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| ph_logo1 | **SOFTWARE CERTIFICATION ENDORSEMENT FORM** | **Reference #:****Endorsement Date**: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_/\_\_\_\_ |
| 1. **HEALTH CARE INSTITUTION (HCI) INFORMATION**
 |
| 1 **Name** |  |
| 2 **Address** |  |
| 3 **PhilHealth Accreditation No.** |  | 7 **Cellphone No.** |  |
| 4 **Name of Head /** **Representative** |  | 8 **Landline No.** |  |
| 5 **Designation of Head /** **Representative** |  | 9 **Email Address for Notification** |  |
| 6 **Software Solution Type** (*Please check*) | □ **In-House Developed** □ **Outsourced** |
| 1. **SERVICE PROVIDER INFORMATION (***FOR OUTSOURCED SOFTWARE SOLUTION ONLY***)**
 |
| 10 **Name of Outsourcing Company** |  |
| 11 **Business Address** |  |
| 12  **Name of Business Owner/** **Authorized Representative** |  | 14 **Contact No.** |  |
| 13 **Designation of Head** **/ Representative** |  | 15 **Email Address** |  |
| 16 **PhilHealth Individual Number (PIN) or PhilHealth Employer Number (PEN)** |  |
| 1. **SOFTWARE SOLUTION (***FOR IN-HOUSE AND OUTSOURCED SOFTWARE SOLUTION***)**
 |
|  |
| 16 **Data Collection Services Applied** **For** (*Please check applicable services*) | □ **All Case Rates** □ **Newborn Care Package**□ **Animal Bite Treatment Package** □ **Outpatient HIV/AIDS Treatment Package**□ **Dialysis Package** □ **Outpatient Malaria Package** □ **Maternal-Care Package** □ **TB-Dots Package**□ **Z-Benefits** □ **Primary Care Benefit (PCB) Package** □ **Others**, *please specify* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 17 **Name/Title**  | 18 **Version No.** |  |
| **PRO CERTIFICATION AND ENDORSEMENT** |
| **The UNDERSIGNED hereby certifies that the HCI named in Item I – Health Care Institution Information has:**1. **applied for software certification for the Unified PhilHealth Electronic Claims System (UPECS);**
2. **the software solution as described in Item III – Software Solution (For In-House and Outsourced Software Solution);**
3. **undergone Stage 1 Test as conducted by our region; and**
4. **PASSED the Stage 1 Test.**

**As such, said HCI is being endorsed to ITMD-IMS for Stage 2 Test.**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Name and Signature of Head of Regional Office Date Signed**  |
| **TO BE FILLED UP BY PHILHEALTH ITMD-IMS** |
| **Received By:**(*Name and Signature*) |  | **Date Received** | \_\_/\_\_/\_\_\_\_ | **Time Received** | \_\_\_\_\_\_ □ am □ pm |
| **FINAL RESULT OF STAGE 2 TEST**  |  | **SOFTWARE CERTIFICATION #** |  |
| **APPROVED BY** |

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_< **Name of Senior Manager**>**Senior Manager, ITMD-IMS** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_<**Name of Chief Information Officer**>**Chief Information Officer, IMS** |

**BACK PAGE OF ANNEX - K**

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| **GUIDELINES IN FILLING OUT THE SOFTWARE APPLICATION FORM** |
| 1 | **Name** | Name of the HCI that appears in its accreditation |
| 2 | **Address** | Complete address of the HCI that appears in its accreditation |
| 3 | **PhilHealth Accreditation No.** | Number that appears in its accreditation |
| 4 | **Name of Head / Representative** | Complete name of the HCI Head like Chief of Hospital. The HCI Head may have authorized representative in his behalf. |
| 5 | **Designation of Head / Representative** | Title of the HCI Head or authorized representative |
| 6 | **Software Solution Type** | In-house refers to a computer software that is done or developed within the Health Care Institution; Outsourced refers to the purchase of a computer software, solution, or product from an outside source like service provider. |
| 7 | **Cellphone No.** | Cellular phone number of the HCI |
| 8 | **Landline No.** | Telephone number of the HCI |
| 9 | **Email Address for Notification** | Email address of the HCI where notifications or messages can be sent |
| 10 | **Name of Outsourcing Company** | Name of service provider if software solution is outsourced |
| 11 | **Business Address** | Complete address of the service provider |
| 12 | **Name of Business Owner/** **Authorized Representative** | Complete name of the Head or authorized representative of the Service Provider |
| 13 | **Designation of Head / Representative** | Title of the Head or authorized representative of the service provider |
| 14 | **Contact No.** | Cellphone Number and/or landline number of the service provider |
| 15 | **Email Address** | Email address of the service provider |
| 16 | **PhilHealth Individual Number (PIN) or PhilHealth Employer Number (PEN)** | The assigned PIN for individual Outsourcing Service Provider or PEN for a firm Outsourcing service provider |
| 17 | **Data Collection Services Applied For** | Services used by the Health Care Institutions to submit or transmit data for all case rates, special benefit packages or Z-benefits, outpatient Benefit packages, and other as defined by PhilHealth  |
| 18 | **Name/Title** | Name or title of the system or software to be verified |
| 19 | **Version No.** | Version reference number or code of the system or software to be verified |

**Page 1 of 2 of Annex A – Software Certification Application Form (as of July 2017)**