



Annex E: Certificate of Classification of Priority Groups and Actual Charges for SARS-Cov-2 Test and Instruction for the Facility

[PHILHEALTH ACCREDITED SARS-CoV-2 TESTING LABORATORY/HCP LOGO]

This certificate (original, photocopy or printed scanned copy) if accomplished by the swabbing center shall be forwarded to the accredited testing laboratory. The testing laboratory together with other supporting documents should be filed within sixty (60) calendar days from the date of specimen collection for all filed claims for SARS-CoV-2 testing package.

Date

To PhilHealth:

This is to certify that based on our records, _____
Patient's last name, first name, name extension, middle name

who belongs to priority group _____ based on the current DOH applicable testing guidelines and protocol, was tested for SARS-CoV-2

at _____
Name of PhilHealth accredited SARS-CoV-2 testing laboratory/HCP

on _____ and incurred the following charges:
Date/s of specimen collection (mm/dd/yyyy)

Place a (✓) in the appropriate tick box

- No charge to patient
 If with actual charges, indicate the following:

Item	Amount (Php)
Total actual charges	
Amount after application of discounts/deductions (senior citizen persons with disability, guarantee letter, etc.)	
PhilHealth benefit package amount	

Official receipt no./s _____

DR. RICARDO B. AUDAN

Signature over printed name of the authorized testing laboratory/HCP representative

MEDICAL CENTER CHIEF II

Designation of the authorized testing laboratory/HCP representative

Date signed

Conforme:

Signature over printed name of the member/patient/ authorized representative

Date signed

Relationship of the representative to member/patient	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Siblings <input type="checkbox"/> Parents <input type="checkbox"/> Others, specify _____
Reason for signing on behalf of the member/patient	<input type="checkbox"/> Patient is incapacitated <input type="checkbox"/> Other reasons