRESS:_____

_____ 1. PhilHealth application form properly accomplished.
_____ 2. Duly notarized Warranties of Accreditation.
_____ 3. DOH License issued 2002.
_____ 4. PHA / PHAP Certificate of Membership issued 2002.
_____ 5. List of functional / serviceable equipment signed by Medical Director / Administrator (Annex A).
_____ 6. List of current hospital's bed rates (Annex B).
_____ 7. List of current hospital service charges (Annex C).
_____ 8. Ancillary Licenses issued / revalidated 2001 - 2002.
  a.) Laboratory License ( optional )
  b.) X-ray License ( optional )
  c.) Hospital Pharmacy License ( optional )
  NOTE: *If a certain ancillary service is present, it should comply with the requirements.*
_____ 9. Certificate of affiliation for Laboratory and X-ray License issued 2002.
_____10. List of available emergency drugs.
_____11. Complete list of hospital staff with respective designation indicating position as full time or part time ( Annex D ).
_____12. Accreditation fee of P1.000.00 for Primary Hospitals by postal money order payable to Philippine Health Insurance Corporation or cash paid directly to cashier and / or photocopy of OR from PRO.
_____13. Ongoing Quality Assurance Program.
_____14. Photocopy of Remittance Form I ( RF1 ) for the last quarter.
_____15. Updated Health Certificate of Kitchen personnel.
_____16. Fire Safety Permit for 2002.

Additional Requirements for Initial Accreditation:

_____ 1. Current photographs of hospital façade, ER, Laboratory, Pharmacy, X-ray (optional), DR, Recovery Room, Isolation Room, CR, Records, Business Office, Nurses Station, CSS and other available hospital facilities.
_____ 2. Current photograph of complete hospital staff.
_____ 3. Current standard operating procedures.
_____ 4. SEC License / DTI certificate / CDA certificate.
_____ 5. DOH licenses of three (3) previous successive years or Mayor's Permit.

DOCUMENTS SUBMITTED TO PRO:
Region: _____
Date Received: _____
Received By: _____
Date Refiled: _____

TO PHILHEALTH CENTRAL OFFICE:
Date Received: _____
Received By: _____
Received and Assessed By: _____

PRO staff are advised to strictly indicate the above data.

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
ACCREDITATION DEPARTMENT
12th Floor City State Centre Bldg., 709 Shaw Blvd. Oranbo, Pasig City
Tel No. 637-62-65 Trunk line 637-99-99 loc 1215, 1216, Telefax. 637-25-27
E-mail: Accre@philhealth.gov.ph

PhilHealth ACCREDITATION FORM
APPLICATION FOR ACCREDITATION ( PRIMARY ) 1 P

_____, 20__

THE PRESIDENT
Philippine Health Insurance Corporation
Pasig City, Philippines

SIR :

I, _____, Filipino of legal age, _____ with address
(Position / Designation)

at _____ and the duly authorized representative to act for and in behalf of _____, hereby applies for accreditation under
( Health Care Institution )

Sec. 16 L of R.A. 7875 and its Implementing Rules and Regulations thereto. For this purpose, I hereby submit the following pertinent information and documentary requirements.

PART I - GENERAL INFORMATION

Name of Hospital : _____

Complete Address : _____ Postal Code : _____

PhilHealth Code No. : _____ Tel No.: _____ Fax No.: _____

Date established : _____ Date of Last Accreditation : _____

Chief / Medical Director : _____ Administrator : _____

DOH License No. _____ valid from _____ to _____ issued on _____, 20__

Ownership / Management

( ) Single Proprietorship ( ) Cooperative
( ) Corporation ( ) Foundation
( ) National Government ( ) Local Government
Others, specify _____

A. PHYSICAL PLANT & ENVIRONMENT

1. Building
( ) Concrete ( ) Old structure
( ) Semi-concrete ( ) Renovated
( ) Wood ( ) New structure

2. Sanitation and Safety Standard
a. Water supply _____
b. Electric Power _____
Stand by generator ( ) Yes ( ) No
c. Sewage Disposal
Solid waste by _____

MMC/Primary/06/07/01

( ) X-ray facility (optional)
X-ray Lic. No. _____ valid from _____ to _____
Affiliation ( ) Yes ( ) No If yes, specify _____
- X-ray Lic. No. _____ valid from _____ to _____
( ) Pharmacy (optional)
Pharmacy Lic. No. _____ valid from _____ to _____
( ) Dental room
( ) Drug room
( ) Labor room
( ) Delivery room
( ) Recovery room
( ) Medical Records room
( ) Kitchen
( ) Others, please specify _____

E. EQUIPMENT Submit complete list of existing functional or serviceable equipment under each facility. ( Please see Annex A )

F. CLINICAL SERVICE

( ) General Medicine
( ) OB - Gyn ( if with DR )
( ) Others, specify _____

G. RECORDS

( ) Admission & discharge records
[ ] Prescribed logbook ( Follow PhilHealth Cir. No. 56 s.1999 & No. 38 s.2000 ) [ ] Computerized

| Case No. | Admission Date & Time | Name of Patient | Age | Sex | Address | Membership | Admitting Diagnosis | Final Diagnosis | Attending Physician | Disposition | Discharge Date & Time |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |

( ) Patient's chart
( ) Laboratory logbook ( optional )

| Case No. | Name of Patient | Age | Sex | Membership | Admitting Diagnosis | Type of Examination |
|---|---|---|---|---|---|---|
| | | | | | | |

( ) X-ray logbook ( optional )

| Case No. | Name of Patient | Age | Sex | Address | Membership | Admitting Diagnosis | Type of Examination | Date of Examination |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

( ) OPD logbook
( ) Outpatient surgical logbook ( Minor surgery )
( ) Mandatory monthly hospital reports

H. QUALITY ASSURANCE PROGRAM OF THE INSTITUTION

1. Plan
2. Mission and Vision
3. Personnel Responsible for the Program
4. Activities
5. Minutes of Meeting

# PART II – WARRANTIES OF ACCREDITATION

The undersigned, as representative to act for and on behalf of

_____
( Hospital )

located at _____ warrants
( address )

the following :

1. ELIGIBILITY

1.1. That the aforenamed health care institution has been in operation for at least three years,
1.2. That it is duly licensed/accredited by the Department of Health,
1.3 That it shows a good track record in the provision of health care,
1.3. That it is a member of good standing of _____ duly recognized by PhilHealth with its
(association)
established standards and criteria,
1.4 That it has the human resources, equipment, physical structure and other requirements in conformity with standards established by the Corporation,
1.5 That it has an ongoing quality assurance program.

2. COMPLIANCE TO PERTINENT LAWS

2.1 That the aforenamed health care institution shall in the course of its participation with the NHI program by virtue of its accreditation comply with the provisions of the National Health Insurance Law (RA 7875), its Implementing Rules and Regulations, all administrative orders of the corporation,
2.2 That it shall comply at all times with the provisions of the Hospital Licensure Act (RA 4226), its prevailing Implementing Rules and Regulations, Administrative Order # 24, s-1994 for ambulatory surgical clinics as well as other Administrative Orders,
2.3 That it shall accept the formal program of Quality Assurance, payment mechanism and utilization review of the NHI program,
2.4 That its personnel shall strictly adhere and comply at all times with the Codes of Ethics of the Medical and Nursing professions and other medical related professions of the Philippines,
*2.5 That it shall strictly enforce a smoke-free policy within the premises of the health care institutions. Premises shall be understood to include all areas of a health care institution's compound regardless whether the same is inside or outside an enclosed structure.*

3. CLINICAL SERVICES

3.1 That the aforenamed health care institution shall guarantee, safe adequate and standard medical care for all patients seeking medical care; and shall exercise observance of public health measures in case of communicable disease,
3.2 That it shall adopt referral protocols, strictly follow guidelines and health resource sharing arrangements of the Program,
3.3 That it shall extend without delay chargeable benefits due qualified members and beneficiaries,
3.4 That it shall not engage in unethical and illegal solicitation of patients for purposes of compensability under the NHI program,
3.5 That it shall maintain serviceable equipment and facilities and required personnel.

4. CLINICAL RECORDS AND PREPARATION OF CLAIMS

4.1 That the aforenamed health care institution shall maintain and accomplish at all times accurate chronological records of all patients, services rendered and health outcomes resulting from such services and health expenditures on patient care,
4.2 That it shall keep a neat and systematic records file in a safe but accessible place for easy retrieval,

ANNEX A

PRIMARY

LIST OF FUNCTIONAL / SERVICEABLE EQUIPMENT / APPARATUSES / INSTRUMENTS

NAME OF HOSPITAL: _____

ADDRESS: _____

| FACILITY | EQUIPMENT | | REMARKS ( Functional, For repair, etc. ) |
|---|---|---|---|
| | TYPE | NUMBER | |
| | | | |

I hereby declare under penalties of perjury that the answers given are true and correct to the best of my knowledge and belief.

_____
Date Accomplished

_____
Medical Director's / Administrator's Signature over printed name

Res. Cert. No.: _____
Issued at : _____
Issued on : _____

MMC/Primary/Annex A

Annex B

PRIMARY

# HOSPITAL'S BED RATES

NAME OF HOSPITAL : _____

ADDRESS : _____

CATEGORY : _____

DOH BED CAPACITY : _____

PHIC ACCREDITED BED : _____

ACCREDITATION NO.: _____

EFFECTIVITY OF ACCREDITATION: _____

| TYPE OF ROOMS | ROOM NO/S. | NO. OF BEDS | ROOM RATES | AMENITIES |
|---|---|---|---|---|
| WARD | | | | |
| MALE | | | | |
| FEMALE | | | | |
| SEMI - PRIVATE | | | | |
| PRIVATE | | | | |
| SUITE | | | | |
| DELIVERY ROOM | | | | |
| OTHERS | | | | |

I hereby declare under penalties of perjury that the answers given are true and correct to the best of my knowledge and belief.

_____
Date Accomplished

_____
Medical Director's / Administrator's Signature
over printed name

Res. Cert. No._____
Issued at _____
Issued on _____

# LIST OF CURRENT HOSPITAL SERVICE CHARGES

| SERVICES | RATE |
|---|---|
| Laboratory procedure ( Optional) | |
| X-ray & other Radiologic procedures ( Optional ) | |
| Other ancillary procedures ( Optional ) | |

I hereby declare under penalties of perjury that the answers given are true and correct to the best of my knowledge and belief.

Date Accomplished

Medical Director's / Administrator's Signature over printed name

Res. Cert. No. _____
Issued at _____
Issued on _____

ANNEX D

PRIMARY

# LIST OF HOSPITAL PERSONNEL

| NAME | POSITION / SPECIALTY | EMPLOYMENT STATUS | | | | PRC NO. for professionals | PHILHEALTH NO. | SIGNATURE |
|---|---|---|---|---|---|---|---|---|
| | | FULLTIME | PARTTIME | VISITING | ON CALL | | | |
| | | | | | | | | |

NOTE : In case of resignation of any of the above listed employees, submit appointment of replacement properly attested and subscribed to

I hereby declare under penalties of perjury that the answers given are true and correct to the best of my knowledge and belief.

Medical Director's / Administrator's Signature over printed name

Date Accomplished

Res. Cert. No. _____
Issued at _____
Issued on _____

# EXHIBIT 2

## Hospital Inspection Report

PRIMARY

# PHILIPPINE HEALTH INSURANCE CORPORATION
## HOSPITAL INSPECTION FORM

**Secondary Hospital**
**(Revised June 1998)**

NAME OF HOSPITAL: _____
ADDRESS: _____
DIRECTOR: _____
OWNER: _____

| LICENSES | License # | Date Granted | Period Covered | Remarks |
|---|---|---|---|---|
| DOH License | | | | |
| PHIC Accreditation | | | | |
| Laboratory License | | | | |
| X-ray License | | | | |
| Pharmacy License | | | | |

PERSONNEL
Director: _____
Administrator: _____

| Staff | Number | Remarks |
|---|---|---|
| Physician/s | | |
| Nurse/s | | |
| Midwives | | |
| Nursing Aide/s | | |
| Pharmacist/s | | |
| X-ray technologist/s | | |
| Dietitian and staff | | |
| Medical records and staff | | |
| Janitor/s | | |
| Others | | |

Attach separate sheet if necessary.

| | YES | NO | REMARKS |
|---|---|---|---|
| Does the personnel complement satisfy the following ratios ? | | | |
| Administrative- 1:5 provided 20% are professional | | | |
| Medical- 1:5 provided at least 70% are licensed MD's of which 40% are full time | | | |
| Medical ancillary- 1:5 provided 50% are professional | | | |
| Pharmacy- 1:25, at least 50% are licensed pharmacist | | | |
| Nursing- 1:3 provided at least 50% are registered nurses | | | |
| Dietetic service- 1:10 provided at least 20% are dietitians | | | |
| Engineering, maintenance, and housekeeping- 1:6 provided at leat 5% are professional | | | |

**HOSPITAL PERSONNEL ATTENDANCE AT THE TIME OF INSPECTION**

| Name (in print) | Designation | Signature |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |



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## PHILIPPINE HEALTH INSURANCE CORPORATION
## HOSPITAL INSPECTION FORM

Secondary Hospital
(Revised June 1998)

Attach a separate sheet if necessary.

**HOSPITAL PLANT**

Building Specification: ☐ Light ☐ Concrete ☐ Semi-concrete

Number of Buildings: _____ Remarks: _____

Number of Floors: _____ Remarks: _____

Remarks:

Water Supply Specify: _____

Waste Disposal System Specify: _____

Occupancy Permit: _____

Fire exits: _____

Toilet facilities:

Male: _____ Female: _____

| Bed Capacity: | | | Number of beds | Remarks |
|---|---|---|---|---|
| Ward: | Medical | Male | | |
| | | Female | | |
| | Pediatric | Male | | |
| | | Female | | |
| | OB-GYN | | | |
| | Surgical | Male | | |
| | | Female | | |
| Others: | Private | | | |
| | Semi-Private | | | |
| | | | | |

☐ ADMINISTRATIVE SERVICE

- ☐ Lobby with information counter area/ Admitting office/ Waiting area
- ☐ Chief of Hospital's office
- ☐ Business office
- ☐ Toilet facilities for staff
- ☐ Conference room
- ☐ Hospital Administrator's office

☐ SURGICAL SERVICE COMPLEX

- ☐ Operating room with air conditioning unit
- ☐ Scrub up area
- ☐ Clean up area
- ☐ Sub-sterilizing room
- ☐ Toilet facilities for staff
- ☐ Nurse's station for OR
- ☐ Male dressing room
- ☐ Female dressing room
- ☐ Janitor's closet
- ☐ Wheeled stretcher's area
- ☐ Recovery room
- ☐ Sterile instruments, supply and anesthesia storage room

☐ PEDIATRIC SERVICE

- ☐ Pathological/ Suspect Nursery
- ☐ Premature nursery
- ☐ Preparation and work area/ counter with sink
- ☐ Viewing window
- ☐ Preparation and work area for premature nursery
- ☐ Nurse station with work space, lavatory, and counter

☐ OB- GYNE SRVICE

- ☐ Delivery room service complex
- ☐ Delivery room with air conditioning unit
- ☐ Labor room with toilet facilities
- ☐ Sub- sterilizing room
- ☐ Scrub up area
- ☐ Clean up room
- ☐ Nurse station area
- ☐ Wheeled stretcher's area
- ☐ Janitor's closet
- ☐ Toilet facilities for staff
- ☐ Doctor's/ Nurse's room

☐ RADIOLOGY SERVICE

- ☐ Waiting and reception area
- ☐ Radiologist's office with film reading and
- ☐ Dark room with exhaust fan
- ☐ Dressing area

viewing area
- [ ] Fixed X-ray room with control booth
- [ ] Toilet facilities
- [ ] Film file and storage area

[ ] LABORATORY SERVICE
- [ ] Head's office
- [ ] Clinical working area with sink/ lavatory
- [ ] Toilet facilities

[ ] PHARMACY
- [ ] Pharmacist's area/ table
- [ ] Medicine and drug display cabinet
- [ ] Dispensing area
- [ ] Drug storage
- [ ] Narcotic drug storage/ cabinet with lock

[ ] EMERGENCY ROOM SERVICE
- [ ] Nurse station with reception counter
- [ ] Equipment and supply storage area
- [ ] Wheeled stretcher's area
- [ ] Sink/ lavatory
- [ ] Directional signage to emergency room

[ ] OUTPATIENT SERVICE/DOCTOR'S OFFICE
- [ ] Waiting area
- [ ] Examination and treatment cubicle
- [ ] Records cubicle
- [ ] Toilet facilities

[ ] MEDICAL RECORDS ROOM
- [ ] Office
- [ ] Medical records storage

[ ] NURSING SERVICE
- [ ] Chief Nurse's office
- [ ] Nurse station with counter, sink, and medicine cabinet
- [ ] Toilet facilities for staff
- [ ] Private room with toilet facilities
- [ ] Isolation room with toilet facilities
- [ ] Semi- private rooms with toilet facilities
- [ ] Wards with toilet facilities (segregated male and female)

[ ] DIETETIC SERVICE
- [ ] Dietitian's office/ area
- [ ] Kitchen proper- food preparation area, cooking and baking area
- [ ] Serving and food assembly area
- [ ] Dirty utility and washing area
- [ ] Dining room/ area
- [ ] Screened doors, windows, and other openings
- [ ] Exhaust fan
- [ ] Toilet facilities

[ ] ENGINEERING, MAINTENANCE, and HOUSEKEEPING SERVICES
- [ ] Laundry area
- [ ] Housekeeping area
- [ ] Maintenance area
- [ ] Central storage room

[ ] CENTRAL STERILIZING AND SUPPLY ROOM
- [ ] Receiving and dispensing space/ counter
- [ ] Working area
- [ ] Sterilizing area
- [ ] Sterile supply and storage

[ ] OTHERS
- [ ] Signage of "No Smoking Area"

**EQUIPMENT AND INSTRUMENTS**

**CLINICAL SERVICE**
- [ ] ECG machine
- [ ] Tracheostomy set
- [ ] Cribs
- [ ] Paracentesis set
- [ ] OB instrument set
- [ ] Stethoscope
- [ ] Sphygmomanometer
- [ ] Cribs
- [ ] Cutdown set
- [ ] Perineal light
- [ ] Nebulizer
- [ ] Beds with guard rails
- [ ] Neurological hammer
- [ ] Oxygen unit (complete set)

# PHILIPPINE HEALTH INSURANCE CORPORATION
## HOSPITAL INSPECTION FORM

Secondary Hospital
(Revised June 1998)

- ☐ Examining light/ Drop light
- ☐ Suction apparatus
- ☐ Surgical instrument sterilizer
- ☐ Clinical weighing scale with measuring rod
- ☐ Ambu bag

**OPERATING ROOM**

- ☐ Major Surgical Set
- ☐ Laparotomy Set
- ☐ OR Table
- ☐ OR Light
- ☐ Laryngoscope w/ blades
- ☐ Spinal Set
- ☐ Sphygmomanometer
- ☐ Suction apparatus
- ☐ Anesthesia machine
- ☐ C/S Set
- ☐ Autoclave
- ☐ Instrument table
- ☐ Oxygen unit (complete set)
- ☐ Stethoscope

**DELIVERY ROOM/LABOR ROOM**

- ☐ Delivery set
- ☐ D & C set
- ☐ DR light
- ☐ Suction apparatus
- ☐ Sphygmomanometer
- ☐ Instrument table
- ☐ Kelly pad
- ☐ OB table with stirrup
- ☐ Stethoscope
- ☐ Oxygen unit (complete set)

**NURSERY**

- ☐ Stethoscope
- ☐ Infant scale
- ☐ Bassinet
- ☐ Sterilizer
- ☐ Suction apparatus
- ☐ Examining light
- ☐ Oxygen unit (complete set)
- ☐ Bili light
- ☐ Incubator
- ☐ Drop light

**RECOVERY ROOM**

- ☐ Stethoscope
- ☐ Sphygmomanometer
- ☐ Suction apparatus
- ☐ Oxygen unit (complete set)
- ☐ Bed with rails

**ER/ OPD SERVICE**

- ☐ Stethoscope
- ☐ Sphygmomanometer
- ☐ Oxygen unit (complete set)
- ☐ Suturing set
- ☐ Suction apparatus
- ☐ Instrument set
- ☐ Ambu bag
- ☐ Tracheostomy set
- ☐ Gooseneck lamp/ Examining lig
- Wheelchair
- ☐ Examining table
- ☐ Sterilizer
- ☐ Instrument table
- ☐ Vaginal speculum
- ☐ Neurological hammer
- ☐ Clinical weig
- ☐ EENT diagnostic set
- ☐ Stretcher

**DIETETIC SERVICE**

- ☐ Refrigerator/freezer
- ☐ Exhaust fan
- ☐ Cooking units
- ☐ Patient trays
- ☐ Kitchen utensils
- ☐ Water heater
- ☐ Kitchen utensils

**LABORATORY**

- ☐ Burner/ alcohol lamp
- ☐ Centrifuge
- ☐ Hemacytometer
- ☐ Hemoglobinometer
- ☐ Hematocrit centrifuge
- ☐ Microscope
- ☐ Urinometer
- ☐ Refrigerator
- ☐ Serofuge
- ☐ Photometer
- ☐ Water bath

**RADIOLOGY**

- ☐ X- ray machine (at least 100 mA)
- ☐ Lead rubber apron



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## PHILIPPINE HEALTH INSURANCE CORPORATION
## HOSPITAL INSPECTION FORM

Secondary Hospital
(Revised June 1998)

- ☐ Set of gonadal shields
- ☐ Pair of lead rubber gloves
- ☐ Caliper
- ☐ Negatoscope

**OTHER REQUIREMENTS**

- ☐ Stand- by generator
- ☐ Transport vehicle for patient use
- ☐ Fire extinguisher

**CLEANLINESS AND SANITATION**

| | Yes | No | Remarks |
|---|---|---|---|
| Laboratory clean and in order? | ☐ | ☐ | |
| Kitchen clean and with screen? | ☐ | ☐ | |
| a. Far enough from rest room? | ☐ | ☐ | |
| b. Kitchen personnel health certificate posted? | ☐ | ☐ | |
| Wards clean and in order? | ☐ | ☐ | |
| Comfort rooms clean and with adequate drainage? | ☐ | ☐ | |

