HCI ENGAGEMENT REGISTRATION FORM

Control No:	
Registration date:	
Request Type[1]:	☐ New ☑ Transfer ☐ Update ☐ Deactivate

HCI / RHU INFORMATION

Name of Facility		PEN	
Address of Facility			
Authorized Representative		Contact No.	
Designation of Representative		Email Address	

ACCREDITATION INFORMATION

Accreditation Number / s	Name of Facility (as appearing in the Accreditation Certificate)	PMCC Number (to be filled-up by PhilHealth)

ENGAGEMENT INFORMATION

Name of Service Provider	**KAISER-DELA CRUZ CONSULTING, INC.**	PEN	**005000000547**
Address of Service Provider	**c/o Lorma Medical Center, Carlatan, City of San Fernando, La Union**		
Authorized Representative	**Rodney J. Frigillana**	Contact No.	**+63 917-8795450**
Designation of Representative	**Systems Manager**	Email Address	**rodney.frigillana@gomedsys.com**

SYSTEM INFORMATION

Name of System	**MEDSYS**	System Version[2]	**Version 8**
Type of System	☐ In-house ☑ Outsourced	Date Implemeted[3]	
Software Certificate No.[4]	**ECLAIMS-04-01-2018-00002**	Date of Certificate Issuance[5]	**January 24, 2018**
Transmission Options[6]	☐ HITP ☐ HCI ☑ HIS ☐ EMR ☐ PHIC		

COMPLIANCE TO eCLAIMS GUIDELINES

The UNDERSIGNED shall ensure compliance to the eClaims guidelines:

1. The system implemented in the HCI shall strictly conform to the existing laws, policies and guidelines implemented by regulatory bodies and registering offices such as but not limited to the Data Privacy Act of 2012;
2. The HCI certifies that all data that shall be transmitted to PhilHealth is complete, accurate and true;
3. The HCI shall be solely responsible for the protection of their equipment and backup of data.
4. The HCI shall not hold PhilHealth liable for any loss or damages in connection with the use/distribution of PhilHealth internally developed systems and web services;
5. All requests for assistance shall be emailed to itsupport@philhealth.gov.ph;

_____ _____

Name and Signature of Authorized Representative | Date Signed

PHILHEALTH PORTION

Received by				Date Received	
SDURF No		Enrolled by		Date Enrolled	

ACCOUNT INFORMATION SLIP

CONTROL NO.

Account Name		Password	
Test Environment		Accessibility Date	
Live Environment		Accessibility Date	

GUIDELINES IN FILLING OUT THE FORM

1. Indicate the type of request. For New requests, ensure that the applications that will be used has already been validated by PhilHealth. For new and transfer requests, attach a copy of the current agreement with the service provider. For changes in the system version, tick the Update checkbox.
2. The implemented version should be the one duly validated by PhilHealth. A separate Software Compliance Test and Certificate shall be issued for every change in the system.
3. The Date for Implementation shall mean the date the system will be used to transmit the claims electronically to PhilHealth.
4. Indicate the Software Certificate No. appearing in the PhilHealth issued Software Compliance Certificate.
5. Indicate whether the system is developed in-house or outsourced. Outsourced shall mean either solutions provided by PhilHealth or a Service Provider.
6. In the Transmission Options please see below:
   a. HITP – For HCIs, select if you will use the services of the accredited Health Information Technology Providers.
   b. EMR – For RHUs, select if you will be using the services of an EMR provider.
   c. PHIC – Check if you will be using either the PHICS or the S-Claims
   d. HCI – Check if you will be using an internally developed application.
   e. HIS – Check if you are using an outsourced application not developed by the HITP or identified EMR provider.
7. The account information or the connection settings shall be sent to the email address of the authorized representative.