

PATIENT:

10. Professional Fees / Charges (use additional sheet if necessary):

Accreditation Number / Name of Accredited Health Care Professional / Date Signed:	Details
Accreditation No.: <u>1201 - 9811988 - 1</u>  <p style="text-align: center;"><b>AUDAN, RICARDO BUNAG</b></p> Signature Over Printed Name  Date Signed: <u>    </u> - <u>    </u> - <u>    </u> month      day      year	<input type="checkbox"/> No Co-pay on top of PhilHealth Benefit <input type="checkbox"/> with Co-pay on top of PhilHealth Benefit P _____
Accreditation No.: <u>    </u> - <u>    </u> - <u>    </u>  Signature Over Printed Name  Date Signed: <u>    </u> - <u>    </u> - <u>    </u> month      day      year	<input type="checkbox"/> No Co-pay on top of PhilHealth Benefit <input type="checkbox"/> with Co-pay on top of PhilHealth Benefit P _____
Accreditation No.: <u>    </u> - <u>    </u> - <u>    </u>  Signature Over Printed Name  Date Signed: <u>    </u> - <u>    </u> - <u>    </u> month      day      year	<input type="checkbox"/> No Co-pay on top of PhilHealth Benefit <input type="checkbox"/> with Co-pay on top of PhilHealth Benefit P _____

**PART III - CERTIFICATION OF CONSUMPTION OF BENEFITS AND CONSENT TO ACCESS PATIENT RECORD/S**

NOTE: Member should sign only after the applicable charges have been filled-out

**A. CERTIFICATION OF CONSUMPTION OF BENEFITS**

- PhilHealth benefit is enough to cover HCI and PF charges.  
 No purchase of drugs/medicine, supplies, diagnostics, and co-pay for professional fees by the member/patient.

	Total Actual Charges*
Total Health Care Institution Fees	
Total Professional Fees	
Grand Total	

- The benefits of the member/patient was completely used up prior to co-pay OR the benefit of the member/patient is not completely consumed BUT with purchase/expenses for drugs/medicines, supplies, diagnostics and others.

a.) The total co-pay for the following are:

	Total Actual Charges*	Amount after Application of Discount (i.e., personal discount, Senior Citizen/PWD)	Philhealth Benefit	Amount after Philhealth Deduction
Total Health Care Institution Fees				Amount P Paid by (Check all that applies): <input type="checkbox"/> Member/Patient <input type="checkbox"/> HMO <input type="checkbox"/> Others (i.e., PCSO, Promissory note, etc.)
Total Professional Fees (for accredited and non-accredited professionals)				Amount P 0.00 Paid by (Check all that applies): <input type="checkbox"/> Member/Patient <input type="checkbox"/> HMO <input type="checkbox"/> Others (i.e., PCSO, Promissory note, etc.)

b.) Purchase/Expenses **NOT** included in the Health Care Institution Charges

Total cost of purchase/s for drugs/medicines and/or medical supplies bought by the patient/member within/outside the HCI during confinement	<input checked="" type="checkbox"/> NONE <input type="checkbox"/> Total Amount P _____
Total cost of diagnostic/laboratory examinations paid for by the patient/member done within/outside the HCI during confinement	<input checked="" type="checkbox"/> NONE <input type="checkbox"/> Total Amount P _____

\*NOTE: Total Actual Charges should be based on Statement of Account (SoA)

**B. CONSENT TO ACCESS PATIENT RECORD/S**

I hereby consent to the examination by PhilHealth of the patient's medical records for the sole purpose of verifying the veracity of this claim. I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim for reimbursement before PhilHealth.

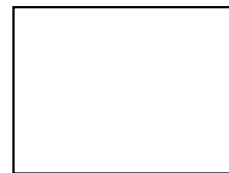
Signature Over Printed Name of Patient/Authorized Representative

Date Signed:      -      -       
                   month      day      year

- Relationship of the representative to the patient:
- Spouse     Child     Parent  
 Sibling     Others, Specify \_\_\_\_\_
- Reasons for signing on behalf of the patient:
- Patient is Incapacitated  
 Other Reasons: \_\_\_\_\_

If patient/representative is unable to write, put right thumbmark. Patient/ representative should be assisted by an HCI representative. Check the appropriate box:

Patient     Representative



**PART IV - CERTIFICATION OF HEALTH CARE INSTITUTION**

I certify that services rendered were recorded in the patient's chart and health care institution records and that the herein information given are true and correct.

**Barbara S. Cezar, DMPA**

Signature Over Printed Name of Authorized HCI Representative

**Chief Finance Officer**

Official Capacity / Designation

Date Signed:      -      -       
                   month      day      year