**RECORD MANAGEMENT**

ADMISSION LOGBOOK CHECKLIST

| | YES | NO | REMARKS |
|---|---|---|---|
| A. Type/No. | | | |
| 1. Book-bound | ☐ | ☐ | |
| 2. Pages pre-numbered | ☐ | ☐ | |
| 3. One only | ☐ | ☐ | |
| 4. Authenticated | ☐ | ☐ | |
| B. Columns and Contents | | | |
| 1. Case No . | ☐ | ☐ | |
| 2. Admission date and time | ☐ | ☐ | |
| 3. Name of patient | ☐ | ☐ | |
| 4. Age(on admission) | ☐ | ☐ | |
| 5. Sex | ☐ | ☐ | |
| 6. Residence/Office Address | ☐ | ☐ | |
| 7. Patient Membership | | | |
| GM-GSIS Member | ☐ | ☐ | |
| GD-GSIS Dependent | ☐ | ☐ | |
| SM-SSS Member | ☐ | ☐ | |
| SD-SSS Dependent | ☐ | ☐ | |
| NM-Non Medicare | ☐ | ☐ | |
| MH-DOH Subsidized | ☐ | ☐ | |
| OFW-Member | ☐ | ☐ | |
| OFW-Dependent | ☐ | ☐ | |
| 8. Admitting Diagnosis | ☐ | ☐ | |
| 9. Final Diagnosis | ☐ | ☐ | |
| 10. Attending Physician | ☐ | ☐ | |
| 11. Disposition | ☐ | ☐ | |
| 12. Disposition Date/Time | ☐ | ☐ | |
| C. Entries Up-dated | ☐ | ☐ | |
| D. Monthly Summary of Activities | ☐ | ☐ | |
| E. COH Certification (Month end/last entry) | ☐ | ☐ | |
| F. QHCA Inspection | ☐ | ☐ | |
| Signature | ☐ | ☐ | |
| Time | ☐ | ☐ | |
| Date | ☐ | ☐ | |
| Certification | ☐ | ☐ | |
| G. Alterations/Erasures/Insertions | ☐ | ☐ | |

H. Other remarks: _____

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# PHILIPPINE HEALTH INSURANCE CORPORATION
## HOSPITAL INSPECTION FORM

Secondary Hospital
(Revised June 1998)

### OPERATING ROOM LOGBOOK

| A. Columns and contents | YES | NO | REMARKS |
|---|---|---|---|
| Name of patient | ☐ | ☐ | |
| Case number | ☐ | ☐ | |
| Address | ☐ | ☐ | |
| Age | ☐ | ☐ | |
| Sex | ☐ | ☐ | |
| Membership | ☐ | ☐ | |
| Admitting diagnosis | ☐ | ☐ | |
| Procedure done | ☐ | ☐ | |
| Surgeon | ☐ | ☐ | |
| Date of operation | ☐ | ☐ | |

B. Number of medium and major surgical operations done for the last six (6) months per O.R. logbook:

| Procedure | Number | Remarks |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

### LABORATORY LOGBOOK

| Columns and contents | YES | NO | REMARKS |
|---|---|---|---|
| Name of patient | ☐ | ☐ | |
| Case No. | ☐ | ☐ | |
| Age | ☐ | ☐ | |
| Sex | ☐ | ☐ | |
| Membership | ☐ | ☐ | |
| Admitting Diagnosis | ☐ | ☐ | |
| Type of Examination | ☐ | ☐ | |

### X-RAY LOGBOOK CHECKLIST

Monitoring Compliance to MC #291 S.1992-4/23/92

| A. Columns and Contents | YES | NO | REMARKS |
|---|---|---|---|
| 1. Name of Patient | ☐ | ☐ | |
| 2. Case No . | ☐ | ☐ | |
| 3. Address | ☐ | ☐ | |
| 4. Age | ☐ | ☐ | |
| 5. Sex | ☐ | ☐ | |
| 6. Membership | ☐ | ☐ | |
| 7. Admitting Diagnosis | ☐ | ☐ | |
| 8. Type of Examination | ☐ | ☐ | |
| 9. Date of Examination | ☐ | ☐ | |
| B. Entries | | | |
| 1. Up-dated | ☐ | ☐ | |
| 2. Alterations/Erasures/Insertions | ☐ | ☐ | |

C. Other remarks: _____

### CLINICAL CHART

| A. Columns and Content | YES | NO | REMARKS |
|---|---|---|---|
| 1. Data sheet<br>Does the case no. & name tally with the logbook? | ☐ | ☐ | |



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# PHILIPPINE HEALTH INSURANCE CORPORATION
## HOSPITAL INSPECTION FORM

Secondary Hospital
(Revised June 1998)

2. Hospitalization Consent ☐ ☐ _____
3. Consent for OR ☐ ☐ _____
4. PHIC Form 3 ☐ ☐ _____
5. TPR Sheet ☐ ☐ _____
6. I / O Sheet ☐ ☐ _____
7. Doctor's Orders _____
   Legibly written? ☐ ☐ _____
   Does the doctor's signature appear on the order sheet? ☐ ☐ _____
   Were the doctor's verbal orders counter-signed by the attending doctor? ☐ ☐ _____
8. History form ☐ ☐ _____
9. Referral sheet ☐ ☐ _____
10. OR/LR Record ☐ ☐ _____
11. Anesthesia Record ☐ ☐ _____
12. Laboratory sheet ☐ ☐ _____
13. Radiology sheet ☐ ☐ _____
14. IV Fluid sheet ☐ ☐ _____
15. Medication sheet ☐ ☐ _____
16. Nurses' Notes ☐ ☐ _____
17. RR Record ☐ ☐ _____

B. Alterations/Erasures/Insertions _____
C. Other Remarks: _____
D. Random examination of claims within the preceding month [get at least three (3) samples].

| Name of patient/member | Confinement period per | | Diagnosis | Management |
|---|---|---|---|---|
| | chart | Logbook | | |
| | | | | |
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| | | | | |
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| | | | | |

**INPATIENT HEADCOUNT**

| | Logbook | Chart | Physical Count | Unaccounted Px | Out on Pass | Remarks |
|---|---|---|---|---|---|---|
| GSIS | | | | | | |
| SSS | | | | | | |
| Non-NHIP | | | | | | |
| Indigent | | | | | | |
| OWWA | | | | | | |
| TOTAL | | | | | | |

Monthly in-patient census for the month of _____

| Total admissions | Present year | Previous year |
|---|---|---|
| SSS | | |
| GSIS | | |
| OWWA | | |



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# PHILIPPINE HEALTH INSURANCE CORPORATION
## HOSPITAL INSPECTION FORM

Secondary Hospital
(Revised June 1998)

| | | |
|---|---|---|
| Indigent | | |
| Non- NHIP | | |
| TOTAL | | |

**PATIENT'S/ GUARDIAN'S INTERVIEW (at least 3 patients/parents)**

1. Name of patient/ guardian: _____ Age: _____ Sex: _____
   Category (SSS member, GSIS dependent, etc.): _____ Date and time of admission: _____
   Reason for hospitalization: _____
   Symptoms & duration: _____

| Medicines given/ Interventions done: (Specify name/ brand if known) | | Frequency | | Total Quantity consumed since start of confinement | | |
|---|---|---|---|---|---|---|
| Tablet | | | | | | |
| | | | | | | |
| | | | | | | |
| Capsule | | | | | | |
| | | | | | | |
| Injectable | | | | | | |
| | | | | | | |
| Sublingual | | | | | | |
| Ointment/ Cream | | | | | | |
| Suppository | | | | | | |
| Nebulization | | | | | | |
| Oxygen | | | | | | |
| Intravenous Fluids | | | | | | |
| | | | | | | |

| | YES | NO | REMARKS |
|---|---|---|---|
| Was blood extracted from patient? | ☐ | ☐ | _____ |
| If yes, specify site(s): | | | _____ |
| Were the foll. lboratory specimens taken? | | | |
| Urine | ☐ | ☐ | _____ |
| Stool | ☐ | ☐ | _____ |
| Was X-ray examination done ? | ☐ | ☐ | _____ |
| If yes, specify body part(s): | | | _____ |
| Were you told of the doctor's diagnosis? | ☐ | ☐ | _____ |
| Were meals served?(Except patients on NPO) | ☐ | ☐ | _____ |

How do you rate the food in terms of
quality: excellent _____ good _____ acceptable _____ needs improvement _____ poor _____
quantity: more than adequate _____ just adequate _____ inadequate_____

How do you rate the overall service of the hospital staff?
excellent _____ good _____ fair _____ needs improvement _____ poor _____

| | | | |
|---|---|---|---|
| Would you recommend this hospital to your relative and friends? | ☐ | ☐ | _____ |

_____ _____
(Signature of Patient/ Guardian over printed name) Date

2. Name of patient/ guardian: _____ Age: _____ Sex: _____
   Category (SSS member, GSIS dependent, etc.): _____ Date and time of admission: _____
   Reason for hospitalization: _____



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# PHILIPPINE HEALTH INSURANCE CORPORATION
## HOSPITAL INSPECTION FORM

Secondary Hospital
(Revised June 1998)

Symptoms & duration: _____

| Medicines given/ Interventions done: (Specify name/ brand if known) | Frequency | Total Quantity since start of confinement |
|---|---|---|
| Tablet | | |
| | | |
| | | |
| Capsule | | |
| | | |
| Injectable | | |
| | | |
| Sublingual | | |
| Ointment/ Cream | | |
| Suppository | | |
| Nebulization | | |
| Oxygen | | |
| Intravenous Fluids | | |
| | | |

| | YES | NO | REMARKS |
|---|---|---|---|
| Was blood extracted from patient? | ☐ | ☐ | _____ |
| If yes, specify site(s): | ☐ | ☐ | _____ |
| Were the ff. laboratory specimens taken? | ☐ | ☐ | _____ |
| Urine | ☐ | ☐ | _____ |
| Stool | ☐ | ☐ | _____ |
| Was X-ray examination done ? | ☐ | ☐ | _____ |
| If yes, specify body part(s): | ☐ | ☐ | _____ |
| Were you told of the doctor's diagnosis? | ☐ | ☐ | _____ |
| Were meals served?(Except patients on NPO) | ☐ | ☐ | _____ |

How do you rate the food in terms of
quality: excellent _____ good _____ acceptable _____ needs improvement _____ poor _____
quantity: more than adequate _____ just adequate _____ inadequate _____

How do you rate the overall service of the hospital staff?
excellent _____ good _____ fair _____ needs improvement _____ poor _____

Would you recommend this hospital to your relatives and friends? ☐ ☐ _____

_____ _____
Patient's/ Guardian's signature over printed name Date

3. Patient's/ Guardian's Name: _____ Age: _____ Sex: _____
Category (SSS member, GSIS dependent, etc.): _____ Date and time of admission: _____
Reason for hospitalization: _____
Symptoms & duration: _____

| Medicines given/ Interventions done: (Specify name/ brand if known) | Frequency | Total Quantity since start of confinement |
|---|---|---|
| Tablet | | |
| | | |
| | | |
| Capsule | | |
| | | |



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## PHILIPPINE HEALTH INSURANCE CORPORATION
## HOSPITAL INSPECTION FORM

Secondary Hospital
(Revised June 1998)

| | | |
|---|---|---|
| Injectable | | |
| | | |
| Sublingual | | |
| Ointment/ Cream | | |
| Suppository | | |
| Nebulization | | |
| Oxygen | | |
| Intravenous Fluids | | |
| | | |

| | YES | NO | REMARKS |
|---|---|---|---|
| Was blood extracted from patient? | ☐ | ☐ | _____ |
| If yes, specify site(s): | | | |
| Were the ff. laboratory specimens taken? | ☐ | ☐ | _____ |
| Urine | ☐ | ☐ | _____ |
| Stool | ☐ | ☐ | _____ |
| Was X-ray examination done ? | ☐ | ☐ | _____ |
| If yes, specify body part(s): | | | |
| Were you told of the doctor's diagnosis? | ☐ | ☐ | _____ |
| Were meals served?(Except for patients on NPO) | ☐ | ☐ | _____ |

How do you rate the food in terms of

quality: excellent _____ good ____ acceptable ____ needs improvement ____ poor ____

quantity: more than adequate _____ just adequate _____ inadequate_____

How do you rate the overall service of the hospital staff?

excellent _____ good _____ fair _____ needs improvement _____ poor _____

| | | | |
|---|---|---|---|
| Would you recommend this hospital to your relatives and friends? | ☐ | ☐ | _____ |

_____

Patient's/Guardian's signature over printed name Date

**INTERVIEW WITH MEDICAL DIRECTOR/ ADMINISTRATOR**

| | Yes | No | Remarks |
|---|---|---|---|
| 1. Was there an instance this year when the hospital had to suspend admission of NHIP beneficiaries? | ☐ | ☐ | |
| 2. When was that time? | _____ | | _____ |
| 3. What was the reason for such a move? | _____ | | _____ |
| 4. Can you provide us the names of NHIP beneficiaries who were refused admission? | Yes ☐ | No ☐ | |
| Name of Beneficiary | | | |
| 5. Was there an instance this year when the hospital had to require full orp artial payment of the hospital bill that could otherwise be covered by NHIP? | Yes ☐ | No ☐ | |
| 6. When was that time? | _____ | | _____ |



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7. What was the reason for such a move? _____

8. Can you provide us the names of NHIP beneficiaries who were charged full or partial hospital bill chargeable against NHIP? Yes ☐ No ☐

| Name | Address | Remarks |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Ask for:

1) Mandatory Monthly Hospital Report (MMHR)
2) Appointment papers of some hospital personnel

GENERAL OBSERVATIONS/ FINDINGS

Accessibility of hospital records: _____

Cooperation of hospital staff during inspection: _____

EVALUATOR: _____ Designation: _____ Date: _____
(Signature over printed name)

NOTED BY: _____ Designation: _____ Date: _____
(Medical Director's or Administrator's Signature over printed name)

# EXHIBIT 3

## Application for Accreditation – Healthcare Professionals

1 x 1
Photo

*Republic of the Philippines*
PHILIPPINE HEALTH INSURANCE CORPORATION
ACCREDITATION DEPARTMENT
City State Centre, 709 Shaw Blvd. Oranbo, Pasig City
Tel No. 637-6265 Trunk line 637-9999 loc 1216, 1217,1223
Telefax. 637-2527

PHIC FORM No. PAC 1

DATE RECEIVED:_____

# APPLICATION FORM FOR ACCREDITATION OF PROFESSIONALS

**Please be reminded that incompletely filled up application form will be returned without any action.**

Accreditation No. | PhilHealth Identification No

**1. PROFESSIONAL'S CLASSIFICATION**
- [ ] GENERAL PRACTITIONER
- [ ] DENTIST
- [ ] MEDICAL SPECIALIST:_____
- Subspecialty: _____

**2. STATUS OF APPLICATION**
- [ ] INITIAL
- [ ] RENEWAL
- [ ] UPGRADING
- [ ] REACCREDITATION

**3. NAME OF APPLICANT**
Last | Middle
First

**4. SEX**
- [ ] Male
- [ ] Female

**5. CIVIL STATUS**
- [ ] Single
- [ ] Widow
- [ ] Married
- [ ] Separated

**6. For Females Only**
Mother's Last Name when Single

**7. BIRTHDATE (mm/dd/yyyy)**

**8. TIN NUMBER**

**9. E-MAIL ADDRESS**

**10. FAX No.**

**11. RESIDENTIAL ADDRESS**
No. / St. / Brgy. | Municipality / City
Province | Zip Code | Telephone No

**12. MAILING / BILLING ADDRESS**
No. / St. / Brgy. | Municipality / City
Province | Zip Code | Telephone No

**13. PRESENT PLACE OF PRACTICE**
No. / St. / Brgy. | Municipality / City
Province | Zip Code | Telephone No

**14. COLLEGE / UNIVERSITY** | DEGREE | YEAR GRADUATED

**15. PRC No.** | Date Issued (mm/dd/yy) | Valid up to (mm/dd/yy)

**16. PMA / PDA No.** | Date Issued (mm/dd/yy) | Valid up to (mm/dd/yy)

**17. COMPONENT SOCIETY**
- [ ] REGULAR MEMBER
- [ ] LIFE MEMBER

**18. SPECIALTY SOCIETY**
- [ ] REGULAR MEMBER
- [ ] LIFE MEMBER

**19. HOSPITAL AFFILIATION**

| HOSPITAL NAME | ADDRESS | STATUS OF EMPLOYMENT FT / PT / ON CALL / VISITING (Please see footnote below) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

*THIS PORTION IS TO BE FILLED OUT BY PHILHEALTH*

- [ ] ID Released — Date: _____ By: _____
- [ ] ID Mailed — Date: _____ By: _____

**Full Time** (FT) : renders hospital service at least 40 hrs/wk
**On Call** MS attending to housecases or GP not regularly holding 24 hr. duty
**Part Time** (PT) renders hospital service at least 10hrs/wk
**Visiting** MS regularly holding private clinic and/or attending to private patients in the hospital, regardless of time duration

NOTA\NSF\ecv19\comp2 decnyc\mlh\amo\rev_prof_form\062101

# *MANAGE HEALTHCARE PROVIDER RELATIONS*

## EXISTING POLICIES

## ACCREDITATION AND QUALITY ASSURANCE

The Corporation shall implement a National Quality Assurance Program (NQAP) applicable to all health care providers for the delivery of health services nationwide. This program shall ensure that the health services rendered to the members by accredited health care providers are of the quality necessary to achieve the desired health outcomes and member satisfaction.

To achieve the above objective, the Corporation shall undertake the following activities:

- Verify, through the accreditation process, the qualification and capabilities of health care providers for the purpose of conferring upon them the privilege of participating in the NHIP and assuring that the health care services they render meet the desired and expected quality.
- Monitor on a periodic basis, the services rendered to members by health care providers through a process of utilization review and patient satisfaction review or index;
- Monitor and review, through outcomes assessment, the outcomes resulting from health care service rendered by health care providers both from the standpoint of effects on health and member satisfaction;
- Initiate and impose changes and corrective action based on the results of performance monitoring and outcomes assessment to ensure quality health service by using mechanisms for feedback and change; and,
- Formulate and review program policies on health insurance based on data culled from conduct of the above, to ensure quality health services.

### A. ACCREDITATION

### 1. HEALTH CARE PROVIDERS:

1.1 The following health providers shall be accredited before they can participate in the NHIP:

1.1.1 Institutional Health Care Providers

- Hospitals
- Out-Patient Clinics
- Health Maintenance Organization (HMOs)
- Preferred Provider Organizations (PPOs)
- Community-Based Health Organizations (CBHOs)

1.1.2 Independent Health Care Professionals

- Physicians
- Dentists
- Nurses
- Midwives
- Pharmacists
- Other duly licensed health care professionals

1.2 Health care professionals under the employment of accredited institutional health care providers must be accredited individually when receiving from the NHIP separate remuneration for rendering health services, whether or not such services are rendered independent of their institutions.

## 2. GENERAL ACCREDITATION REQUIREMENTS AND CONDITIONS:

2.1 The following requirements shall apply to all health care providers in appropriate cases:

2.1.1 Health care institutions must have been operating for at least (3) years prior to initial applications for accreditation as defined in the succeeding section, with a good track record in the provision of health care services within the same period.

2.1.2 Health care institutions must have the human resources, equipment, physical structure and other requirements in conformity with the standards of the relevant facility, as determined by the DOH and the Corporation.

2.1.3 Health care professionals must submit a certificate of Good Standing from their respective specialty societies and from the recognized national association of physicians for general practitioners.

2.1.4 Health care providers must accept the formal program of quality assurance and utilization review of the NHIP and the payment mechanisms promulgated thereby. They must have their own formal ongoing quality assurance program.

2.1.5 They must adopt all referral protocols, practice guidelines and health resource sharing arrangements of the NHIP.

2.1.6 They must recognize and respect the rights of patients.

2.1.7 They must comply with all information system requirements and regular transfer of information requirements including but not limited to reporting mechanisms established by the Corporation and maintenance of accurate records of all patients, services rendered and health outcomes resulting from such services, and health expenditures on patient care and continuous patient education.

2.1.8 They must accept any and all corrective actions to be prescribed by the Corporation to ensure quality of services.

2.1.9 They must allow the Corporation to inspect their medical and financial records and to visit, enter and inspect their respective premises and facilities, consistent with Section (m) of RA 7875.

2.1.10 They must give NHIP indigent members preferential access to their social welfare funds, which may be used to augment the benefit package provided, in case of insufficiency to fully cover all confinement charges.

2.1.11 The health care professionals must be members of the NHIP. All professionals applying for initial/renewal of accreditation are required to be a member of PhilHealth. The professional shall present proof of active participation to the National Health Insurance Program not only as a health care provider but also as a PHIC member by presenting the proof of payments (such as validated ME-5/RF-1) together with the application for accreditation. (**PhilHealth Circular No. 22,s.2001**)

2.1.12 Health care providers must comply at all times with all the requirements and provisions of RA 7875, this Rules and other administrative issuances of the Corporation.

## 3. THREE (3) YEAR OPERATION REQUIREMENT:

3.1 The date of reckoning of the three (3) year operation requirement shall be the effectivity date of the initial business permit issued by the office of the local chief executive in the case of private hospitals, or such date as certified by the local chief executive or the Department of National Defense (DND), in case of government and military hospitals respectively.

Other documents that shall be required by the Corporation to show proof that the facility has been in operation for at least a minimum period of three (3) years shall include all of the following:

3.1.1 Patients' records

3.1.2 Sworn testimonies from the parish priest, other religious leaders or community leaders.

3.1.3 Tax Returns of the facility for the past three (3) years

3.1.4 Identification of precursor health facility.

Prior to the approval of the hospital's initial accreditation, the precursor health facility shall be certified closed by the owner. **(PhilHealth Circular No. 22s, 2002)**

3.2 Hospitals that have temporarily stopped operation due to upgrading, expansion, and change of ownership or any other causes shall have their length of operation computed on a cumulative basis from the date of the initial operation of the former hospital.

