




## SOFTWARE SOLUTION VALIDATION TEST FORM

Software	PhilHealth eClaims Web Service
Version No.	2023.2

<b>Name of Health Care Institution/ Facility</b>			
<b>In-house</b> <input type="checkbox"/>	<b>Outsourced</b> <input type="checkbox"/>	<b>Name of Service Provider</b>	
<b>Software Name / Title</b>		<b>Version #</b>	
<b>Date of Test</b>		<b>Time of Test</b>	

CRITERIA	CYCLE # _____			CYCLE # _____			CYCLE # _____		
	P	F	Remarks	P	F	Remarks	P	F	Remarks
<b>A Data Completeness</b>									
<b>eSOA – Compliance to PC 2023-0004</b>									
The system demonstrated its capability to capture the following eSOA data elements :									
1. Summary of Fees									
a. Particulars									
b. Actual Charges									
c. VAT Exemption									
d. Senior Citizen/PWD									
e. Case Rate 1									

 <b>PhilHealth</b> <i>Your Partner in Health</i>	<h2>SOFTWARE SOLUTION VALIDATION TEST FORM</h2>
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	<ul style="list-style-type: none"> <li>f. Case Rate 2</li> <li>g. Other Funding Sources</li> <li>h. Balance</li> </ul>						
	<ul style="list-style-type: none"> <li>2. Professional Fees               <ul style="list-style-type: none"> <li>a. Physician Accreditation No. (PAN)</li> <li>b. Physician Name</li> <li>c. Amount</li> <li>d. Mandatory Discount</li> <li>e. PhilHealth Benefits</li> <li>f. Other Funding Sources</li> <li>g. Balance</li> </ul> </li> </ul>						
	<ul style="list-style-type: none"> <li>3. Itemized Billing               <ul style="list-style-type: none"> <li>a. Service Date</li> <li>b. Item Name</li> <li>c. Unit of Measurement</li> <li>d. Price</li> <li>e. Quantity</li> <li>f. Amount</li> </ul> </li> </ul>						
<b>B</b>	<b>PROCESS REQUIREMENT</b>						
	<ul style="list-style-type: none"> <li>1. The system successfully generated eSOA in XML format</li> </ul>						



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	2. The system successfully uploaded the encrypted eSOA XML data								
	3. The system successfully attached the encrypted eSOA XML data to the claim								
<b>C</b>	<b><u>SECURITY REQUIREMENT</u></b>								
	1. Encryption of XML								
	2. Decryption of XML								

**E. SECURE / ADEQUATE LINK / BANDWIDTH**

- ISP Provider : \_\_\_\_\_
- Type of Connection  
(Dedicated/not Personal): \_\_\_\_\_
- Bandwidth : \_\_\_\_\_

**RESULT:**                      **PASSED / FAILED:** \_\_\_\_\_

**EVALUATORS:**

Cycle # \_\_\_\_\_

Cycle # \_\_\_\_\_

Cycle # \_\_\_\_\_



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Position

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\_\_\_\_\_  
Position



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**Annex B: Minimum Data Elements for the SOA**

**Statement of Account**

HCP Logo: \_\_\_\_\_ SOA Reference No: \_\_\_\_\_

Name of Health Care Provider: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Contact No/s: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_  
 Address: \_\_\_\_\_ Date and Time Admitted: \_\_\_\_\_  
 Final Diagnosis (ICD-10/RVS): \_\_\_\_\_ Date and Time Discharged: \_\_\_\_\_  
 Other Diagnosis (ICD-10/RVS): 1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_

**Summary of Fees**

Fee Particulars	Amount	Maximum Discount	PhilHealth	Other Funding Sources	Balance
Room and Board	5,000.00	-	-	-	-
Drugs and Medicines	3,500.00	-	-	-	-
Laboratory and Diagnostics	4,000.00	-	-	-	-
Operating Room Fees	7,000.00	-	-	-	-
Medical Supplies	2,000.00	-	-	-	-
<b>Total</b>	<b>21,500.00</b>	<b>(8,500.00)</b>	<b>(8,500.00)</b>	<b>(2,000.00)</b>	<b>8,500.00</b>

**Professional Fees**

Physician Identification Number (check appropriate ones with account)	Physician Name	Amount	Discount	PhilHealth	Other Funding Sources	Balance
123456	Dr. Juan dela Cruz	18,750.00	(3,750.00)	-	-	15,000.00
654321	Dr. Angel Santos	21,000.00	(4,000.00)	(2,000.00)	(3,000.00)	12,000.00
<b>Total</b>						<b>27,000.00</b>

**Itemized Charges**

Service Date	Item Name	Unit of Measurement	Price	Quantity	Amount
8/10/2023	Gloves	Box	373.00	2	746.00
7/1/2023	N95 Face Mask	Box	246.00	2	492.00
<b>Total</b>					<b>1,238.00</b>

Prepared by: \_\_\_\_\_ Billing Clerk/Accountant  
 (Signature over printed name)  
 Date Signed: \_\_\_\_\_  
 Contact No.: \_\_\_\_\_

Conformed: \_\_\_\_\_ Patient/ Representative  
 (Signature over printed name)  
 Relationship of representative to patient: \_\_\_\_\_  
 Date Signed: \_\_\_\_\_  
 Contact No.: \_\_\_\_\_

MASTER COPY  
 DC: 11/3 Date: 9/5/23

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