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

Accreditation Number / Name of Accredited Health Care Professional / Date Signed	Details
Accreditation No.: ____-_________-_ Signature Over Printed Name Date Signed: __-__-____ (Month) (Day) (Year)	☐ No Co-pay on top of PhilHealth Benefit ☐ with Co-pay on top of PhilHealth Benefit P ______
Accreditation No.: ____-_________-_ Signature Over Printed Name Date Signed: __-__-____ (Month) (Day) (Year)	☐ No Co-pay on top of PhilHealth Benefit ☐ with Co-pay on top of PhilHealth Benefit P ______
Accreditation No.: ____-_________-_ Signature Over Printed Name Date Signed: __-__-____ (Month) (Day) (Year)	☐ No Co-pay on top of PhilHealth Benefit ☐ 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 facility and PF charges.
No purchases of drugs/medicines, supplies, diagnostics, and co-pay for professional fees by the member/patient.

	Total Actual Charges*
Total Health Care Institution Fees	0.00
Total Professional Fees	0.00
Grand Total	0.00

☑ The benefit of the member/patient was completely consumed prior to co-pay OR the benefit of the member/patient is not completely consumed BUT with purchases/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	7,999.82	6,399.84	6,000.00	Amount P 399.84 Paid by (Check all that applies): ☐ Member/Patient ☐ HMO ☐ Others (i.e., PCSO, Promissory note, etc.)
Total Professional Fees (for accredited and non-accredited professionals)	700.00	700.00	350.00	Amount P 350.00 Paid by (Check all that applies): ☐ Member/Patient ☐ HMO ☐ Others (i.e., PCSO, Promissory note, etc.)

b.) Purchases/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	☑ None ☐ Total Amount P ______
Total cost of diagnostic/laboratory examinations paid for by the patient/member done within/outside the HCI during confinement	☑ None ☐ 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.

Conforme of patient/authorized representative:

____
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 ______

Reason 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
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.

____
Signature Over Printed Name of Authorized HCI Representative

____
Official Capacity / Designation

Date Signed: 04-16-2025 (Month) (Day) (Year)