3.3 Transfer of location for the purpose of upgrading, expansion, or any other reason acceptable to the Corporation, whether within or outside the same municipality, city or province, shall be subject to the provisions of Section 73 c of this Rules and shall comply with the DOH guidelines on licensing.

3.4 Hospital extensions or branches in another location shall be required to apply for a separate accreditation.

3.5 Industrial hospitals or clinics that cater exclusively to employees and their dependents within the Special Economic Zones shall be eligible for accreditation. Provided, That the Special Economic Zones are allowed to operate such hospital or clinic by the special law or charter governing or creating them.

## 4. SPECIFIC ACCREDITATION REQUIREMENTS AND CONDITIONS

### 4.1 FOR HOSPITALS

In addition to the general requirements and conditions prescribed in this Rules, hospitals shall comply with the following specific requirements and conditions for accreditation:

4.1.1 It must be licensed by the DOH.

4.1.2 It must comply at all times with the provisions of Republic Act 4226 otherwise known as the Hospital Licensure Act and its prevailing Implementing Rules and Regulations as well as other applicable administrative issuances.

4.1.3 It must be a member in good standing of any national association of licensed hospitals in the Philippines duly recognized by the Corporation in accordance with its established standards and criteria.

4.1.4 All secondary hospitals must establish Therapeutics and Infection Control Committee and other committees that will assure rational drug use.

4.1.5 All tertiary hospitals must establish Therapeutics and Infection Control Committee and other committees that will assure rational drug use.

4.1.6 It must have an ongoing quality assurance program in conformity with the provision of this Rules.

4.2 FOR PHYSICIANS

In addition to the general requirements and conditions in this Rules, physicians shall comply with the following specific requirements and conditions:

4.2.1 The physicians must be duly licensed to practice medicine in the Philippines by the Professional Regulation Commission (PRC)

4.2.2 They must be a member in good standing of any national association of licensed physicians in the Philippines duly recognized by the Corporation in accordance with its established standards and criteria.

4.2.3 They must abide by the Code of Ethics as prescribed under Section 24, Paragraph 12 of the Medical Act of 1959, as amended.

4.2.4 They must agree to follow all practice guidelines or protocols, peer review and payment mechanisms of the NHIP.

4.2.5 They must agree not to charge over and above the professional fees provided by the NHIP for members admitted to a ward type of accommodation.

4.3 FOR OTHER HEALTH CARE PROFESSIONALS (DENTISTS, NURSES, MIDWIVES, PHARMACISTS AND OTHER LICENSED HEALTH CARE PROFESSIONALS)

In addition to the general requirements and conditions in this Rules, dentists, nurses, midwives, pharmacists and other licensed health care professionals shall with the following specific requirements and conditions.

4.3.1 They must be licensed to practice their profession by the PRC.

4.3.2 They must be a member in good standing of any national association of licensed practitioners of their profession in the Philippines duly recognized by the Corporation in accordance with its established standards and criteria.

4.3.3 They must not charge members over and above the professional fees provided by the NHIP for members admitted to a ward type of accommodation.

4.3.4 They must follow all practice guidelines or protocols, peer review and payment mechanisms of the NHIP.

4.4 FOR HMOs AND PPOs

In addition to the general requirements and conditions prescribed in this Rules, HMOs and PPOs shall comply with the following specific requirements and conditions for accreditation as a direct provider of health care services to individual members or to an affiliate of accredited health care institutions:

4.4.1 It must have a Clearance to Operate from the DOH in accordance with the provisions of Executive Order 119 and pertinent DOH issuances.

4.4.2 It must be duly registered with the SEC.

4.4.3 Its laboratory, x-ray and diagnostic facilities, if any, must comply with all the rules, regulations and licensing requirements of the DOH.

4.4.4 A corporate HMO must be a member in good standing of any national association of HMOs in the Philippines cleared to operate in the Philippines in accordance with Section (a) thereof, duly recognized by the Corporation in accordance with its established standards and criteria. A cooperative HMO must be a member of good standing of any regional or national federation of cooperatives and must be duly recognized by the Corporation in accordance with its established standards and criteria.

4.4.5 It must have an ongoing quality assurance program in conformity with the provisions of this Rules.

4.5 FOR CBHOs

In addition to the general requirements and conditions prescribed in this Rules, CBHOs shall comply with the following specific requirements and conditions for accreditation as a direct provider of health care services to beneficiaries:

4.5.1 It must be organized, owned and/or managed by an association of members of the community for the purpose of improving the health status of the community through preventive, promotive and curative health services.

4.5.2 It must be duly registered with the SEC and/ or with the Cooperative Development authority.

4.5.3 Its laboratory, x-ray and diagnostic facilities, if any, must comply with all the rules, regulations and licensing requirements of the DOH.

4.5.4 It must have an ongoing quality assurance program in conformity with the provisions of this Rules.

4.6 FOR RURAL HEALTH UNITS ( RHUs)

The Out-Patient Consultation and Diagnostic Benefit Package are intended to ensure delivery of preventive health services at the local level. Rural Health Units (RHUs) and/or Health Centers (HCs) owned and managed by the Local Government Units are accredited to deliver the package.

The **Standards for Accreditation** are the following :

4.6.1 Service Capability

The RHU should be able to provide medical consultation to a wide range of common diseases for pediatric, internal medicine, general surgery and obstetric cases.

The RHU should be able to provide the following diagnostic services:

- Complete Blood Count
- Routine Urinalysis
- Routine Fecalysis
- Sputum Microscopy
- Chest X-ray

The RHU should identify a PhilHealth accredited center with x-ray services nearest to them.

4.6.2 Technical Standards

- General Infrastructure
  - A large and clear bearing the name of the RHU with an additional sign indicating as "PhilHealth Medicare Para Sa Masa" / "Greater Medicare Access" provider
  - Generally clean environment
  - Sufficient seating for patients in a well ventilated area
  - Adequate lighting
  - Adequate water supply
  - Covered garbage containers with color-coded segregation
  - Examination room with privacy
  - Examination table with clean linen
  - Cleaning solution for the clinical instruments
- Equipment Supplies
  - Binocular microscope
  - Reagents
  - Centrifuge

- Glass slides and cover slips
- Test tubes
- Test strip for qualitative analysis for urine
- Applicator stick
- Heparinized test tube
- Capilette
- Blood lancet
- Counting chamber
- WBC diluting fluid
- Sucking tube
- Decontamination solutions
- Thermometer
- Stethoscopes
- Sphygmomanometer with adult and pediatric cuff
- Tape measure
- Weighing scale-adult and infant (Beam and Ming scale)
- Disposable gloves
- Speculums –large and small
- Lubrication jelly
- Disposable needles and syringes
- Sharps containers
- Sterile cotton and swabs
- Covered pan and stove
- Office supplies
- Recording and reporting forms

- Clinic Staff

- Physician
- Nurse
- Midwife
- Medical Technologist

4.6.3 Qualification Standards

- The Physician should be a licensed medical practitioner and should be able to handle consultations on general medical problems of members of PhilHealth.
- The Nurse should be licensed and has one (1) year clinical experience in delivering competent clinical care. He/She should also be skilled in recording keeping, writing reports, supervising the midwives and in managing the supplies of the RHU.
- The Midwife should be registered and licensed to deliver competent clinical care. He/She should also be proficient in record keeping and in operating the RHU's receiving area.
- The Medical Technologist should be registered and licensed to perform routine laboratory procedures and has undergone training in sputum microscopy. In case he/she is not trained in sputum microscopy, the midwife or any RHU staff should have undergone the required training.
- Accreditation of the health personnel is not required but they should be members of the National health Insurance program.

4.6.4 Quality Assurance Activities

The RHU should have quality assurance activities to ensure quality care given to the members of PhilHealth. These activities include training, updates and feedback from members of PhilHealth.

- **Accreditation Process**
  - The RHU to be accredited should submit an application form to the Regional Health Insurance Office
  - The Accreditation Division of the Regional Health Insurance Office will conduct inspection of the RHU.
  - The accreditation fee of P500 will be paid annually. Mode of payment can either be through the Postal Money Order payable only to the Philippine Health Insurance Corporation or cash paid directly to the cashier. Accreditation fee is non-refundable.

- The validity period of accreditation is good for one year.
- The accreditation is renewable on the anniversary date.
- The application forms and inspection report shall be immediately forwarded to the Accreditation Department, Central Office for deliberation and approval by the Accreditation Committee.
- Once approved certificate will be given to the RHU

4.6.5 Others

- LGUs with more than one RHUs or HC that could not comply with the requirement of one licensed medical technologist and one functional microscope per RHU/HC may be accredited provided that the RHU/HC has a REFERRAL SYSTEM with a laboratory facility owned and managed by the LGU. The following requirements must, however, be complied with.
- The laboratory should be licensed by the Department of Health (DOH) and the license should be updated and posted in a conspicuous area of the laboratory. This shall apply only to a Central Laboratory.
- The distance between the laboratory and the RHUs/ HCs should not exceed thirty (30) minutes in travel time.
- The laboratory may be an attached facility of a hospital or RHU/HC or it may be an independent entity owned and managed by the LGU.
- In an LGU with an available X-ray facility, their patients may be referred for chest x-ray service to said facility provided that it is licensed by the Department of Health (DOH),
- Sentrong Sigla certification shall not be required for the initial accreditation of RHUs/HCs. This shall, however, be a requirement for the renewal of accreditation.
- RHUs/HCs applying for accreditation under the referral system shall be relieved of the following requirements.
  - On service capability, the ability to provide complete blood count, fecalysis, routine urinalysis, sputum microscopy and chest x-ray
  - On the technical standards of possession of a binocular microscope, reagents, centrifuge, counting chamber, test strip for qualitative analysis of urine, WBC diluting fluid, WBC and RBC diluting pipette and sucking tube

6.9 Motions for reconsideration of health care providers for Rizal province and NCR shall be filed at the PhilHealth Central Office through the Accreditation Department. On the other hand, motions of providers for the other regions shall be filed at the PhilHealth Regional Office where the application is filed. Only one (1) motion for reconsideration will be entertained. Petitions and requests, in any form, filed by the provider relative to the same application that is denied shall be treated as a motion for reconsideration. **(PhilHealth Circular No. 32 s, 2002)**

6.10 In case the motion for reconsideration is denied, an appeal may be filed to the Board within fifteen (15) calendar days from receipt by the provider of the notice of denial. Unless otherwise provided by the Board on appeal of the provider, the decision of the President on the motion for reconsideration shall be immediately executory

6.11 The PhilHealth Regional Offices are directed not to conduct re-inspection of hospitals which has pending motion for reconsideration. The documentary requirements of application of the hospital shall be directly forwarded to the Central Office, Accreditation Department for proper evaluation and consideration by the Accreditation Committee.

6.12 Revocation of an accreditation is permanent. It shall operate to disqualify the health care providers from obtaining another accreditation in their own name, under a different name, or through another person, whether natural or juridical. If the facilities of the revoked institutional health care provider are sold, such will be treated as an application for initial accreditation.

6.13 Accreditation shall operate prospectively. Claims for services rendered before the effectivity of accreditation shall be denied.

6.14 For renewal of accreditation, applications shall be filed within the thirty (30) calendar days before the ninety (90) calendar days prior to the expiration of the existing accreditation. In case of incomplete submission of the requirements, the application shall be returned for completion by the health care provider who should refile the same within thirty (30) calendar days from receipt thereof.

6.15 A violation of this provision would mean that the hospital's filing of application for renewal of accreditation is considered late. In view of this, late filers should be notified by their respective Regional Health Insurance Offices with a letter informing them possible lapses in accreditation as a consequence of being late filer and to stop admitting NHIP patients and NHIP beneficiaries once the validity period of the previous accreditation has ended so as not to cause any confusion in the filing and reimbursement of claims.

6.16 Even after accreditation has been granted, the Corporation may decide to downgrade the category of an institutional health care provider or suspend the accreditation due to adverse findings and reports.

6.17 Accreditation of health care providers with deficiencies shall not be renewed until a detailed inspection has been conducted and the health care provider is found to have corrected all its deficiencies.

## 7. GENERAL PROVISION FOR ACCREDITATION OF HEALTHCARE PROFESSIONALS

7.1 The Corporation shall determine the period of accreditation and reserves the right to issue or deny accreditation after an evaluation of the capability and integrity of the health care professional.

7.2 The Corporation shall determine the documents to be submitted to comply with the requirements and conditions for accreditation. Such documents shall be subject to verification and authentication at the discretion of the Corporation.

7.3 The documentary requirements for the accreditation of a professional as medical specialist, only Diplomate/ Fellow certificate issued by the Philippine Specialty Board is considered or accepted by PhilHealth. Certifications such as passing the oral and written examinations, residency training, certificates issued abroad, Certificate as Associate Fellow, Charter Fellow, Active Member, Certified Specialist, Junior Fellow, DOH specialist certificates and Diplomate/Fellow certificates issued by the Philippine Academy of Medical Specialist are not considered by this Corporation. Physicians applying for initial or upgrading of accreditation as a medical specialist but could not produce the required certificate will be accredited as a general practitioner. Upgrading of the accreditation status may be done anytime upon submission of the Philippine Specialty Board certificate as Diplomate or Fellow of a particular medical society.

7.4 Application reaccreditation of HealthCare Professionals with an accumulated gap of at least one (1) year shall be treated as an initial application. All requirements have to be submitted again, including the Diplomate or Fellow certificate issued by the Philippine Specialty Board for those applying as medical specialist. Professionals who were approved as medical specialist by virtue of DOH Specialist certificate or Diplomate/ Fellow certificate issued by the Philippine Academy of medical Specialist (PAMS) prior to the effectively of PhilHealth Circular 28 2001 but have accumulated a gap in their accreditation of one year or more shall be required to submit a Diplomate/Fellow certificate issued by the Philippine specialty Board. Failure to submit the said Diplomate/Fellow certificate will result to downgrading of their accreditation to general practitioner as provided in PhilHealth Circular No. 1s. 2002. **(PhilHealth Circular No. 19, 2002)**

7.5 The Corporation shall impose an accreditation fee and such other fees at rates prescribed by the President and CEO.

7.6 The Corporation may limit accreditation to health care professionals performing specific health care services, as applicable, depending on training, experience, capabilities and specialty certification.

7.7 Until the accreditation function is decentralized to the LHIOs, all actions on applications for accreditation, as recommended by the Accreditation Committee, shall be approved by the President and CEO.

7.8 A revocation of accreditation is permanent.

7.9 Accreditation shall operate prospectively. Claims for services rendered before the effectively of accreditation shall be denied except in emergency cases.

7.10 For renewal of accreditation, applications shall be filed within the thirty (30) calendar days before the ninety (90) calendar days prior to the expiration of the existing accreditation. In case of incomplete submission of the requirements, the application shall be returned for completion by the health care professional who should refile the same within thirty (30) calendar days from receipt thereof.

7.11 A Professional applying for accreditation is required to submit either a personal TIN card, W2 or Certification issued by the BIR reflecting the TIN, as a documentary requirement for accreditation. Remuneration for services rendered by an accredited professional to NHIP members is automatically deducted 10% tax which is remitted to the Bureau of Internal Revenue (BIR) by PhilHealth. Certifications stating that the TIN card is still in process but does not indicate the TIN will not be accepted by PhilHealth. Failure to comply will result to non-payment of claims. **(PhilHealth Circular No. 29, 2002 )**

7.12 To facilitate the processing and payment of claims filed by accredited health care professionals, only one name should be used consistently both for accreditation and claims purposes. In case there is a need to update any information on record in the accredited professional's data, such as surname, address, TIN, etc., a formal written notice, together with all the pertinent supporting documents, should be forwarded to PhilHealth Accreditation Department within fifteen (15) days from date of change. Failure to do so may result to non-payment of claims. (PhilHealth Circular No. 30, 2002)

7.13 To effect prompt payment of the professional fees of accredited doctors in the National Capital Region, payment of professional fees shall be made through automatic credit to an ATM account which was opened at the Land Bank of the Philippines (LBP) at the nearest residential address or in accordance with the hospital practice lifted from the application for accreditation on file with this Corporation.

## 8. PROCESS OF ACCREDITATION OF INSTITUTIONAL HEALTH CARE PROVIDERS

8.1 The institutional health care provider shall apply for accreditation by submitting the duly accomplished forms and documents required and upon payment of the required fees.

8.2 An inspection shall be conducted within sixty (60) calendar days upon receipt of the completed application.

8.3 A decision shall be made within a reasonable period of time from receipt of the application.

8.4 An Accreditation Card shall be issued to the health care professional upon approval of the application.

## 9. SPECIFIC PROVISIONS FOR INITIAL ACCREDITATION

9.1 Accreditation shall be given to qualified health care providers who are applying for the first time, or those treated as if applying for the first time under certain circumstances for institutional health care providers as provided for this Rules.

9.2 The accreditation shall take effect upon approval of the application.

## 10. SPECIFIC PROVISIONS FOR RENEWAL OF ACCREDITATION

10.1 Accreditation shall be renewed after compliance with the requirements and conditions set forth in this Rules.

10.2 A health care provider under suspension cannot apply for renewal of accreditation until such suspension has been lifted and all requirements, conditions, and corrective actions set by the Corporation have been complied with.

10.3 Health care providers may file their application for renewal within the specified period to avoid breaks or gaps in their accreditation. All claims for services rendered to member/s between the expiration period and the effectivity of accreditation shall be denied accordingly. **(PhilHealth Circular No. 32s., 2001)**

## 11 PROCEDURES ON FILING INITIAL AND RENEWAL OF ACCREDITATION OF HOSPITAL AND AMBULATORY SURGICAL CLINICS (ASCs)

11.1 Secure application forms from PhilHealth Central Office or from any of the PhilHealth Offices (PROs). Application forms may be reproduced as needed.

11.2 Accomplish the forms legibly and completely and be duly signed by the Medical Director or Chief of Hospital. **(PhilHealth Circular No. 32s. 2001)**

11.3 Submit the notarized Warranties of Accreditation, the accomplished application form and other required documents to PhilHealth Central Office (PCO) or at the respective PhilHealth Regional Offices (PROs) where the hospital is located. Incomplete application requirements shall not be processed and shall be returned to the applicant hospital.

11.4 Submit all requirements as provided for in the attached Checklist of Requirements for Accreditation

11.4.1 Accreditation Fees:

- Primary Hospitals - P1,000.00
- Secondary Hospitals - P2,000.00
- Tertiary Hospitals - P3,000.00

11.5 Accreditation fees must be paid in cash or Postal Money Order (PMO) to the respective PhilHealth Regional Offices. PMOs should be filled up as follows, and

the receipt of which should be attached to the application forms submitted to PhilHealth.

Pay to : Philippine Health Insurance Corporation
From : Name of Hospital
Signature of issuing officer must be present,
Month, date and year of issue must be clearly stamped
Back of PMO check must be left blank

11.6 After verification and inspection of the hospital in the region, the corresponding PRO shall forward all pertinent papers, together with their recommendation, to the PhilHealth Central Office for evaluation, deliberation, and approval of the Accreditation Committee.

11.7 Application for the renewal of accreditation of hospitals in the National Capital Region (NCR) and Rizal should be filed directly to the Accreditation Section at the PhilHealth Members Assistance Center (PMAC), ground floor, PhilHealth Central Office, Pasig City.

## 12. SPECIFIC PROVISIONS FOR RE-ACCREDITATION

12.1 A health care provider whose previous accreditation had lapsed or whose subsequent application was denied may apply for re-accreditation.

12.2 An institutional health care provider in good standing, but whose ownership has changed, must apply for re-accreditation within ninety (90) calendar days from actual change of ownership, subject to the provisions of this Rules.

12.3 An institutional health care provider in good standing, which has transferred location, must apply for re-accreditation within (90) calendar days of the transfer, subject to the provisions of this Rules. Beyond this period, the accreditation shall automatically lapse and all claims filed with the corporation shall not be paid.

12.4 Where the accreditation lapsed due to the voluntary act of a health care provider to evade the consequences of a previous violation or adverse findings indicating fraud, as determined by the Corporation, the application for re-accreditation shall be denied.

12.5 Re-accreditation shall also be given to a health care provider who:

- Acquires new skills
- Qualifies as a specialist
- Upgrades or downgrades its facilities in the case of institutional health care providers

## 13. SPECIFIC PROVISION FOR RENISTATEMENT OF ACCREDITATION

13.1 Accreditation that has been suspended may be reinstated after all requirements and conditions set by the Corporation have been complied with

17.1.2 It must be national in scope and must have a significant number of members throughout the country.

17.1.3 It must possess a juridical personality.

17.1.4 It must undertake a continuing professional education program or its equivalent and require from its members minimum number of units or hours of attendance to the program for a particular period.

17.1.5 It must cooperate with the Corporation in the implementation of quality assurance programs and in the investigation, discipline, and imposition of penalties to erring accredited members of the association.

18. COOPERATION BETWEEN THE CORPORATION AND THE RECOGNIZED NATIONAL ASSOCIATIONS

18.1 The Corporation shall coordinate closely with the recognized national associations to encourage and ensure cooperation from the provider-members as well as to promote compliance with the requirements and conditions for participation in the NHIP.

19. PENALTIES FOR VIOLATIONS – Gross violation of this requisite shall constitute ground for suspension and/or revocation of accreditation.

20. REPORTING & MONITORING SYSTEM

20.1 The monitoring system shall include, among others, the following activities:

20.1.1 Periodic inspection of facilities and offices

20.1.2 Gathering of utilization data from services rendered by all health care providers who shall be required to submit mandatory reports thereon

20.1.3 Periodic review of these data for purposes of determining quality and cost effectiveness as well as adherence to practice guidelines by health care providers; and,

20.1.4 Submission of Mandatory Reports and other reportorial requirements, as determined by the Corporation.

20.2 Mandatory Monthly Hospital Report (MMHR) is one of the measures used by PhilHealth to monitor the performance of accredited health care providers. Results of analysis of the MMHRs serve as guide for future accreditation and other policy decisions.

20.3 All categories of hospitals in the National Capital Region, whether private or government, shall submit the MMHR to PhilHelth Accreditation Department at the Central Office not later than 10th day of the ensuing month. Hospital should retain a copy.

20.4 Hospitals in the provinces shall submit their MMHR to the Regional Health Insurance Offices not later than the 10th day of the ensuing month. The RHIOs

shall then forward the reports to the Accreditation Department on or before the 15th day of the ensuing month. Hospital and the RHIOs should retain a copy of said reports.

20.5 The modified format of the MMHR shall be followed.

20.6 Failure to submit any or all of the reports shall be ground for administrative disciplinary action including but not limited to suspension of payment of claims, suspension, denial or revocation of accreditation.

20.7 To expedite the authentication of admission of logbooks of accredited hospitals located in distant areas, authority is hereby given to Accreditation and Quality assurance Officers to authenticate said logbook by signing for the Regional Manager during the conduct of pre-accreditation and re-inspection. No other admission logbook should be authenticated until and unless the first one is consumed or closed. Regional Health Office should maintain a control of hospital logbook authenticated. **(PhilHealth Circular No. 24,s. 2001 dated July 24, 2001)**

20.8 The Admission logbook should have the required 12 column heading of which are items (1) to (10) below and should be properly and completely accomplished as follows:

20.8.1 Case number

20.8.2 Date and time of admission

20.8.3 Complete name of patient

20.8.4 Age

20.8.5 Sex

20.8.6 Complete residential/office address

20.8.7 Membership

- NHIP Beneficiaries:
  - Employed:
    - GM – Government – member
    - GD – Government – dependent
    - PM – Private- member
    - PD – Private – dependent
  - Individually- paying:
    - SM – Self-employed-member
    - SD – Self-employed –dependent
    - OFM – OFW- dependent

- OWM – OWWA –dependent
- OT – others

- Indigent:
  - IM – Indigent –member
  - ID – Indigent –dependent
- Pensioner/ Retiree:
  - P/RM – Pensioner/Retiree-member
  - P/RD – Pensioner/Retiree-dependent

- Non-NHIP:
  - NN- Non-NHIP

20.8.8 Admitting diagnosis

20.8.9 Final diagnosis

20.8.10 Attending physician

## B. QUALITY ASSURANCE

### 1. PERFORMANCE MONITORING OF HEALTH CARE PROVIDERS

1.1 The Corporation shall develop and implement a performance monitoring system of all health care providers, which shall provide safeguards against:

1.1.1 Over-and under-utilization of services;

1.1.2 Unnecessary diagnostic and therapeutic procedures and interventions;

1.1.3 Irrational drug use;

1.1.4 Inappropriate referral practices;

1.1.5 Gross, unjustified deviations from currently accepted practice guidelines or treatment protocols;

1.1.6 Use of fake, adulterated or misbranded pharmaceuticals or unregistered drugs; and,

1.1.7 Use of drugs other than those recognized in the PNDF and those for which exemptions were granted by the Board.

1.2 The practices enumerated above are grounds for suspension, revocation, denial of accreditation and/or filing of a criminal complaint with the proper courts if so warranted, without prejudice to the reduction or denial of claims as provided in this Rules.

## 2. SYSTEM OF OUTCOMES ASSESSMENT

2.1 The Corporation shall implement a system of assessing outcomes of service rendered by health care providers to include the following:

2.1.1 Review of mortality and morbidity rates, post-surgical infection rates and other health outcomes indicators;

2.1.2 Undertaking of outcomes research projects; and

2.1.3 Client satisfaction surveys.

2.2 A periodic report of outcome assessment shall be submitted to the President and to the Board.

## 3. MECHANISM FOR FEEDBACK

3.1 A mechanism aimed at improving quality of service shall be established by the Corporation to periodically inform health care providers, program administrators and the public of the performance of accredited health care providers. The Corporation shall make known to the general public the list of health care providers of good standing as well as those suspended by the Corporation.

3.2 In pursuit of informed choice as enunciated in the Act, feedback reports may include information on the average support value of the benefit package based on actual charges billed by the accredited health care provider.

## 4. ASSESSMENT OF MEDICAL TECHNOLOGY

4.1 The Corporation shall assess the advantage and appropriateness of medical technologies, equipment, devices, and modalities of treatment consistent with actual needs and current standards of medical practice and ethics and with national health objectives.

4.2 As the need arises, the Corporation shall likewise assess the advantage and appropriateness of acquiring and using new, scarce and expensive medical technologies, equipment, devices and modalities of treatment consistent with actual needs and current standards of medical practice and ethics and with national health objectives, including modern dental technology employing highly technical equipment. In this regard, the Corporation may require specific types of health care providers to upgrade their facilities, equipment and manpower complement as a prerequisite to accreditation.

## 5. POLICY FORMULATION AND REVIEW

5.1 POLICY FORMULATION – In formulating and designing policies to pursue the principles and objectives of the NHIP, the Corporation shall utilize and incorporate data, results, reports and other information derived from the conduct of the preceding formal set of activities to assure quality health care.

5.2 POLICY REVIEW - The Corporation shall continuously evaluate and validate the relevance, efficacy and acceptability of existing NHIP policies in the light of the outcomes and results derived from the conduct of the NQAP.

5.3 REMEDIAL MEASURES - As the need arises and based on data obtained from performance monitoring, remedial measures and changes on treatment protocols or the clinical practice guidelines shall be imposed by the Corporation on particular health care providers found to be deficient in the delivery of cost-efficient and quality services with satisfactory outcomes and results.

## 6. QUALITY ASSURANCE OF HEALTH CARE PROVIDERS

6.1 REQUISITE FOR ACCREDITATION

The existence of a formal ongoing assurance program shall be a requisite for accreditation of health care providers.

6.2 OBJECTIVES -The objectives of the program shall be to:

6.2.1 Ensure that health care professionals of the accredited health care institution possess the proper training and credentials to render quality health care services to beneficiaries of the NHIP;

6.2.2 Work towards the promotion of uniform health care standards throughout the country;

6.2.3 Ensure appropriateness of medical procedures and administration of drugs and medicines consistent with the generally accepted standards of medical practice and ethics.

6.3 ACTIVITIES – The program shall include, among others, the following activities;

6.3.1 The proper review of credentials of individuals health care professionals working in the health care institution;

6.3.2 The provision of referral and practice guidelines for the health care providers;

6.3.3 A utilization review and monitoring scheme for the performance of health care providers;

6.3.4 A measurement of health outcomes and patient satisfaction including mortality, morbidity, infection rates and other related activities;

6.3.5 A data gathering and retrieval system from the health records to support performance monitoring and outcomes measurement activities;

6.3.6 A system of feedback to the health care professionals and mechanism for change in practice patterns as needed;

6.3.7 The appointment of a specific person responsible for quality assurance in the institutions;

6.3.8 The implementation of remedial measures to correct defects identified in the health system;

6.3.9 A documentation of regular meetings for members of quality circles or QAP Committee, and,

6.3.10 The documentation of processes evaluated and improved and new processes installed.

7. **MONITORING AND VERIFICATION** – The Corporation shall periodically monitor and verify compliance to this requisite during inspection of the health care provider and may require submission of periodic reports as a means of monitoring compliance.

# DELIVER AND MANAGE BENEFITS

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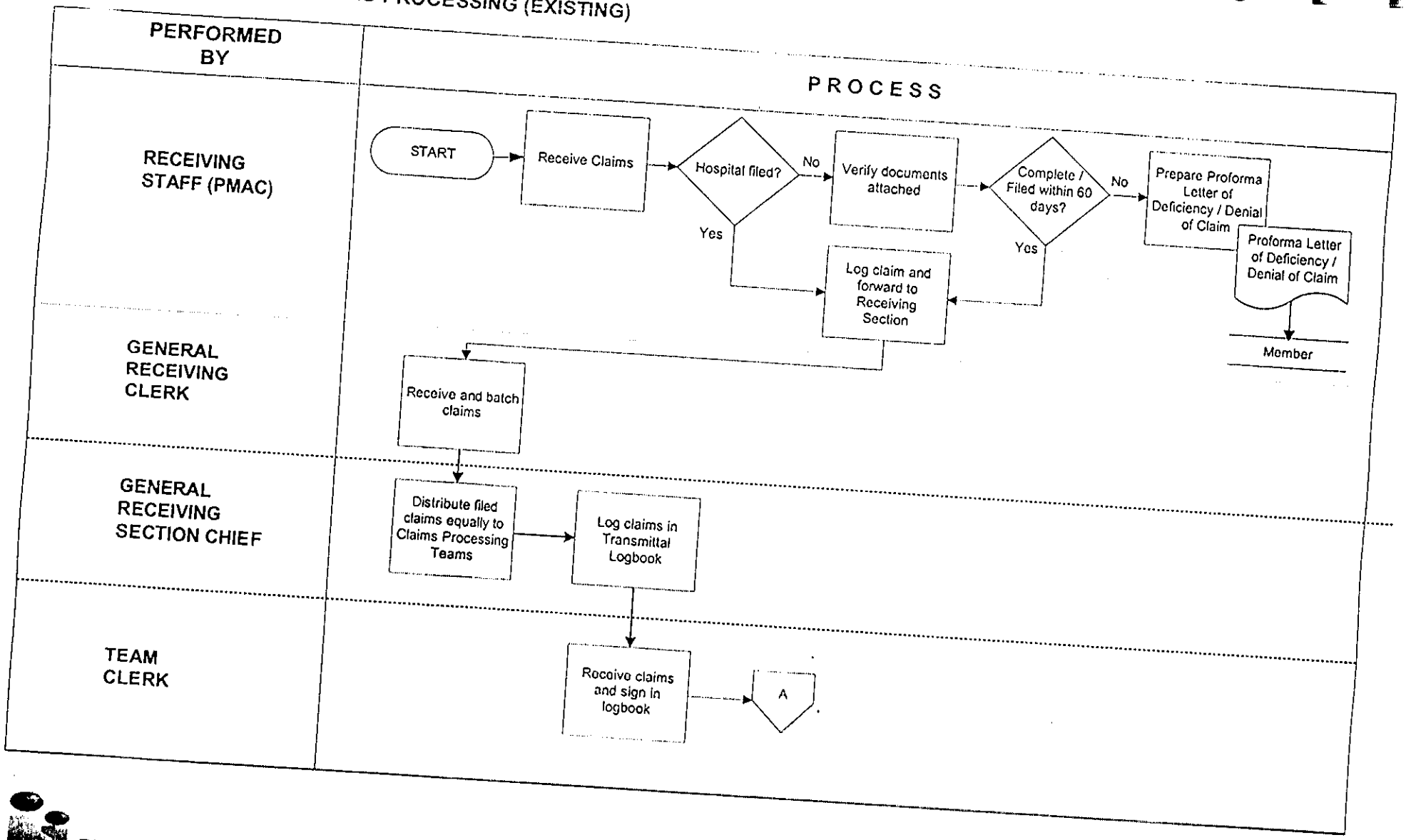
SUBPROCESS NAME : CLAIMS PROCESSING (EXISTING)




PHILIPPINE HEALTH INSURANCE CORPORATION

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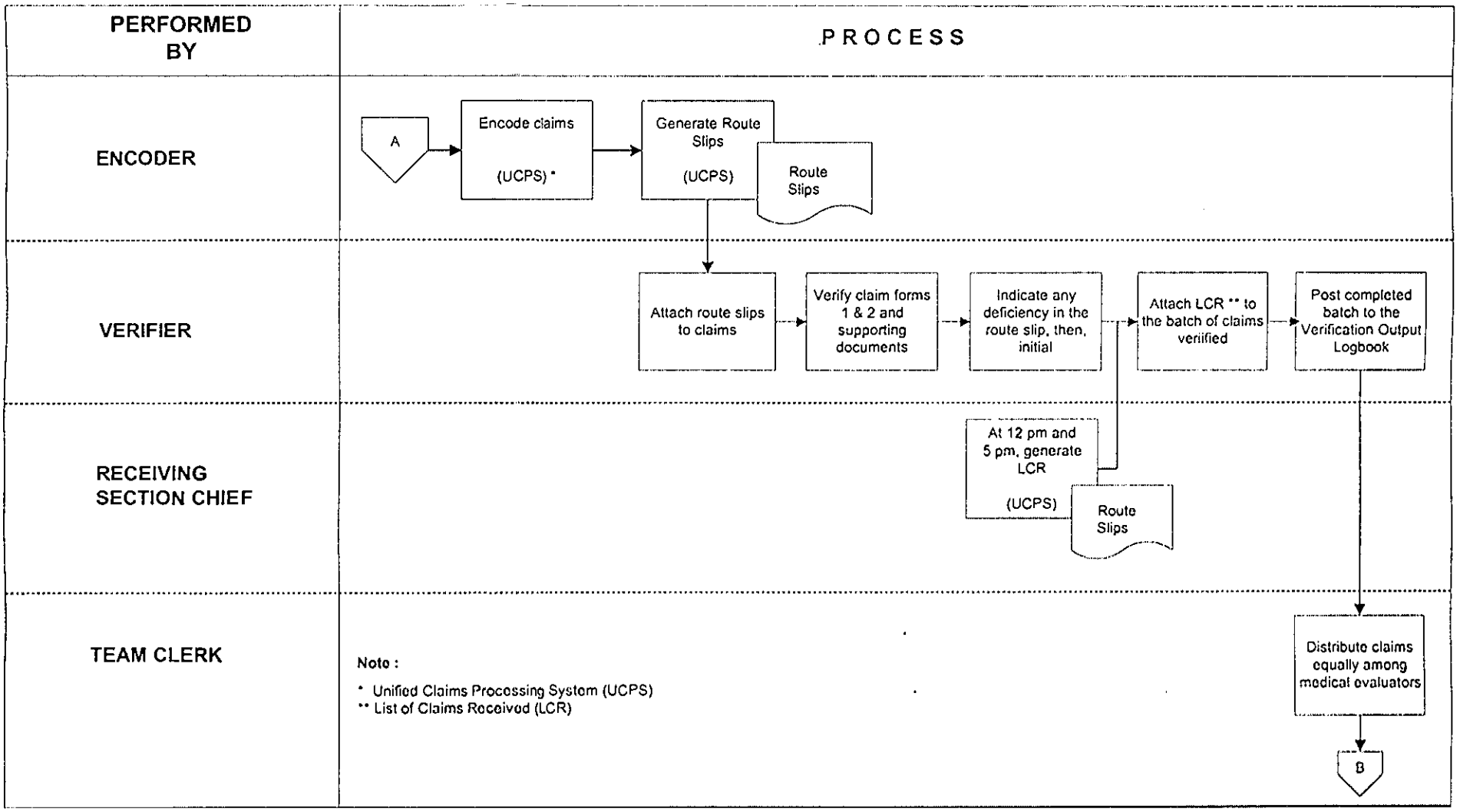
SUBPROCESS NAME : CLAIMS PROCESSING (EXISTING)



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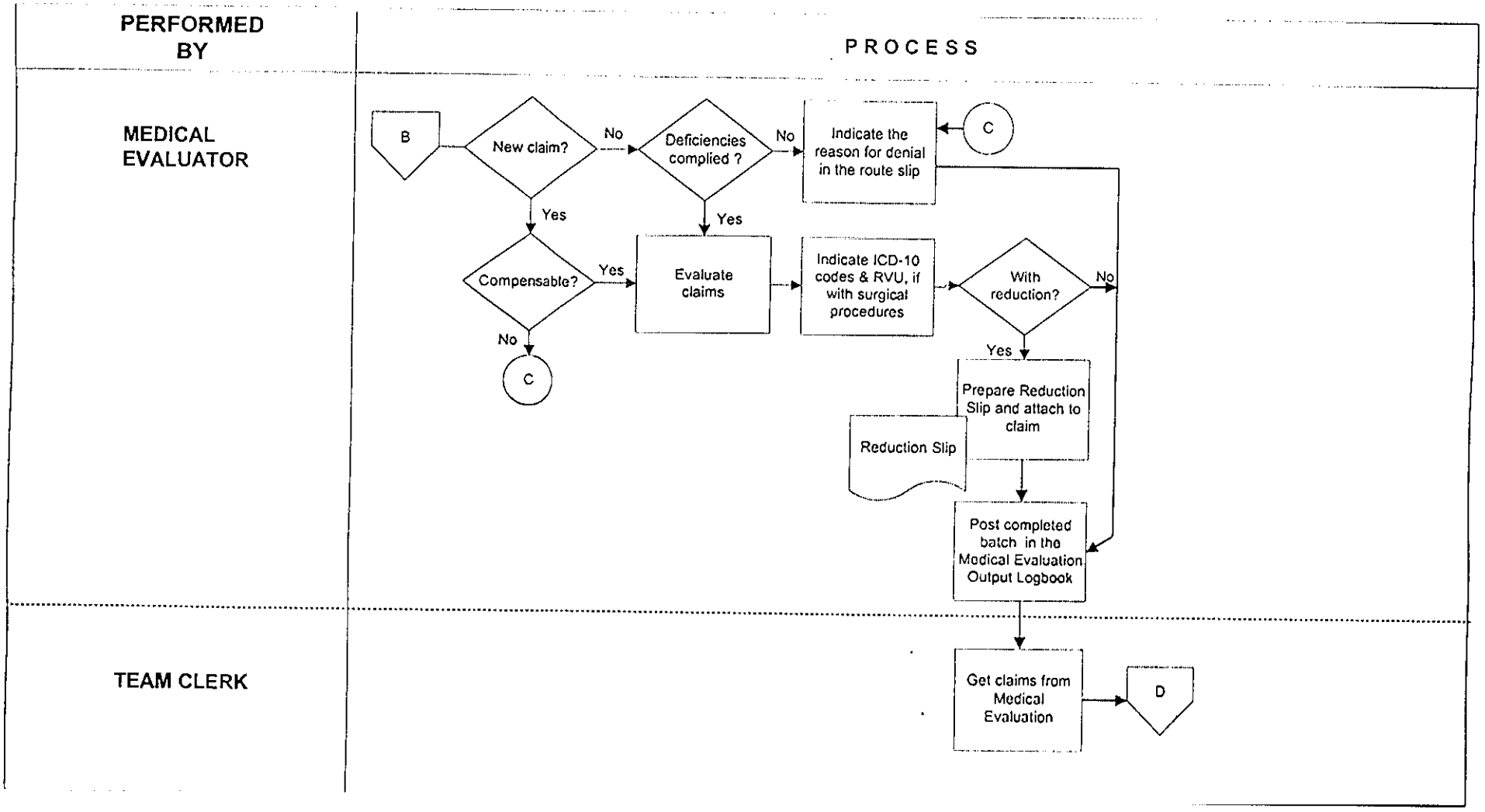




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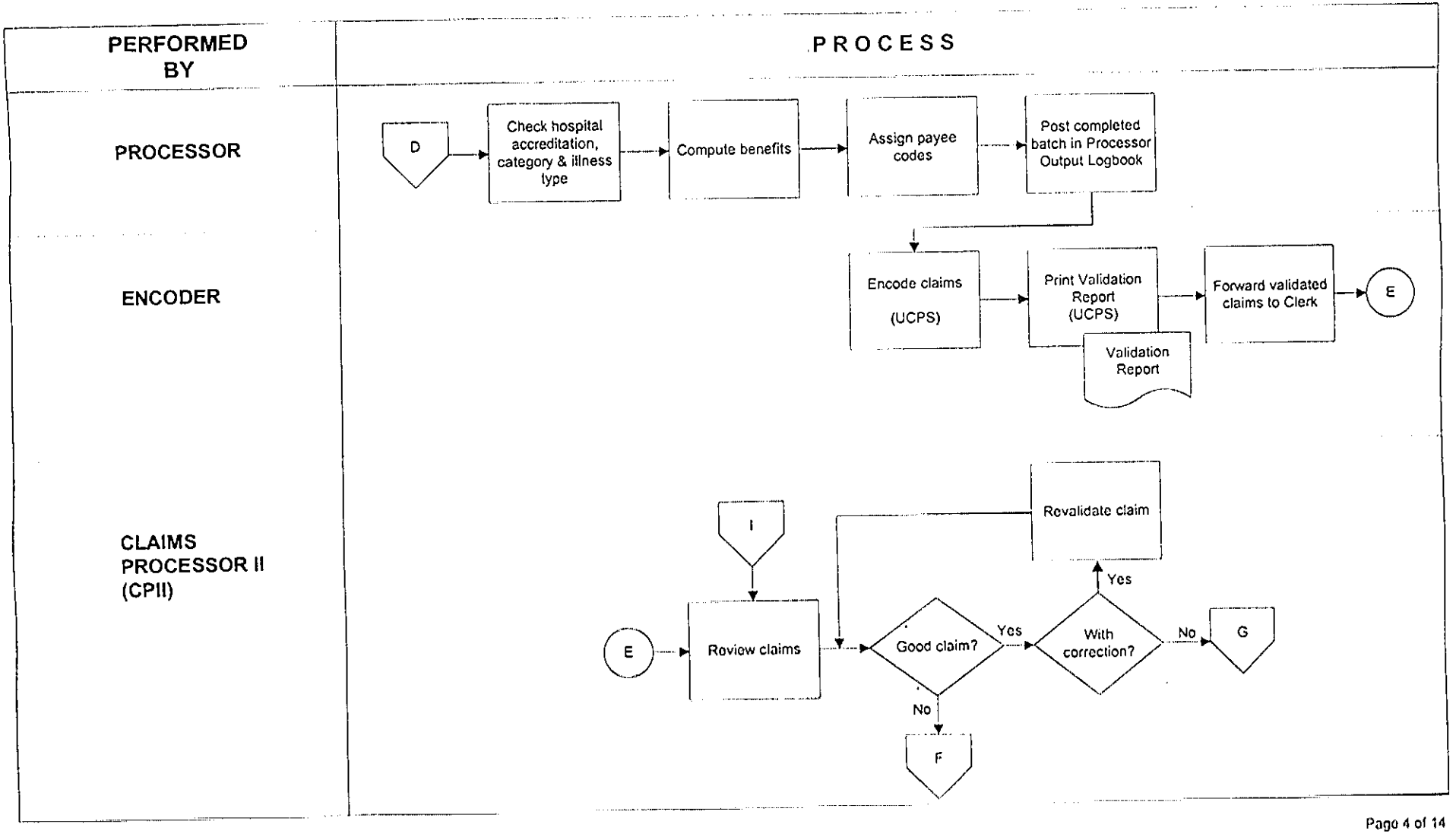




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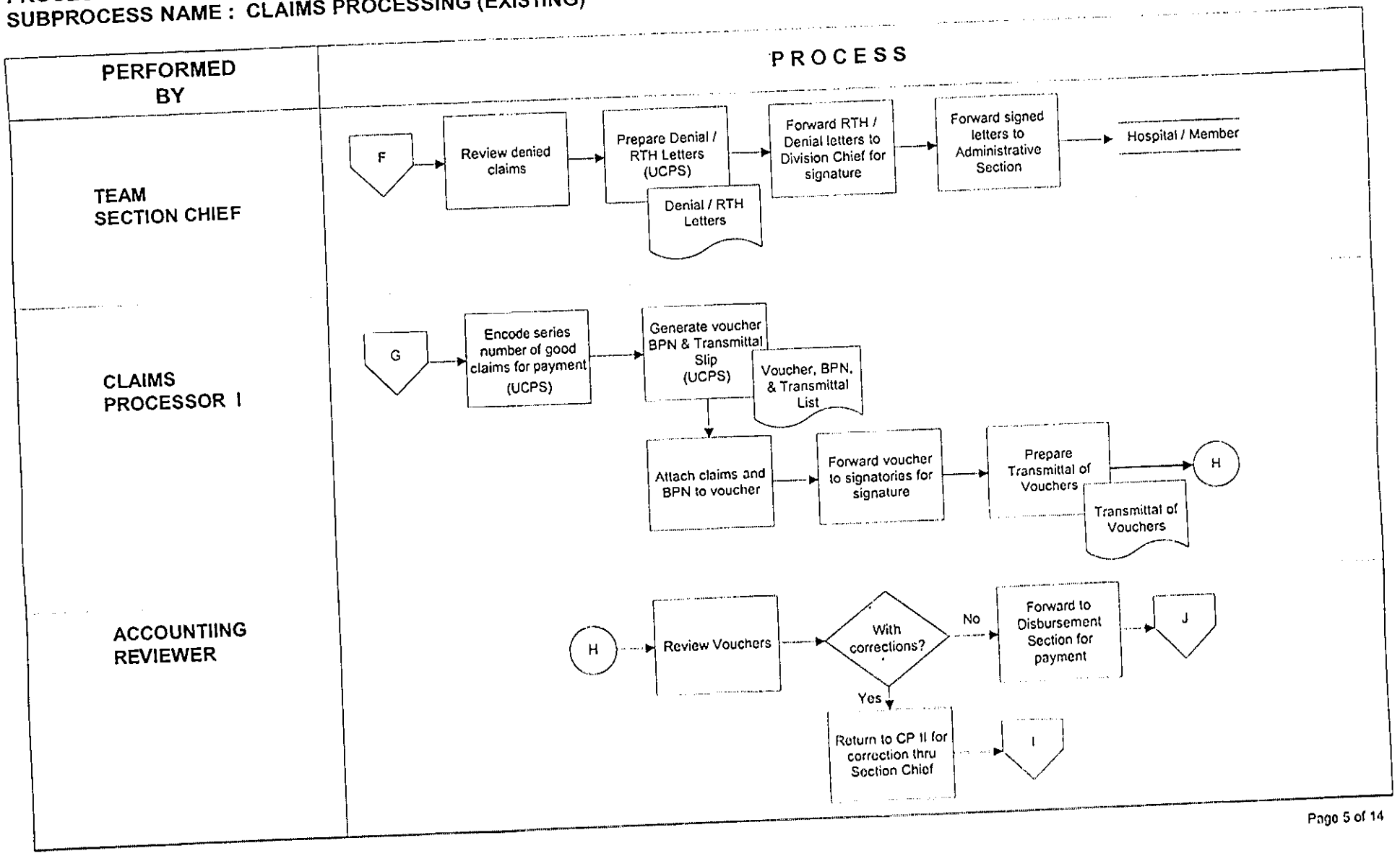




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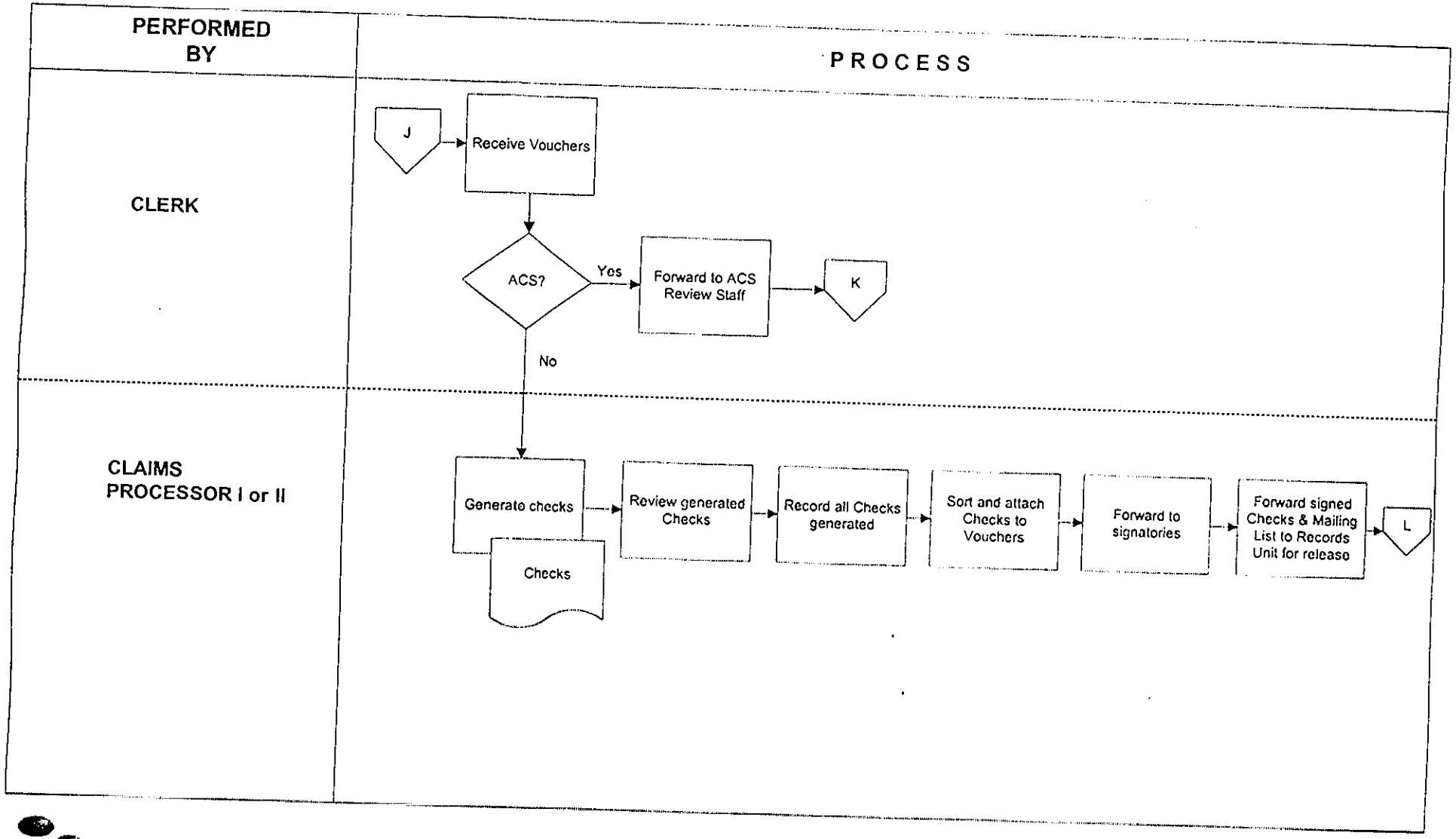




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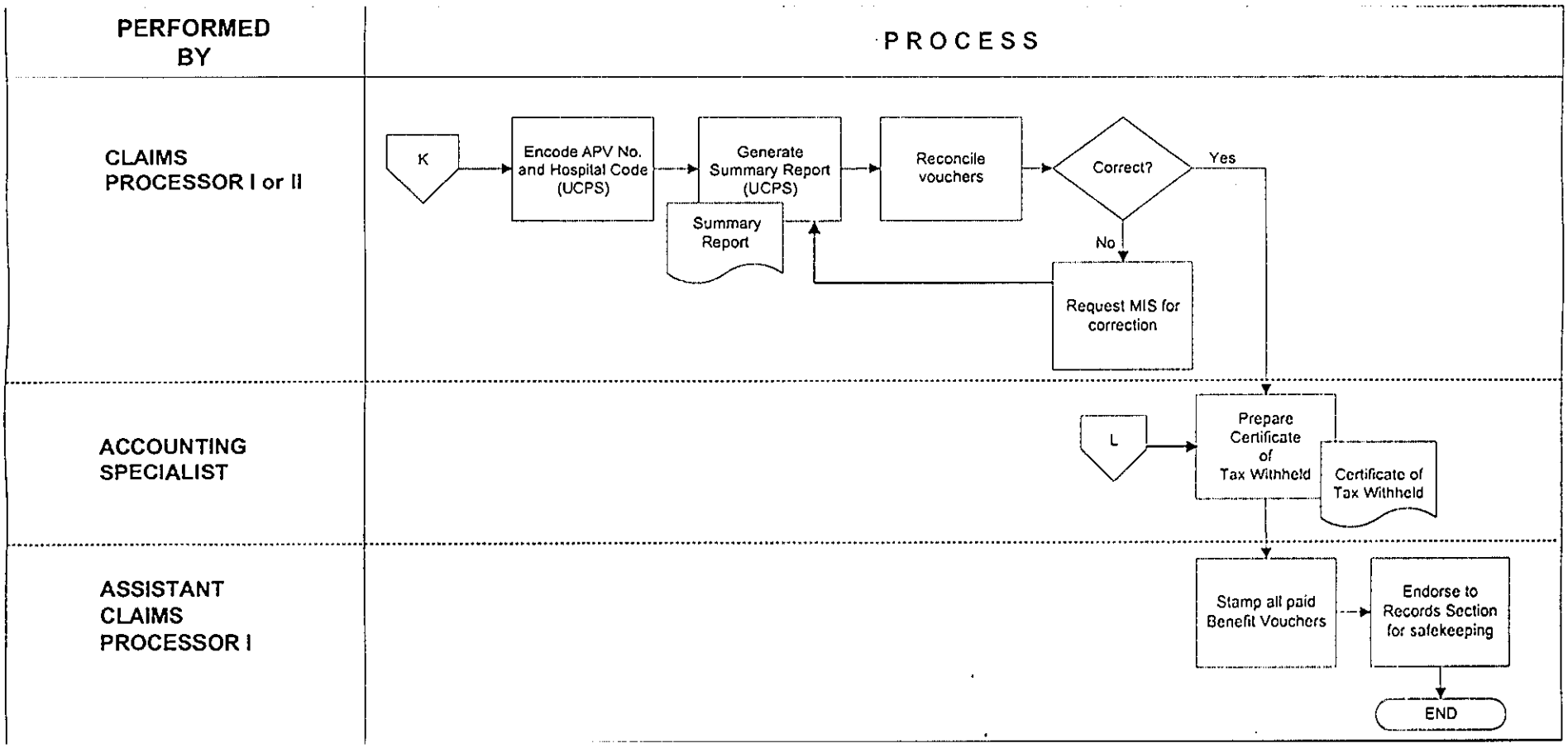

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SUBPROCESS NAME : CLAIMS PROCESSING ("TO BE")

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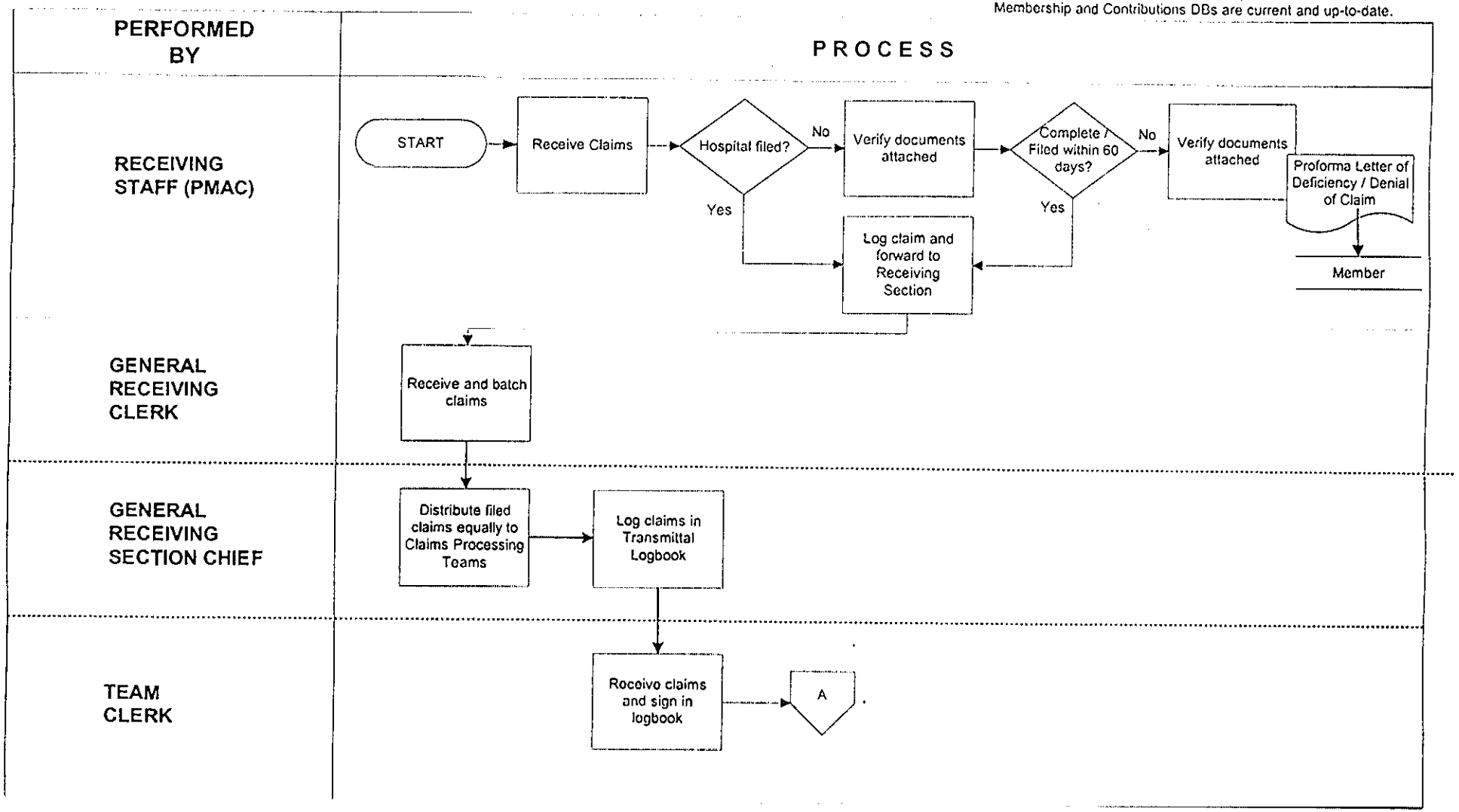

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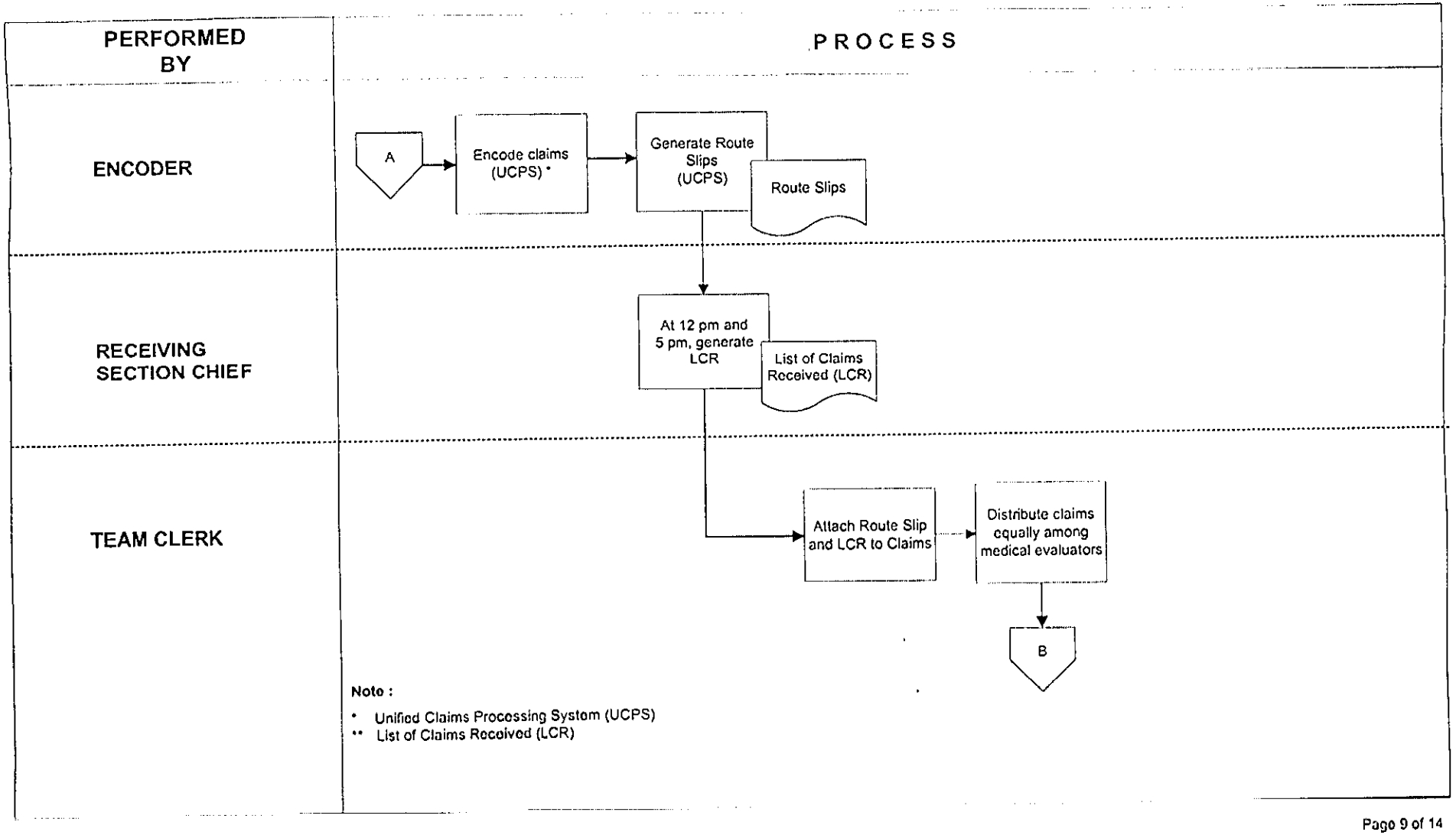




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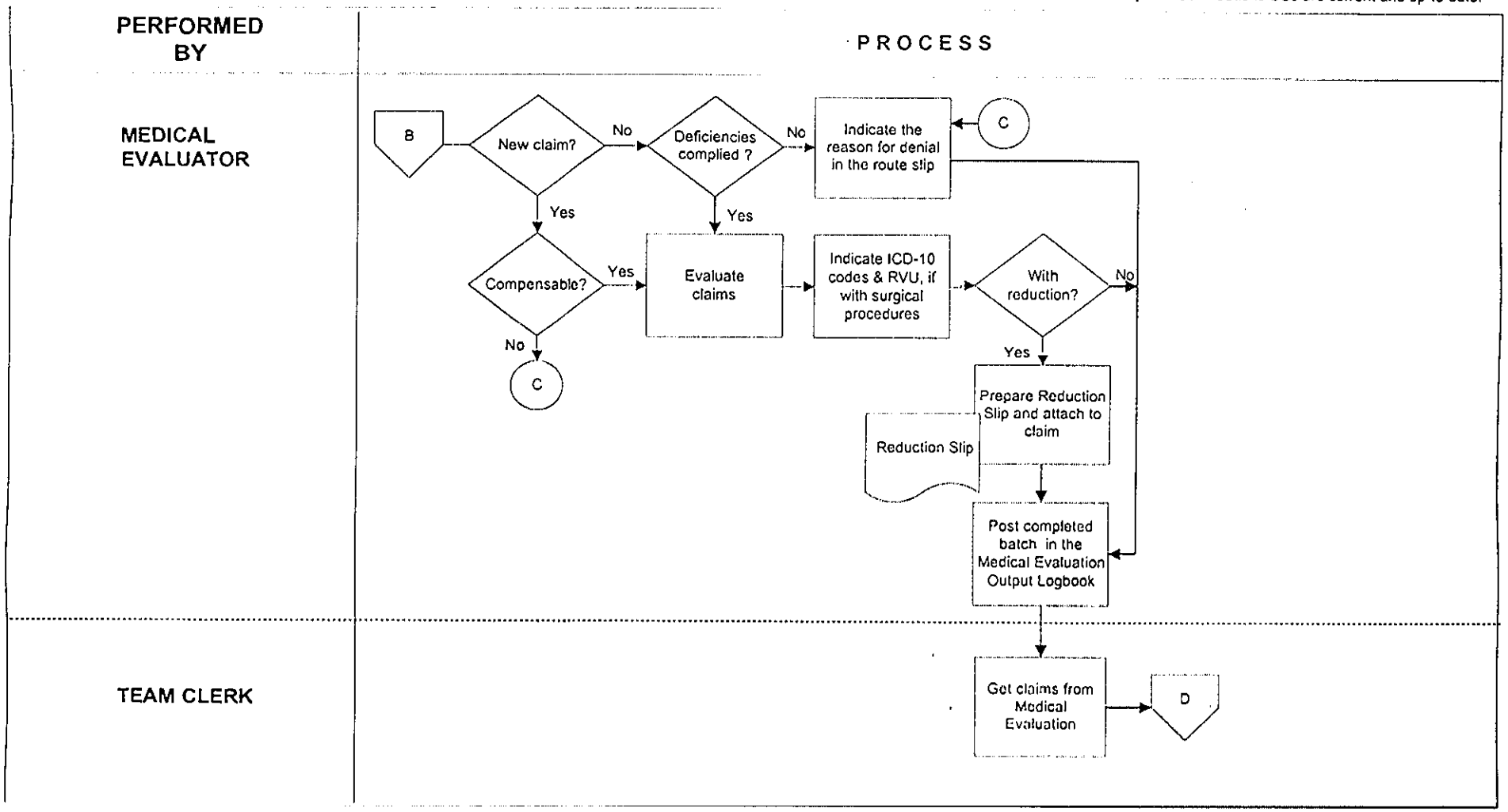

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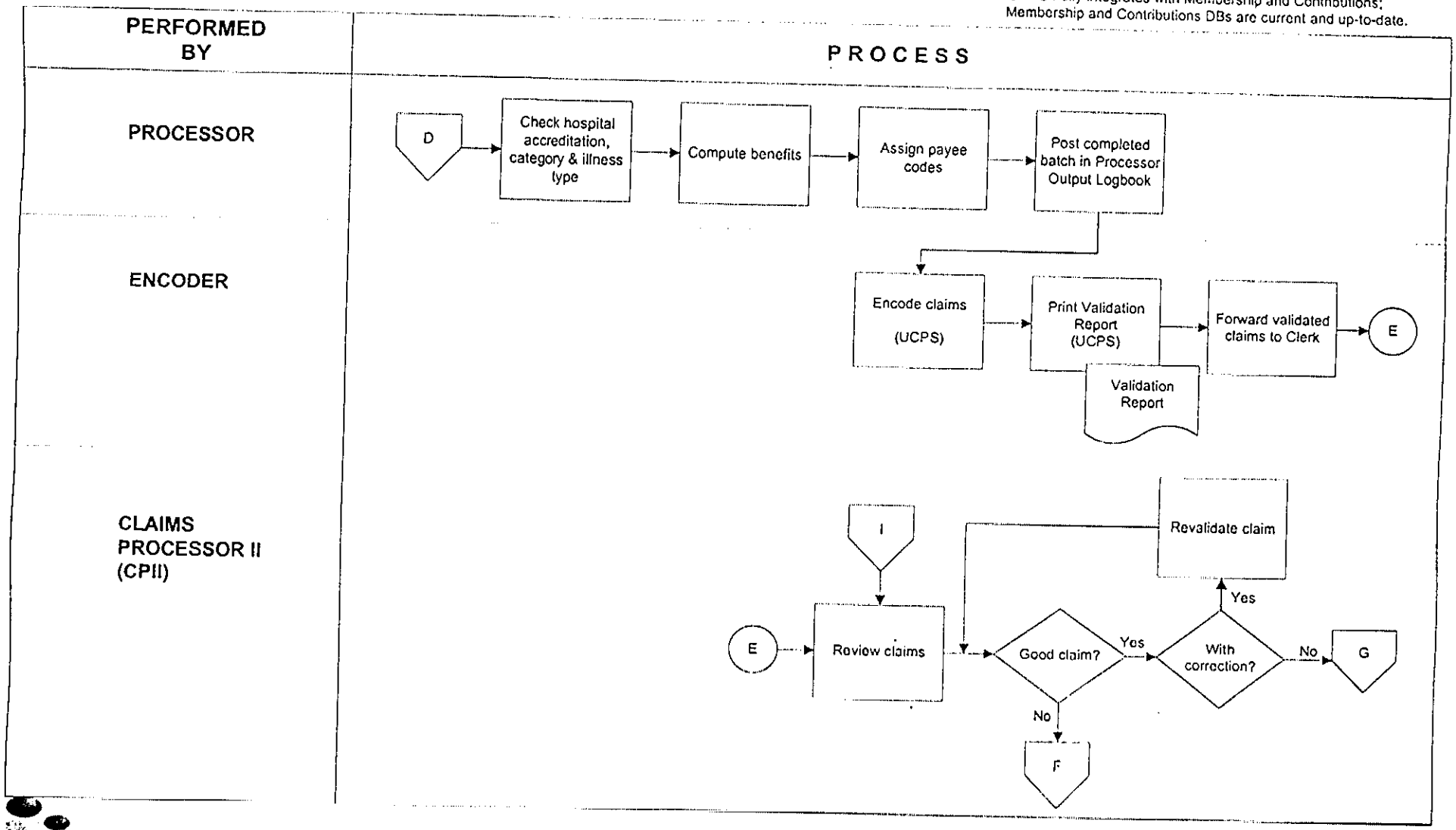

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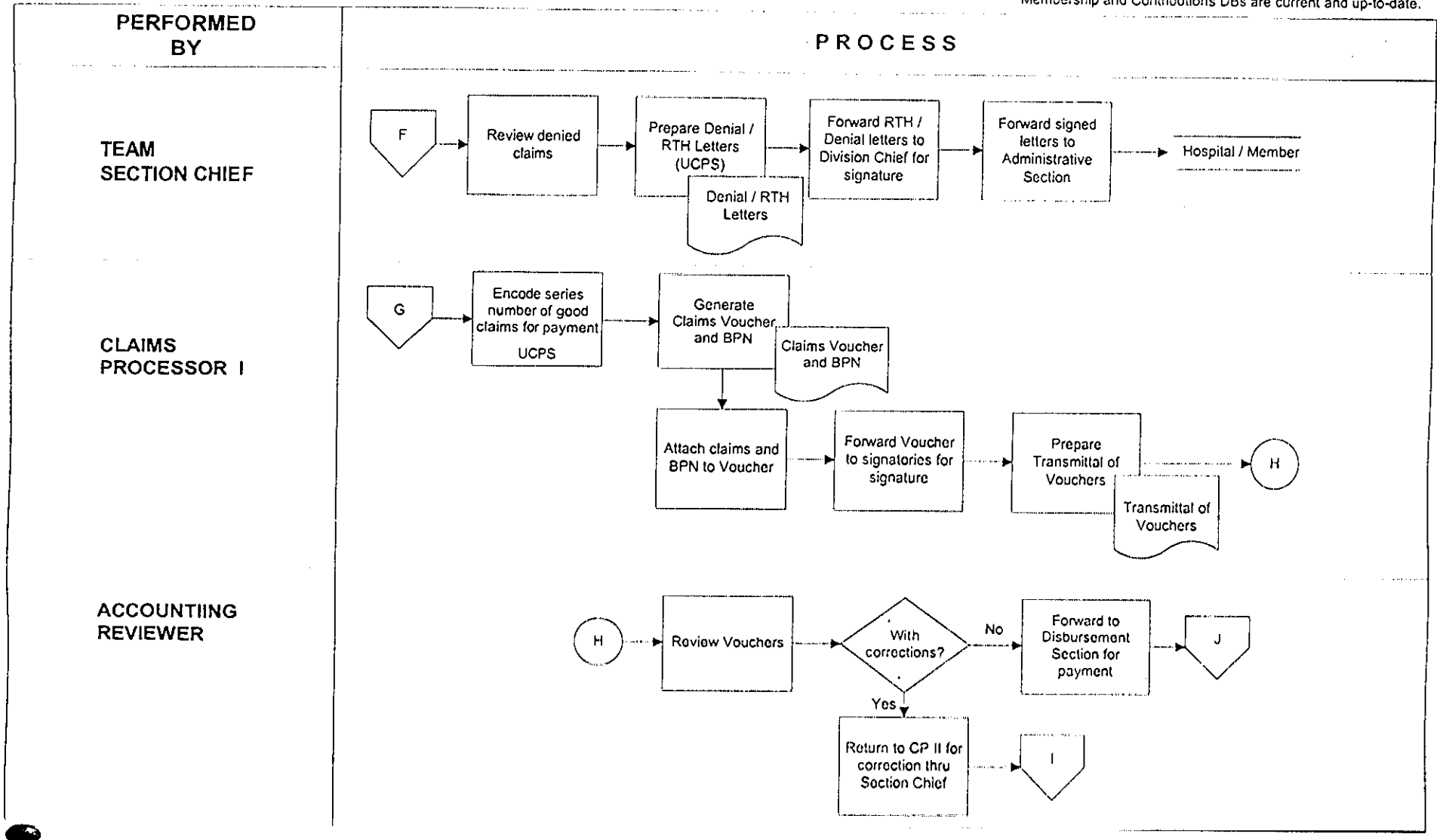


PHILIPPINE HEALTH INSURANCE CORPORATION

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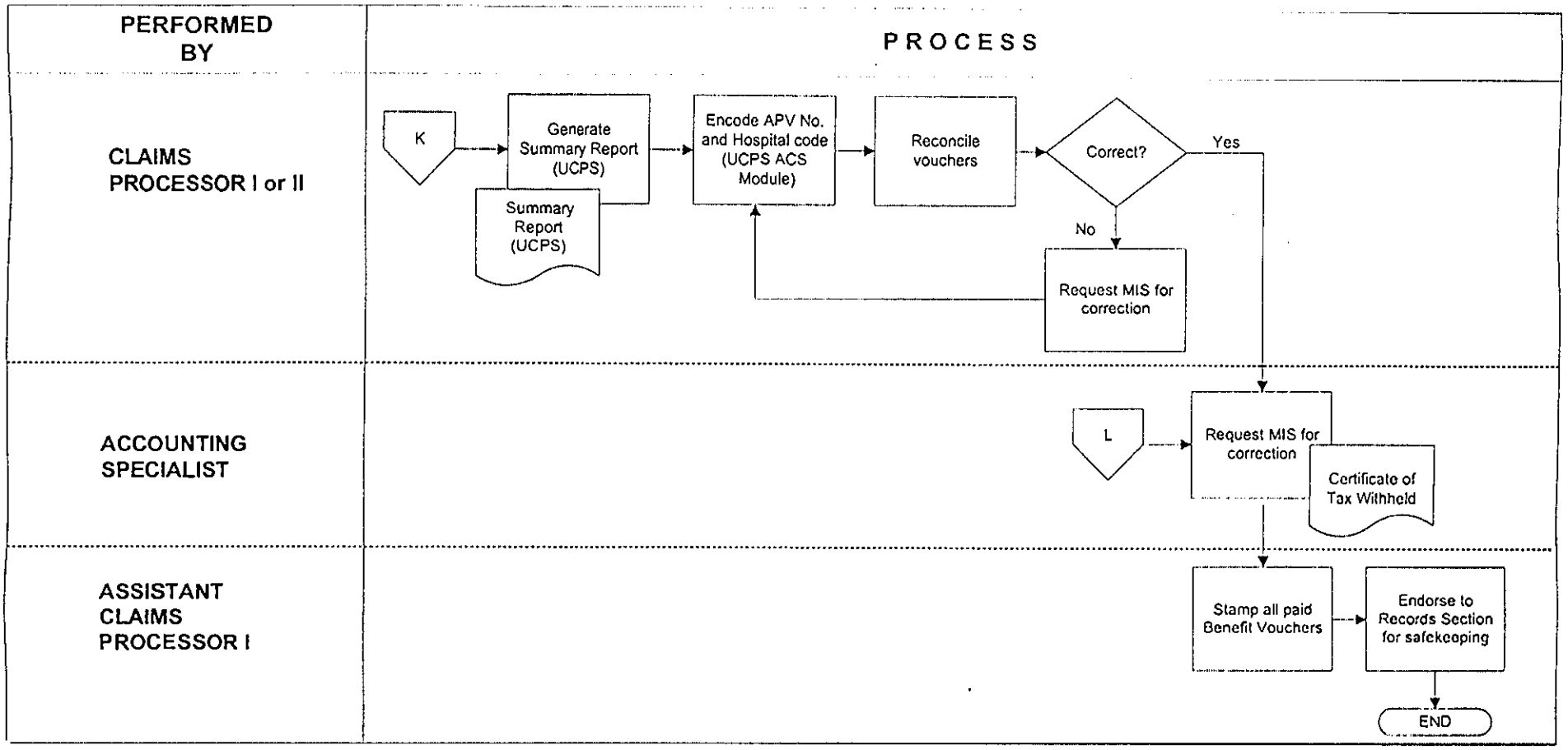




PHILIPPINE HEALTH INSURANCE CORPORATION

# DELIVER AND MANAGE BENEFITS

# PROCEDURAL NARRATIVES

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| Job / Unit Responsible | Activity / Task |
|---|---|
| RECEIVING STAFF AT PMAC | **1. RECEIVE CLAIMS FOR REIMBURSEMENT.** |

1.1 For Hospital claims, count claims, log and stamp receipt date on the transmittal list.

1.2 For Directly filed claims, check if the claim was filed within 60 days. Verify the attached documents, as follows :

1.2.1 Fully accomplished PhilHealth Forms 1 & 2 / Form 3, if confined in a primary hospital (Exhibit 1).

1.2.2 Waiver from hospital and for professional fees.

1.2.3 Additional documentary requirements for the Member's dependents, as follows:

1.2.3.1 Employed Members

- For a spouse, copy of the Marriage Contract
- For Parents over 60 years of age and children below 21 years old, copy of the Birth or Baptismal Certificate
- For disabled children above 21 years old, original copy of doctor's certification that the child is disabled

1.2.3.2 Individually Paying Members

- Copy of MI5
- For a spouse, copy of the Marriage Contract
- For Parents over 60 years of age and children below 21 years old, copy of the Birth or Baptismal Certificate
- For disabled children above 21 years old, copy of doctor's certification

1.2.3.3 Indigent Members

- Photocopy of Member's PhilHealth ID
- For a spouse, copy of the Marriage Contract
- For Parents over 60 years of age and

| Job / Unit Responsible | Activity / Task |
|---|---|
| RECEIVING STAFF AT PMAC | children below 21 years old, copy of the Birth or Baptismal Certificate<br>▪ For disabled children above 21 years old, original copy of doctor's certification that the child is disabled |
| | 1.2.3.4 SS/GSIS Retirees/Pensioners<br>▪ Copy of Retiree/Pensioner Certification issued by SSS/GSIS indicating date of effectivity, and;<br>▪ Certification of 120 monthly contributions from SSS/GSIS or previous employer/s.<br>1.2.3.5 AFP, PNP, BJMP and BFP Retirees/ Pensioners<br>▪ Certification of 120 monthly contributions from SSS/GSIS or previous employer/s, and;<br>▪ Copy of General/Special Order.<br>1.2.3.6 Retired Supreme Court and Regional Trial Court Judges<br>▪ Certification of Retirement from the office of the Supreme Court Administration (OCA) and;<br>▪ Certification of 120 monthly contributions from SSS/GSIS or previous employer/s.<br>1.2.4 If claim was filed over 60 days, prepare Letter of Denial and return the claim to the member with the letter. Advise of requirements, in case of appeal.<br>1.2.5 If documents are incomplete, return claim to the member with a Deficiency Letter, specifying the required documents to be submitted. |
| GENERAL RECEIVING CLERK | 1.3 Receive and batch claims, then, forward to the General Receiving Section Chief. |
| GENERAL RECEIVING SECTION CHIEF | **2. DISTRIBUTE FILED CLAIMS TO CLAIMS PROCESSING TEAMS.** |

| Job / Unit Responsible | Activity / Task |
|---|---|
| GENERAL RECEIVING SECTION CHIEF | 2.1 Distribute claims equally to CP teams.<br>2.2 Log claims received in Transmittal Logbook. |
| TEAM CLERK | 3. **RECEIVE CLAIMS AND SIGN IN LOGBOOK.** |
| ENCODER | 4. **ENCODE CLAIMS.**<br>4.1 Encode the following information:<br>4.1.1 Name of member<br>4.1.2 Name of patient<br>4.1.3 Name of hospital<br>4.1.3.1 If the hospital is not accredited, assign a pseudo code.<br>4.1.3.2 For a GSIS member without a membership number, assign a pseudo code.<br>4.1.4 Date of confinement<br>4.1.5 Courier / postal dates for mailed claims<br>4.1.6 Date received by Encoder<br>4.2 Generate the route slip (Exhibit 2) per claim.<br>4.3 Forward encoded claims to Verifier. |
| VERIFIER | 5. **VERIFY CLAIMS FOR REIMBURSEMENT.**<br>5.1 Attach route slips to claims.<br>5.2 Check the data in the route slip against Forms 1 & 2.<br>5.3 Check if Form 2 is properly accomplished with the following information :<br>5.3.1 Patient Benefit Claim under box #12<br>5.3.2 Name, signature, and official capacity of hospital representative and date signed |

| Job / Unit Responsible | Activity / Task |
|---|---|
| VERIFIER | 5.3.3 Printed Name, signature and accreditation number of attending physicians, surgeon, anesthesiologist<br>5.3.4 Eligibility of patient availing of benefits<br>5.4 Indicate any deficiency in route slip then initial.<br>5.5 Validate number of claims against the List of Claims Received (LCR) (Exhibit 3).<br>5.6 Post completed batch to the Verification Output Logbook.<br>5.7 Forward claims to the Team clerk. |
| RECEIVING SECTION CHIEF | 6. **GENERATE LIST OF CLAIMS RECEIVED.**<br>6.1 Generate LCR at 12:00 PM and 5:00 PM. |
| TEAM CLERK | 7. **RECEIVE CLAIMS.**<br>7.1 Check number of claims per attached LCR.<br>7.2 Divide claims equally among the Medical Evaluators.<br>7.3 Log the number of claims to be given to each Medical Evaluator.<br>7.4 Forward claims to Medical Evaluator. |
| MEDICAL EVALUATOR | 8. **EVALUATE CLAIMS.**<br>8.1 For re-filed claims, check compliance. If member/ hospital did not comply, deny claim and indicate reason in route slip.<br>8.2 For new claims, determine if claim is compensable. If not, deny claim and indicate reason in the route slip.<br>8.3 Indicate ICD-10 code.<br>8.4 If with surgical procedure, indicate RVU.<br>8.5 Indicate case type: ordinary, intensive or catastrophic.<br>8.6 Review payment of professional fees, medicines, laboratory examinations and supplies used. |

| Job / Unit Responsible | Activity / Task |
|---|---|
| MEDICAL EVALUATOR | 8.6.1 Deny medicines falling under the following categories and mark with an "X":<br><br>8.6.1.1 Not in the PNDF or PHIC short list<br><br>8.6.1.2 Not indicated for that particular illness, even if included in the PNDF or PHIC short list<br><br>8.6.1.3 Over-medication<br><br>8.6.2 Deny laboratory examinations not indicated for the illness.<br><br>8.6.3 Deny non-compensable supplies.<br><br>8.6.4 Reduce/slash medicines that are over-charged or exceeding the quantity based on the confinement period.<br><br>8.6.4.1 Fill up reduction slip (Exhibit 4) in duplicate and state reason for slashing/reduction.<br><br>8.6.4.2 Attach reduction slip to claim.<br><br>8.6.5 Classify attending physician.<br><br>8.6.5.1 SP for Specialist and GP for General Practitioner<br><br>8.6.5.2 GP or specialist attending to cases outside of their areas of specialty<br><br>8.6.6 Indicate number of visits allowed per doctor, if with co-management.<br><br>8.7 Evaluate claims from non-accredited hospitals.<br><br>8.7.1 If emergency case, payment will be made.<br><br>8.7.2 If non-emergency case, deny claim.<br><br>8.8 Post completed batch in the Medical Evaluation Output Logbook.<br><br>8.9 Forward claims to Team Clerk. |



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| Job / Unit Responsible | Activity / Task |
|---|---|
| TEAM CLERK | **9. RECEIVE EVALUATED CLAIMS.**<br>9.1 Forward evaluated claims to Processor. |
| PROCESSOR | **10. PROCESS CLAIMS.**<br>10.1 Check hospital accreditation, category, and illness type in Form 2.<br>10.2 Compute benefits to be paid.<br>10.2.1 Refer to table of benefits and charges in Form 2 as basis of computation.<br>10.2.2 Exclude RTH claims from the computation of benefits.<br>10.3 Assign payee codes.<br>10.4 Post completed batch in Processor Output Logbook.<br>10.5 Forward claims to Encoder. |
| ENCODER | **11. ENCODE MANUALLY COMPUTED CLAIMS.**<br>11.1 Get workload as to date of receipt.<br>11.2 Encode the following information:<br>11.2.1 ICD-10 code<br>11.2.2 Case Type (Ordinary, Intensive or Catastrophic<br>11.2.3 RVS Codes and date of operation for surgical case<br>11.2.4 Hospital charges<br>11.2.5 PhilHealth Charges<br>11.2.6 Payee codes and fund source<br>11.3 Generate Validation Report.<br>11.4 Forward encoded claims to clerk. |

| Job / Unit Responsible | Activity / Task |
|---|---|
| CLAIMS PROCESSOR II | **12. REVIEW CLAIMS.**<br>12.1 Verify if the forms are properly accomplished and if attachments and documentary requirements are complete.<br>12.2 Check eligibility of member.<br>12.3 Segregate claims<br>12.3.1 Forward good claims to CP I for payment.<br>12.3.2 Revalidate claims with encoding errors. |
| TEAM SECTION CHIEF | **13. REVIEW DENIED/RTH CLAIMS.**<br>13.1 Prepare Denial / RTH Letters.<br>13.2 Forward letters to Division Chief for signature.<br>13.3 Forward signed letters to Administrative Section for release to hospital/member. |
| CLAIMS PROCESSOR I | **14. GENERATE VOUCHER FOR GOOD CLAIMS.**<br>14.1 Encode series number of good claims for payment.<br>14.2 Generate voucher with corresponding APV number per hospital and membership category.<br>14.3 Generate Benefits Payment Notice (BPN) and Transmittal List.<br>14.4 Forward vouchers to signatories for signature.<br>14.5 Prepare Transmittal of Vouchers.<br>14.6 Forward to Accounting Reviewer. |
| ACCOUNTING REVIEWER | **15. REVIEW BENEFIT VOUCHERS.**<br>15.1 Review the accuracy of the mathematical computation of processed claims under each PhilHealth Benefit Voucher vertically and horizontally.<br>15.2 Compare and verify the uniformity of the amounts |

| Job / Unit Responsible | Activity / Task |
|---|---|
| ACCOUNTING REVIEWER | indicated in the Validation Report vis a vis the Benefit Voucher vis a vis the BPN.<br><br>15.3 Verify the validity of the payee-doctor, member.<br><br>15.4 Check the total number of checks to be issued.<br><br>15.5 Check the number of ACS doctors included in the benefit voucher.<br><br>15.6 Compare the amounts in the summary part immediately placed below the Benefit Vouchers.<br><br>15.6.1 If the amounts in the Benefit Vouchers are correct, forward to the Accountant for the signing of the Certificate of Funds Availability; then, to the Disbursement Section for payment.<br><br>15.6.2 If there are corrections to be made, return to the CP II through the Section Chief for correction / adjustment. |
| CLERK | **16. RECEIVE BENEFIT VOUCHERS.**<br><br>16.1 Segregate into ACS and non-ACS Vouchers.<br><br>16.2 Forward ACS vouchers to the ACS review staff.<br><br>16.3 Forward Non-ACS vouchers to the Check Preparation Staff for the corresponding check generation. |
| CP I or II | **17. GENERATE CHECKS.**<br><br>17.1 Review / verify the correctness of checks issued with the Benefit Voucher and Mailing List. Attach Mailing to the Benefit Voucher or Benefit Payment Notice. Check the consistency of the following:<br><br>17.1.1 Check number and check date<br><br>17.1.2 Name and address of payee<br><br>17.1.3 Check amount in words and figures<br><br>17.2 Record all checks generated.<br><br>17.3 Sort and attach Checks to corresponding Vouchers. |

| Job / Unit Responsible | Activity / Task |
|---|---|
| CP I or II | 17.4 Forward Benefit Vouchers together with checks to the signatories.<br><br>17.4.1 Division Chief – to countersign checks in the amount of P50,000.00 and below.<br><br>17.4.2 Department Manager for Claims – to countersign checks in the amount of P50,000.00 but not to exceed P500,000.00.<br><br>17.4.3 SVP Operations – to countersign checks in the amount of P500,000.00 and above.<br><br>17.5 Review if all checks are duly signed.<br><br>17.6 Forward signed checks to the Records Unit for release. Have them sign in the Accounting copy of the mailing list and the listed check series in the check release logbook. |
| CP I or II | **18. GENERATE SUMMARY REPORTS.**<br><br>18.1 Encode APV Number and Hospital Code.<br><br>18.2 Reconcile Vouchers.<br><br>18.2.1 If all entries in the vouchers are correct, forward to the Accounting Specialist.<br><br>18.2.2 If there are errors, request MIS for correction. |
| ACCOUNTING SPECIALIST | **19. PREPARE CERTIFICATE OF TAX WITHELD ON A QUARTERLY BASIS.** |
| CLERK | **20. FILE ALL PAID CLAIMS.**<br><br>20.1 Stamp "Paid" all paid Benefit Vouchers and supporting documents.<br><br>20.2 Arrange according to check series and check dates.<br><br>20.3 Prepare transmittal and affix box code number, check series number, check date per fund, and the disposal date on the paid claim box.<br><br>20.4 Endorse paid claim boxes to the Record Section for safekeeping/handling. |

| Job / Unit Responsible | Activity / Task |
|---|---|
| RECEIVING STAFF AT PMAC | 1. RECEIVE CLAIMS FOR REIMBURSEMENT.<br><br>1.1 For Hospital claims, count claims, log and stamp receipt date on the transmittal list.<br><br>1.2 For Directly filed claims, check if the claim was filed within 60 days. Verify attached documents, as follows :<br><br>1.2.1 Fully accomplished PhilHealth Forms 1 & 2 and Form 3, if confined in a primary hospital (Exhibit 1).<br><br>1.2.2 Waiver from the hospital and for professional fees.<br><br>1.2.3 Additional documentary requirements for the Member's dependents, as follows:<br><br>1.2.3.1 Employed Members<br>▪ For a spouse, copy of the Marriage Contract<br>▪ For Parents over 60 years of age and children below 21 years old, copy of the Birth or Baptismal Certificate<br>▪ For disabled children above 21 years old, original copy of doctor's certification that the child is disabled<br><br>1.2.3.2 Individually Paying Members<br>▪ Copy of MI5<br>▪ For a spouse, copy of the Marriage Contract<br>▪ For Parents over 60 years of age and children below 21 years old, copy of the Birth or Baptismal Certificate<br>▪ For disabled children above 21 years old, original copy of doctor's certification<br><br>1.2.3.3 Indigent Members<br>▪ Photocopy of Member's PhilHealth ID<br>▪ For a spouse, copy of the Marriage Contract<br>▪ For Parents over 60 years of age and |

| Job / Unit Responsible | Activity / Task |
|---|---|
| RECEIVING STAFF AT PMAC | children below 21 years old, copy of the Birth or Baptismal Certificate<br>▪ For disabled children above 21 years old, original copy of doctor's certification that the child is disabled |
| RECEIVING STAFF AT PMAC | 1.2.3.3 SSS/GSIS Retirees/Pensioners<br>▪ Copy of Retiree/Pensioner Certification issued by SSS / GSIS indicating date of effectivity, and;<br>▪ Certification of 120 monthly contributions from SSS / GSIS or previous employer/s.<br>1.2.3.4 AFP, PNP, BJMP and BFP Retirees/ Pensioners<br>▪ Certification of 120 monthly contributions from SSS / GSIS or previous employer/s, and;<br>▪ Copy of General / Special Order.<br>1.2.3.5 Retired Supreme Court and Regional Trial Court Judges<br>▪ Certification of Retirement from the Office of the Supreme Court Administration (OCA) and;<br>▪ Certification of 120 monthly contributions from SSS/GSIS or previous employer/s.<br>1.2.4 If claim was filed over 60 days, prepare Letter of Denial and return the claim to the member, together with the letter. Advise of requirements, in case of appeal.<br>1.2.5 If not all required documents were submitted, return the claim to the member with a Deficiency Letter, specifying the required documents to be submitted. |
| GENERAL RECEIVING CLERK | 1.3 Receive and batch claims; then, forward to General Receiving. |
| GENERAL RECEIVING CHIEF | **2. DISTRIBUTE FILED CLAIMS TO CLAIMS PROCESSING TEAMS.** |

| Job / Unit Responsible | Activity / Task |
|---|---|
| GENERAL RECEIVING CHIEF | 2.1 Distribute claims equally to CP teams.<br>2.2 Log claims received in Transmittal Logbook. |
| TEAM CLERK | **3. RECEIVE CLAIMS AND SIGN IN LOGBOOK.** |
| ENCODER | **4. ENCODE CLAIMS.**<br>4.1 Encode the following information:<br>4.1.1 Name of member<br>4.1.2 Name of patient<br>4.1.3 Name of hospital<br>4.1.3.1 If the hospital is not accredited, assign a pseudo code.<br>4.1.3.2 For a GSIS member without a membership number, assign a pseudo code.<br>4.1.4 Date of confinement<br>4.1.5 Courier/postal dates for mailed claims<br>4.1.6 Date received by Encoder<br>4.2 Generate the route slip (Exhibit 2) per claim.<br>4.3 Forward encoded claims to Section Chief. |
| RECEIVING SECTION CHIEF | **5. GENERATE LIST OF CLAIMS RECEIVED (LCR).**<br>5.1 Generate LCR (Exhibit 3) at 12:00 PM and 5:00 PM. |
| TEAM CLERK | **6. RECEIVE CLAIMS.**<br>6.1 Check number of claims and attach route slip.<br>6.2 Divide claims equally among the Medical Evaluators.<br>6.3 Log the number of claims to be given to each Medical Evaluator. |

| Job / Unit Responsible | Activity / Task |
|---|---|
| TEAM CLERK | 6.4 Forward claims to Medical Evaluator. |
| MEDICAL EVALUATOR | **7 EVALUATE CLAIMS.** |

7.1 For re-filed claims, check compliance. If member/ hospital did not comply, deny claim and indicate reason in route slip.

7.2 For new claims, determine if claim is compensable. If not, deny claim and indicate reason in the route slip.

7.3 Indicate ICD-10 code.

7.4 If with surgical procedure, indicate RVU.

7.5 Indicate case type: ordinary, intensive or catastrophic.

7.6 Review payment of professional fees, medicines, laboratory examinations and supplies used.

7.6.1 Deny medicines falling under the following categories and mark with an "X":

7.6.1.1 Not in the PNDF or PHIC short list

7.6.1.2 Not indicated for that particular illness, even if included in the PNDF or PHIC short list

7.6.1.3 Over-medication

7.6.2 Deny laboratory examinations not indicated for the illness.

7.6.3 Deny non-compensable supplies.

7.6.4 Reduce/slash medicines that are over-charged or exceeding the quantity based on the confinement period.

7.6.4.1 Fill up reduction slip (Exhibit 4) in duplicate and state reason for slashing/reduction.

7.6.4.2 Attach reduction slip to claim.

7.6.5 Classify attending physician.

7.6.5.1 SP for Specialist and GP for General

| Job / Unit Responsible | Activity / Task |
|---|---|
| | Practitioner<br><br>7.6.5.2 GP or specialist attending to cases outside of their areas of specialty<br><br>7.6.6 Indicate number of visits allowed per doctor if with co-management.<br><br>7.7 Evaluate claims from non-accredited hospitals.<br><br>7.7.1 If emergency case, payment will be made.<br><br>7.7.2 If non-emergency case, deny claim.<br><br>7.8 Post completed batch in the Medical Evaluation Output Logbook.<br><br>7.9 Forward claims to the Team Clerk. |
| TEAM CLERK | **8 RECEIVE EVALUATED CLAIMS.**<br><br>8.1 Forward evaluated claims to Encoder. |
| ENCODER | **9 ENCODE CLAIMS.**<br><br>9.1 Get workload as to date of receipt.<br><br>9.2 Encode the following information:<br><br>9.2.1 ICD-10 code<br><br>9.2.2 Case Type (Ordinary, Intensive or Catastrophic<br><br>9.2.3 RVS Codes and date of operation for surgical case<br><br>9.2.4 Hospital charges<br><br>9.2.5 PhilHealth Charges<br><br>9.2.6 Payee codes and fund source<br><br>9.3 Generate Validation Report.<br><br>9.4 Forward encoded claims to clerk. |

| Job / Unit Responsible | Activity / Task |
|---|---|
| CLAIMS PROCESSOR II | **10 REVIEW CLAIMS.**<br>10.1 Verify if the forms are properly accomplished and if attachments and documentary requirements are complete.<br>10.2 Check eligibility of member.<br>10.3 Segregate claims.<br>10.3.1 Forward good claims to CP I for payment.<br>10.3.2 Revalidate claims with encoding errors. |
| TEAM SECTION CHIEF | **11 REVIEW DENIED / RTH CLAIMS.**<br>11.1 Prepare Denial / RTH Letters.<br>11.2 Forward letters to Division Chief for signature.<br>11.3 Forward signed letters to Administrative Section for release to hospital / member. |
| CLAIMS PROCESSOR I | **12 GENERATE VOUCHER FOR GOOD CLAIMS.**<br>12.1 Encode series number of good claims for payment.<br>12.2 Generate voucher with corresponding APV number per hospital and membership category.<br>12.3 Generate Benefits Payment Notice (BPN) and Transmittal List.<br>12.4 Forward vouchers to signatories for signature.<br>12.5 Prepare Transmittal of Vouchers.<br>12.6 Forward to Accounting Reviewer. |
| ACCOUNTING REVIEWER | **13 REVIEW BENEFIT VOUCHERS.**<br>13.1 Review the accuracy of the mathematical computation of processed claims under each PhilHealth Benefit Voucher vertically and horizontally.<br>13.2 Compare and verify the uniformity of the amounts |

| Job / Unit Responsible | Activity / Task |
|---|---|
| ACCOUNTING REVIEWER | indicated in the Validation Report vis a vis the Benefit Voucher and the BPN.<br><br>13.3 Verify the validity of the payee-doctor, member.<br><br>13.4 Check the total number of checks to be issued.<br><br>13.5 Check the number of ACS doctors included in the benefit voucher.<br><br>13.6 Compare the amounts in the summary part immediately placed below the Benefit Vouchers.<br><br>13.6.1 If the amounts in the Benefit Vouchers are correct, forward the vouchers to the Accountant for the signing of the Certificate of Funds Availability; then. to the Disbursement Section for payment.<br><br>13.6.2 If there are corrections to be made, return to CP II through the Section Chief for correction / adjustment. |
| CLERK | **14 RECEIVE BENEFIT VOUCHERS.**<br><br>14.1 Segregate into ACS and non-ACS vouchers.<br><br>14.2 Forward ACS vouchers to the ACS review staff.<br><br>14.3 Forward Non-ACS vouchers to the Check Preparation Staff for the corresponding check generation. |
| CP I or II | **15 GENERATE CHECKS.**<br><br>15.1 Review / verify the correctness of checks issued with the Benefit Voucher and Mailing List; attach the Mailing List to the Benefit Voucher and Benefit Payment Notice. Check the consistency of the following:<br><br>15.1.1 Check number and check date<br><br>15.1.2 Name and address of payee<br><br>15.1.3 Check amount in words and figures<br><br>15.2 Record all checks generated.<br><br>15.3 Sort and attach Checks to corresponding Vouchers. |

| Job / Unit Responsible | Activity / Task |
|---|---|
| CP I or II | 15.4 Forward Benefit Vouchers together with checks to the signatories.<br><br>15.4.1 Division Chief – to countersign checks in the amount of P50,000.00 and below.<br><br>15.4.2 Department Manager for Claims – to countersign checks in the amount of P50,000.00 but not to exceed P500,000.00.<br><br>15.4.3 SVP Operation – to countersign checks in the amount of P500,000.00 and above.<br><br>15.5 Review if all checks are duly signed.<br><br>15.6 Forward signed checks to the Records Unit for release. Have them sign in the Accounting copy of the mailing list and the listed check series in the check release logbook. |
| CP I or II | **16 GENERATE SUMMARY REPORTS.**<br><br>16.1 Encode APV Number and Hospital Code.<br><br>16.2 Reconcile Vouchers.<br><br>16.2.1 If all entries in the vouchers are correct, forward to Accounting Specialist.<br><br>16.2.2 If there are errors, request MIS for correction. |
| ACCOUNTING SPECIALIST | **17 REPARE CERTIFICATE OF TAX WITHELD ON A QUARTERLY BASIS.** |
| CLERK | **18 FILE ALL PAID CLAIMS.**<br><br>18.1 Stamp "Paid" all paid benefit vouchers and supporting documents.<br><br>18.2 Arrange according to check series and check dates.<br><br>18.3 Prepare the transmittal list and affix the box code number, check series number, check date per fund, and the disposal date on the paid claim box.<br><br>18.4 Endorse paid claim boxes to the Record Section for safekeeping/handling. |

# DELIVER AND MANAGE BENEFITS

## FORMS

## Table of Contents


| Exhibit No | PARTICULARS |
|---|---|
| 1 | Claims Form |
| 2 | Route Slip |
| 3 | List of Claims Received (LCR) |
| 4 | Reduction Slip |

# EXHIBIT 1

## Claims Form

This form may be reproduced and is NOT FOR SALE

# PHILHEALTH

(DATE RECEIVED)

## CLAIM FORM 1

Revised May 2000

NOTE: THIS FORM TOGETHER WITH CLAIM FORM 2 SHOULD BE FILED WITH PHILHEALTH WITHIN 60 CALENDAR DAYS FROM DATE OF DISCHARGE.

### PART I - MEMBER'S CERTIFICATION (Member to Fill In All Items/Indigent to be Assisted by Hospital Representative)

1. Type of Membership ☐ Employed ( ) Private Sector ( ) Gov'L Sector ☐ Individually paying: ( ) Self-employed ( ) OFW ( ) Others ( ) OWWA ☐ Indigent ☐ Retiree/Pensioner: ( ) SSS ( ) GSIS ( ) Military ( ) Judiciary

Identification No.

2. Name of Member
Last Name
First Name
Middle Name

3. Date of Birth
m m d d y y y y

4. Civil Status ☐ Single ☐ Separated ☐ Married ☐ Widow/er

5. Sex ☐ Male ☐ Female

6. Address of Member
No., Street
Barangay
Municipality/City
Province
Zip Code

7. Name of Spouse
Last Name
First Name
Middle Name
☐ Not Applicable

8. Name of Patient ☐ Patient is the Member
Last Name
First Name
Middle Name

9. Date of Birth
m m d d y y y y

10. Age

11. Sex ☐ Male ☐ Female

12. Relationship of Patient to Member ( Check applicable box if patient is a dependent )
☐ Legitimate spouse who is not an NHIP Member.
☐ Unmarried and unemployed, legitimate, legitimated, acknowledged and illegitimate or legally adopted/step child, below 21 years old.
☐ Parent who is 60 years old and above, not an NHIP member/retiree/pensioner and wholly dependent on me for support.
☐ Unmarried child 21 years old & above with physical/ mental disability, congenital or acquired and wholly dependent on me for support.

13. CERTIFICATION of MEMBER: I certify that the foregoing information are true and correct and that the three(3) applicable monthly contributions had been paid within six(6) month prior to the month of this confinement.

Signature of Member

Printed Name & Signature of Witness to Thumbmark

If unable to write, affix Right thumbmark

### PART II - EMPLOYER'S CERTIFICATION (For employed members only)

14. Registered Name of Employer

Identification No. of Employer

15. Address of Employer ( No., Street, Barangay/Municipality/City, Province, Zip Code )
No., Street
Barangay
Municipality/City
Province
Zip Code

16. CERTIFICATION of EMPLOYER: This is to certify that three(3) applicable monthly contributions were collected during the six(6) month period prior to the month of this confinement and that the *data supplied by the member on Part I are true and conform with our available records.*

Signature Over Printed Name of Authorized Representative | Date Signed | Official Capacity

✂ -- cut here

Member's Copy

This portion should be completely filled up, detached by the hospital and given to member

ACKNOWLEDGEMENT RECEIPT

Name of Member : _____ SSS/GSIS/MEC/PhilHealth No. : _____

Name of Patient : _____ Confinement Period : _____

Name of Hospital : PhilHealth Forms Received by : _____

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# PHILHEALTH

CLAIM FORM 2
Revised May 2000

## HEALTH CARE PROVIDER'S CERTIFICATION

( DATE RECEIVED )

NOTE: THIS FORM TOGETHER WITH CLAIM FORM 1 SHOULD BE FILED WITH PHILHEALTH WITHIN 60 CALENDAR DAYS FROM DATE OF DISCHARGE.

### PART I - HOSPITAL DATA AND CHARGES ( Hospital to Fill In All Items )

1. PhilHealth Accreditation No.
2. Accreditation Category ☐ Primary ☐ Secondary ☐ Tertiary ☐ Ambulatory
3. Name of Hospital/Ambulatory Clinic
4. Address of Hospital/Ambulatory Clinic
   No., Street — Barangay
   Municipality/City — Province — Zip Code
5. Name of Member and Identification
   Last Name — First Name
   Middle Name — Identification No.
6. Address of Member
   No., Street — Barangay
   Municipality/City — Province — Zip Code
7. Name of Patient
   Last Name
   First Name
   Middle Name
8. Age
9. Sex ☐ M ☐ F
10. Admission Diagnosis
11. Confinement Period
    a. Date Admitted m m d d y y y y
    b. Time Admitted : AM/PM
    c. Date Discharged m m d d y y y y
    d. Time Discharged : AM/PM
    e. Claimed No.of Days
    f. Date of Death (If Applicable) m m d d y y y y

| 12. Hospital/Ambulatory Services | ACTUAL HOSPITAL/ AMBULATORY CHARGES | BENEFIT CLAIM | | REDUCTION CODE |
|---|---|---|---|---|
| | | HOSPITAL | PATIENT | |
| a. Room and Board | | | | |
| b. Drugs and Medicines ( Part III for details ) | | | | |
| c. X-ray/Lab. Test/Others ( Part IV for details ) | | | | |
| d. Operating Room Fee | | | | |
| e. Medicines bought & laboratory performed outside hospital during confinement period | | | | |
| TOTAL | | | | |

13. CERTIFICATION of HOSPITAL/AMBULATORY CLINIC: I certify that the services rendered are duly recorded in the patient's chart and that the information given in this form are true and correct.

Signature Over Printed Name of Authorized Representative — Date Signed — Official Capacity

### PART II - PROFESSIONAL DATA AND CHARGES ( Doctor/s to Fill In Respective Portions )

14. Complete Final Diagnosis
15. Case Type ☐ Ordinary ☐ Intensive ☐ Catastrophic
16. Name of Attending Physician — Signature & Date Signed
17. PHIC Accreditation No.
18. BIR/TIN No. - -
19. Services Performed
20. Actual Professional Charges: P — Benefit Claim: Physician P — Patient P
21. Name of Surgeon — Signature & Date Signed
22. PHIC Accreditation No.
23. BIR/TIN No. - -
24. Services Performed
    Date of Operation
25. Actual Professional Charges: P — Benefit Claim: Surgeon P — Patient P
26. Name of Anesthesiologist — Signature & Date Signed
27. PHIC Accreditation No.
28. BIR/TIN No. - -
29. Services Performed
30. Actual Professional Charges — Benefit Claim: Physician — Patient

FOR PHILHEALTH USE
Relative Unit Value
Illness Code
Reduction Code
Reduction Code
Reduction Code

368

## PART III - DRUGS AND MEDICINES

| Generic name | Brand | Preparation (cap/sy/inj/tab with ml/mg/gm content) | Qty. | Unit Price | Actual Charges | Benefit Claim | |
|---|---|---|---|---|---|---|---|
| | | | | | | Hospital | Patient |
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. | | | | | | | |
| 6. | | | | | | | |
| 7. | | | | | | | |
| 8. | | | | | | | |
| 9. | | | | | | | |
| 10 | | | | | | | |
| 11. | | | | | | | |
| 12. | | | | | | | |
| 13. | | | | | | | |
| 14. | | | | | | | |
| 15. | | | | | | | |
| | | TOTAL | | | | | |

NOTE: OFFICIAL RECEIPTS FOR DRUGS AND MEDICINES PURCHASED BY PATIENT MUST BE ATTACHED TO THIS CLAIM.

## PART IV - X-RAY, LABORATORIES AND OTHERS

| Particulars | Qty. | Unit Price | Actual Charges | Benefit Claim | |
|---|---|---|---|---|---|
| | | | | Hospital | Patient |
| A. X-ray/Lab. | | | | | |
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| B. Supplies | | | | | |
| 1. | | | | | |
| 2 | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| C. Others | | | | | |
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| TOTAL | | | | | |

NOTE: OFFICIAL RECEIPTS FOR LABORATORY PROCEDURES PERFORMED OUTSIDE THE HOSPITAL DURING CONFINEMENT PERIOD MUST BE ATTACHED TO THIS CLAIM.

## PART V - CERTIFICATION of PATIENT/MEMBER

I hereby certify that:

- ☐ The amount of P _____ was deducted from the hospital charges.
- ☐ The amount of P _____ was deducted from the professional fee charges.
- ☐ The amount of P _____ was paid for medicines/lab. acquired outside the hospital during this confinement ( Official Receipts attached ).
- ☐ No deduction was made from the hospital charges.
- ☐ No deduction was made from the professional fee charges.

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# PHILHEALTH

(DATE RECEIVED)

CLAIM FORM 3

## PATIENT'S CLINICAL RECORD

Revised May 2000

Note: This form should be filed with PhilHealth within 60 calendar days from date of discharge

Case No

Admission

Date m m d d y y y y Time AM/PM

Name of Hospital/Ambulatory Clinic

Accreditation No

Address of Hospital/Ambulatory Clinic

No. Street

Barangay

Municipality/City

Province

Zip Code

## PATIENT'S CLINICAL RECORD

1 Patient Name

Last Name

First Name

Middle Name

2 Age

3 Sex

[ ] Male

[ ] Female

4

Printed Name & Signature of Admitting Officer

5 Admitting Diagnosis

6 Chief Complaint

7 Reason for Admission

8 Brief History of Present Illness/OB History

9 Physical Examination ( Pertinent Findings per System )

General Survey:

Vital Signs: BP _____ HR _____ RR _____ Temperature _____

HEENT:

Chest/Lungs:

CVS

Abdomen

GU ( IE )

Skin/Extremities

Pertinent Laboratory and Technical Diagnostic Findings (CBC, Urinalysis, Fecalysis, X-ray, Biopsy, etc.)

12. Surgical Operation

Date [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] Time [ ] [ ] [ ] [ ] [ ] [ ] AM/PM

Printed Name & Signature of Surgeon

Printed Name & Signature of Anesthesiologist

Type of Anesthesia

13. Discharge

a. Date [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

b. Time [ ] [ ] [ ] [ ] [ ] [ ] AM/PM

c. Final Diagnosis

d. Condition at Discharge

e. Signature of Attending Physician

14. Signature or Right Thumbmark of patient or his/her representative

Printed Name & Signature of Patient or his/her Representative

Right thumbmark

(In case patient and representative could not write)

Printed Name & Signature of Witness to Thumbmark

EXHIBIT 2

Route Slip

Local Health Insurance Office 99
Unified Claims Processing System

PHIC claim route slip

Claim Number : 030120-99-01132

Patient Name : HARVEY S. ARBOLADO

Member Address : LECO BRIDGE SAMPALOC TANAY RIZAL 1990

Member Name : HENRY S. ARBOLADO

Hospital Name : 1-012025 - MORONG DOCTORS HOSPITAL

MEM PIN# : [illegible]

Date Admitted : [illegible]

Date Discharged : [illegible]

| Stage | Initial | Date In | Date Out | Deficiency Codes | Remarks |
|---|---|---|---|---|---|
| 1. Receiving | SOJ | 01/10/2003 | | | |
| 2. Medical Evaluation | | | | | |
| 3. Computation | | | | | |
| 4. Encoding/Process | | | | | |
| 5. Review/Validation | | | | | |
| 6. Payment Advice | | | | | |
| 7. Voucher Preparation | | | | | |
| 8. Check Preparation | | | | | |
| 9. Check Releasing | | | | | |
| 10. Filing of claims | | | | | |

__ RTM __ RTO __ RTO __ RTM __ Denied

Letter generated by: _____ Date: _____

# EXHIBIT 3

## List of Claims Received (LCR)

List of Claims Received
Claims Processing Division
MHIP for GSIS,SSS & Indigent Members

MORNING BATCH of 20030121
Printed: 20030123 13:06

| No | Sex | Control No | MHIP Number | Name of Patient | Name of Hospital | Remark |
|---|---|---|---|---|---|---|
| 0148 | MFG | 03012399000865 | SOS-1442609-6 | BINGCO, ROSWITA S. | MEDICAL CENTER MANILA | |
| 0149 | MFG | 03012399000866 | PI9050383A694 | CAMAHORT, JOSE ENRIQUE S. | MEDICAL CENTER MANILA | |
| 0150 | MFG | 03012399000867 | PI9050350196J | CASTRO, LEONILA EDITHA M. | MEDICAL CENTER MANILA | |
| 0151 | MFG | 03012399000868 | SOS-6751178-7 | CIPRES, LYDIA R. | MEDICAL CENTER MANILA | |
| 0152 | MFG | 03012399000870 | P0505001175845 | COMODA, CLARO P | MEDICAL CENTER MANILA | |
| 0153 | MFG | 03012399000873 | PI9025012A445 | DINGCONG, MYRNA D | MEDICAL CENTER MANILA | |
| 0154 | MFG | 03012399000874 | PI9051286930J | FLORENDO, BENITO S | MEDICAL CENTER MANILA | |
| 0155 | MFG | 03012399000876 | PI9025233400J | LIBUTAN, TERESITA D | MEDICAL CENTER MANILA | |

CLAIMS RECEIVED (Summary of Claims Received per Encoder ):

| Encoder | Total | Date/Time | Remark |
|---|---|---|---|
| LOT | 54 | | |
| HEV | 5 | | |
| 143 | 21 | | |
| INK | 10 | | |

| Encoder | Total | Date/Time | Remark |
|---|---|---|---|
| MFL | 31 | | |
| MFG | 33 | | |
| GPS | 1 | | |

RELEASED (FROM RECEIVING SECTION) : DATE: TIME: By:

RECEIVED (MEDICAL EVALUATION ) : DATE: TIME: By:

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# EXHIBIT 4

## Reduction Slip

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
NCR Claims Processing Department
14th Floor, City State Bldg, 709 Shaw Blvd, Brgy Oranbo, Pasig City

## CLAIMS PROCESSING DEPARTMENT

HOSPITAL/ADDRESS: _____

PATIENT: _____

CONFINEMENT DAYS: _____

**REDUCTION INFORMATION:**

- ☐ Overmedication*: _____
- ☐ Medicine/s used not indicated for the illness: _____
- ☐ Medicine/s used not in PNDF/PHIC inclusion list: _____
- ☐ Over utilization of laboratory & services: _____
- ☐ Overcharged**: _____
- ☐ Others: _____

_____
MEDICAL EVALUATOR

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# *DELIVER AND MANAGE BENEFITS*

# EXISTING POLICIES

## A. BENEFITS

1. The Philippine Health Insurance Corporation (PhilHealth) shall continuously endeavor to improve its benefit package to meet the needs of its members.

2. The benefits under the NHIP shall consist of the following:

   2.1 Inpatient Hospital Care

   2.1.1 Room and board

   2.1.2 Services of healthcare professionals

   2.1.3 Diagnostic, laboratory and other medical examination services

   2.1.4 Use of surgical or medical equipment and facilities

   2.1.5 Prescription drugs and biologicals

   2.1.6 Inpatient education packages

   2.2 Outpatient Care

   2.2.1 Services of healthcare professionals

   2.2.2 Diagnostic, laboratory and other medical services

   2.2.3 Personal preventive services

   2.2.4 Prescription drugs and biologicals

   2.3 Emergency and transfer services; and,

   2.4 Such other healthcare services that the Corporation determines to be appropriate and cost-effective.

3. The benefits for confinement of members and their dependents shall not exceed the following:

| Benefit Item | Hospital Category | | |
|---|---|---|---|
| | Primary | Secondary | Tertiary |
| Room and Board<br>*Not exceeding 45 days for the members and his/her dependents* | 120 / day | 220 / day | 345 / day |
| Drugs and Medicines<br>*Per single period of confinement*<br><br>Ordinary Case | | | |

| Benefit Item | Hospital Category | | |
|---|---|---|---|
| | Primary | Secondary | Tertiary |
| Drugs and Medicines | 1,165 | 1,595 | 2,670 |
| X-Ray and Lab | 305 | 760 | 1,625 |
| Intensive Case | | | |
| Drugs and Medicines | 2,430 | 3,280 | 7,660 |
| X-Ray and Lab | 590 | 1,680 | 3,405 |
| Catastrophic Case | | | |
| Drugs and Medicines | | 6,575 | 11,885 |
| X-Ray and Lab | | 3,405 | 9,810 |
| Operating Room fee for surgical procedures under the ff. brackets of RUV: | | | |
| RUV of 5.0 and below | 385 | 670 | 1,060 |
| RUV of 5.1 to 10.0 | | 1,140 | 1,350 |
| RUV above 10 units | | 2,160 | 3,490 |
| Medical / Dental Practitioner's Fees | | | |
| General Practitioner | | 105 / day | |
| Specialist | | 150 / day | |
| The practitioner's fee per single period of confinement shall not exceed: | | | |
| Ordinary Case | 540 | 540 | 540 |
| General Practitioner | 810 | 810 | 810 |
| Specialist | | | |
| Intensive / Catastrophic | 810 | 810 | 810 |
| General Practitioner | 1,350 | 1,350 | 1,350 |
| Specialist | | | |
| Surgeon's Fee | | Maximum of 15,930 | |
| Anesthesiologist Fee | | Maximum of 4,785 | |
| Fees for surgical family planning procedures: | | | |
| Vasectomy | 900 | 900 | 900 |
| Tubal Ligation | 1,125 | 1,125 | 1,125 |

4. The Corporation shall also provide outpatient services to its members, such as:

   4.1 Chemotherapy

   4.2 Radiation therapy

   4.3 Dialysis

   4.4 Cataract extraction; and,

   4.5 Minor surgical procedures performed in an operating room complex of an accredited facility.

5. The Corporation shall develop other packages including basic diagnostics and consultations with general practitioners and other packages.

6. The PhilHealth Board of Directors shall cause the inclusion of all benefits provided after it has been pilot tested to determine its viability, impact on costs and acceptability to providers and beneficiaries. In all cases, actuarial studies must be undertaken.

7. The PhilHealth Board of Directors shall provide for a basic inpatient education program as part of the benefits available to a program beneficiary. This package shall include training and instructions on disease prevention, health promotion and rehabilitation.

8. Expenses for the following services shall not be covered except when PhilHealth, after actuarial studies, recommends their inclusion subject to Board approval:

   8.1 Outpatient psychotherapy and counseling for mental disorders;

   8.2 Home and rehabilitation services;

   8.3 Normal obstetrical delivery;

   8.4 Non-prescription drugs and devices;

   8.5 Drug and alcohol abuse or dependency treatment;

   8.6 Cosmetic surgery;

   8.7 Optometric services; and,

   8.8 Cost-ineffective procedures as defined by the Corporation.

9. Members and / or their dependents shall be entitled to benefits, if the following conditions are met:

   9.1 Confinement in an accredited healthcare institution due to illness or injury requiring hospitalization; or, undergoes a surgical procedure on an outpatient basis in an accredited health care institution; or, receives outpatient benefits provided by the Corporation in an accredited health care institution.

9.2 The member must have paid at least three (3) monthly premium contributions within the immediate six (6) months prior to confinement. If covered through the Indigent Program and OWWA Medicare Program, members are entitled to avail of benefits on the date of effectivity stated in the ID card or Eligibility Certificate (EC).

10. To avail of benefits, a member must present the PhilHealth Identification Card or any proof of identification and contribution in its absence.

11. Members and/or their dependents shall be eligible to avail of benefits while they are outside the country provided the following requirements are submitted:

11.1 Official receipt of payment or statement of account from the healthcare institution where the member/dependent was confined; and,

11.2 Certification from the attending physician as to the final diagnosis, period of confinement, and services rendered.

12. Qualified dependents who have survived SSS pensioners and consequently became SSS survivorship pensioners prior to the effectivity of the Act on March 4, 1995 shall continue to be entitled to the benefits of the NHIP. The survivors shall cease to qualify as dependents for the following reasons :

12.1 Spouse

12.1.1 Gainfully employed

12.1.2 Subsequent marriage

12.2 Children

12.2.1 Gainfully employed

12.2.2 When they reach the age of 21

12.2.3 When they get married

## B. PAYMENT OF CLAIMS

1. Payment Mechanisms

1.1 Payment of a health care provider shall be made through any of the following mechanisms:

1.1.1 Fee for service;

1.1.2 Capitation of health care professionals and institutions or networks of the same, including HMOs, medical cooperatives, and other legally formed health service groups; and

1.1.3 Such other mechanisms, as may hereafter be determined by the Corporation.

2. Fee for Service Guidelines on Claims Payment

2.1 The health care provider shall file the claim using the prescribed forms.

2.2 All claims for payment of services rendered shall be filed within 60 calendar days from the date of discharge of the patient.

2.3 Claims not filed within 60 calendar days from patient's discharge date shall be barred from payment, except if the delay in the filing of the claim is due to natural calamities and other fortuitous events.

2.3.1 If the delay in the filing of claims is due to natural calamities or other fortuitous events, the healthcare provider shall be accorded an extension of 60 calendar days.

2.3.2 If the delay in the filing of the claim is caused by the healthcare provider and the NHIP benefits had already been deducted, the claim will not be paid. If the claim is not yet deducted, it will be paid to the member chargeable to the future claims of the healthcare provider.

2.4 Claims returned for completion of requirements should be re-filed within 60 calendar days from receipt of notice. The date of reckoning shall be based on the date the returned claims were received by the health care institution or member, as stamped on the envelope or receipt by the postal/courier service, if sent through the mail, or on the claims as stamped by the Corporation, in case of directly-filed claims.

2.5 When the member has complied with the requisites for availment, the healthcare provider shall deduct from the total charges, all expenses reimbursable by the Corporation upon discharge.

2.5.1 Payment of medical benefits shall be made directly to the healthcare provider.

2.5.2 Failure of an individually paying member to remit at least 3 months or one quarter contributions and to establish sufficient regularity of premium contributions as defined in this Rule shall result in the suspension of benefits.

2.5.3 Benefit availment shall be subject to the three-month waiting period. The qualifying three month premium contribution shall refer to the three regular monthly premiums within 6 months prior to availment.

2.5.4 Health care institutions are not allowed to charge processing fees from the member when claiming reimbursement from the Corporation.

- With regard to claims for multiple outpatient procedures, one claim maybe filed for multiple outpatient procedures indicating multiple dates in Form 2 which shall include hemodialysis, chemotheraphy and radiotheraphy.

- On professional fees, claims without the signature of the attending physician, surgeon, and/or anesthesiologist shall be processed but only hospital charges will be correspondingly paid. Professional fees will not be paid.

- Claims without actual charges for professional fees shall be returned to the hospital for completion. The same will actually apply to claims with concommitant to HMO benefits.

- In case the signature is not affixed, the physician may request for the payment of professional fees, provided these documents are submitted within 60 days upon receipt of refund.

2.5.5 No direct payment to the member is allowed, except in the following cases:

- The member or dependent was confined abroad;

- Drugs, medicines, and other medical supplies were bought by the member within the confinement period, supported with official receipts and used during such confinement;

- Full payment was made by the member because of failure to submit the required documents; and

- The member paid professional fees directly. In this case, the healthcare provider shall have the responsibility of informing the member of the existence of this payment option and shall issue an official receipt or waiver in favor of the member.

2.6 The Corporation may deny or reduce any benefit provided herein when the claims are attended by any of the following circumstances:

2.6.1 Over-utilization and under-utilization of services;

2.6.2 Unnecessary diagnostic and therapeutic procedures and intervention;

2.6.3 Irrational medication and prescriptions;

2.6.4 Fraud;

2.6.5 Gross, unjustified deviations from currently accepted standards of practice and/or treatment protocols;

2.6.6 Inappropriate referral practices;

2.6.7 Use of fake, adulterated or misbranded pharmaceuticals, or unregistered drugs; or,

2.6.8 Use of drugs other than those recognized in the latest PNDF and those for which exemptions were granted by the Board.

2.7 The Corporation may deny or reduce the payment for claims when such claims are attended by fraudulent, false or incorrect information and when the claimant fails without justifiable cause to comply with the pertinent provisions in the law and rules and regulations.

2.7.1 When the claim is reduced or denied, the amount thus reduced or denied shall not be charged directly or indirectly to the beneficiary involved.

2.7.2 To minimize the incidence of slashing or reduction in claim applications, policies on medical evaluation are reiterated.

2.8 The outcome of a peer review conducted by a professional organization or healthcare institution without the authority or consent of the Corporation shall not in any way bind the latter with respect to payment of claims.

2.9 All prescriptions and orders for drugs and medicines in institutional health care providers shall be in generic terminology.

2.9.1 DOH Administrative Order No. 62 s.1989,"Rules and Regulations to Implement Prescribing Requirements Under the Generics Act of 1988" shall be used as the guide in evaluating the appropriateness of prescription and written orders in the patient chart.

2.9.2 Drugs and medicines that are de-listed by the DOH through the BFAD because of failure to satisfy the eligibility standards/registration criteria and cause adverse drug reaction shall also be used as reference guide in parallel with the prescribed edition of the PNDF.

2.10 PHIC abides by the World Health Organization's ICD-10 definition of the primary illness or main condition. This definition will be used in evaluating the claims of accredited institutional health care providers for admission, beginning January 1, 2002.

2.10.1 In addition to ICD 10 codes, hospitals should continue indicating the complete diagnosis on item 14 of PHIC Claims Form 2.

2.10.2 Claims without complete diagnosis will be returned to the hospital for completion of diagnosis.

2.10.3 Claims with complete diagnosis but without ICD 10 codes shall still be processed but monitored for compliance by the QARPDG.

2.10.4 All claim applications with diagnosis not coded using the ICD 10 shall be denied effective July 1, 2001 admissions.

2.11 Primary hospitals are required to submit a copy of the prescribed PHIC Form and/or clinical records of patients in connection with their claims. Otherwise, such claims shall not be processed.

2.12 Secondary and tertiary hospitals may be required, on a case-to-case basis, to submit clinical records in order to facilitate the processing of claims.

2.12.1 All employee hospitalization claims under the Employees' Compensation Program, shall be automatically considered as claims under the NHIP. Provided, that the claim has been filed within the reglementary period of 60 calendar days.

2.12.2 When the claims filed by a healthcare institution indicate that its bed occupancy rate exceeds its accredited bed capacity, such claims shall be accompanied by a justification in writing. Otherwise, the same shall not be processed.

2.12.3 Any operation performed beyond the accredited capability of the accredited healthcare institution shall be considered a violation and a claim for such will be denied by the Corporation, except when the same is done in an emergency case or when referral to a higher category health care institution is physically impossible. Primary care hospitals shall be compensated only for simple surgical operations as determined by the Corporation.

- The policies and guidelines that govern surgical operations undertaken by primary hospitals in line with the implementation of RVS 2001 are, as follows:
  - Primary care hospitals shall only be compensated for simple surgical operations (RVU of 30 and below)
  - Any operation performed beyond the accredited capability of primary hospitals shall be denied, except when the same is done in an emergency case
  - The vasectomy and ligation / transection of fallopian tubes are construed as simple surgical operations, as their benefit value is below the preset value of a procedure with RVU 30.
  - All claims for services filed by a healthcare institution after its category is downgraded shall be paid based on rates for such downgraded category, as determined by the Corporation.
- Professional fees for services rendered by salaried healthcare providers may be retained by the healthcare institution in which services are rendered for pooling and distribution among healthcare personnel. The manner of distributing the professional fees is left to the discretion of the healthcare institution.
  - Effective June 1, 2000, payment of professional fees of accredited doctors residing and rendering service in the National Capital Region shall be made through automatic credit to their respective ATM accounts at Land Bank of the Philippines.
  - Government doctors accredited with PHIC rendering private practice will be included in the scheme provided that only claims from said practice shall be processed.

- Special discounts usually given by practitioners to their patients are not automatically considered as PhilHealth benefits. The doctor should have the responsibility to clarify to the member on how the discount should be considered and how PhilHealth benefits are accounted for, for purposes of computing the bill.

- It is suggested that doctors should issue official receipts to patients indicating the gross amount and the Medicare subsidy.

- Public healthcare institutions shall be allowed to retain charges paid for use of facilities. Such revenues shall be kept in a Trust Fund and shall be used to defray operating costs to maintain or upgrade equipment, plant or facility and to maintain or improve the quality of service in the public sector, except for remuneration of personnel services.

2.13 All claims, except those under investigation, shall be acted upon within 60 calendar days.

2.14 Hospital confinements of less than 24 hours shall not be compensated under the NHIP (CN07, s1996) except in the following instances:

2.14.1 When the patient died;

2.14.2 When the patient is transferred to another health care institution; or

2.14.3 In emergency cases

2.15 Claims of healthcare institutions that are not accredited but with current license from the DOH shall be compensated; provided, that the following conditions are met:

2.15.1 The claim is based on an emergency as determined by the Corporation.

2.15.2 Physical impossibility to transfer the patient to an accredited healthcare institution, as determined by the Corporation.

- If the above conditions are met, hospital charges, drugs, medicines and medical supplies purchased by the member shall be reimbursed.

- Professional fees of accredited healthcare professionals shall be reimbursed by the Corporation. When filed, such claims should include the complete clinical chart of the patient.

2.16 All claims of healthcare institutions that are not accredited by the Corporation and not licensed / accredited / cleared to operate by the DOH shall not be paid.

2.17 Hospitals are obliged that in cases where the member pays in full and requests the hospital to file claim in their behalf, the hospital should ensure that the documentation presents / warrants direct payment to the member by PhilHealth. In addition, the hospital should file the claim on behalf of the member within the reglementary period.

2.17.1 Hospitals/doctors should be obliged to refund the difference within thirty (30) calendar days from receipt of refund check.

2.17.2 In any instance when the member can show proof of under deduction while complete payment is made to the provider, the provider is bound to refund the balance to the member within 30 calendar days from receipt of the refund check.