	<b>SOFTWARE SOLUTION VALIDATION TEST FORM</b>	
Software	PhilHealth eClaims Web Service	
Version No.	3.0	

<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>	

## PART I

CRITERIA		CYCLE # _____			CYCLE # _____			CYCLE # _____		
		Yes	No	Remarks	Yes	No	Remarks	Yes	No	Remarks
<b>STAGE 1 (for PhilHealth Regional Offices Use)</b>										
<b>A</b>	<b>I. <u>COMPLETENESS</u></b>									
	1. The system successfully received Receipt Ticket Number (RTN)?									
	2. The Transmission Control Number was generated?									
	3. The RAW Image was sent via email?									
	4. The XML was retrieved in eClaims DB using RTN/TCN?									
	5. The Screenshot of System Sign-on was									



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	Yes	No	Remarks		Yes	No	Remarks		Yes	No	Remarks
captured?											
<b>II. <u>Module I – Claims Eligibility</u></b>											
1. Is the interface for the eligibility call, with all parameters visible such as PIN (member or dependent), name, date of birth, and the option for the purpose of PBEF whether or not for outpatient hemodialysis claim?											
2. Is the printout of the PBEF compliant with the prescribed format?											
3. Does the printout PBEF passed the PBEF validator?											
4. Is there an interface for searching for an employer?											
5. Is there an interface for the verification of member PIN?											
6. Is there an interface for getting the PhilHealth Accreditation Number of healthcare professional?											
7. Is there an interface for the checking of accreditation status of healthcare professional for a specified date?											



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	Yes	No	Remarks		Yes	No	Remarks		Yes	No	Remarks
<b><u>Module 2 – Electronic Claims Submission</u></b>											
1. Is there an interface of the encoding of the Claims (CF1/CF2)?											
2. Does the system provide a notification or any mechanism indicating successful upload captured?											
3. Is there a printout of the Receipt Ticket Number/Transmission Control Number?											
4. Does the system provide mapping of the PhilHealth claim series number and health facility claim ID?											
5. Is there an interface for searching case rate?											
6. Is there an interface and notification for submitting additional documents to RTH claims?											
<b><u>Module 3 – Claims Status Verification</u></b>											
1. Is there an interface for getting the status of the claims?											
2. Is there an interface for getting the voucher information of good claim?											



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		Yes	No	Remarks		Yes	No	Remarks		Yes	No	Remarks
<b>B</b>	<b><u>DOCUMENT FORMAT AND CONTENT</u></b>											
	1. Is the PDF file compliant with PDF/A-1b format?											
	2. Are the data used reflected in the PDF and XML does not contain Personally Identifiable Information (PII)?											
	3. Are the manually submitted via email PDF files the same with PDF file shown in the NClaims Web?											
<b>C</b>	<b><u>OFFLINE</u></b>											
	1. Is there an offline data encoding?											
	2. Are the data encoded during offline mode encrypted?											
	3. Are the scanned images saved while offline?											
	4. Is the system capable of submitting offline data to PhilHealth eClaims WebService once online?											

	<h2 style="text-align: center;">SOFTWARE SOLUTION VALIDATION TEST FORM</h2>
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### PART II

	CRITERIA	CYCLE # _____				CYCLE # _____				CYCLE # _____		
		P	F	Remarks		P	F	Remarks		P	F	Remarks
	<b><u>STAGE 1 (for PhilHealth Regional Offices Use)</u></b>											
A	<b>Data Completeness</b>											
	<b><u>I. eSOA</u></b> – Compliance to PC 2023-0004											
	Did the system demonstrate its capability to capture the following eSOA data elements: (See Fig 1)?											
	1. Summary of Fees											
	a. Particulars b. Actual Charges c. VAT Exemption d. Senior Citizen/PWD e. Case Rate 1 f. Case Rate 2 g. Other Funding Sources h. Balance											



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CRITERIA	CYCLE # _____				CYCLE # _____				CYCLE # _____		
	P	F	Remarks		P	F	Remarks		P	F	Remarks
2. Professional Fees a. Physician Accreditation No. (PAN) b. Physician Name c. Amount d. Mandatory Discount e. PhilHealth Benefits f. Other Funding Sources g. Balance											
3. Itemized Billing a. Service Date b. Item Name c. Unit of Measurement d. Price e. Quantity f. Amount											
<b><u>II. QR Code</u></b>											
1. Did the system able to scan the QR code from the device of the member?											
2. Was the message validation displayed to confirm the data sharing request of the member?											



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CRITERIA	CYCLE # _____				CYCLE # _____				CYCLE # _____		
	P	F	Remarks		P	F	Remarks		P	F	Remarks
3. Are the following CF1 data of member displayed?											
a. Member Information											
b. Dependent Information (if one of the dependents is the patient)											
c. Employer's Information (if employed)											
<b><u>III. Claim Form 5 (CF 5)</u></b>											
1. Does the system accepts only (1) Primary Diagnosis (PDx)?											
2. Does the system accepts up to twelve (12) Secondary Diagnosis (SDx)?											
3. Does the system accept up to twenty (20) Procedures using RVS codes?											
4. Does the system accept laterality left right or both, as applicable?											
5. Does the system ensure there are no repeated codes across all the secondary diagnosis and with the primary diagnosis?											



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CRITERIA	CYCLE # _____				CYCLE # _____				CYCLE # _____		
	P	F	Remarks		P	F	Remarks		P	F	Remarks
6. Does the system accept extension code for each procedure, as necessary?											
7. Does the system accept admission weight for newborn patients in kilograms (kg) up to one (1) decimal place?											
<b><u>IV. eClaims Cloud Storage API (eCCSA)</u></b>											
1. Does the system has a feature to change or use multiple cloud storage to store eClaims file attachments?											
2. Are the required documents (CF4, CSF, SOA) should be viewable in NClaims application per cycle?											
3. Can the attachments be successfully downloaded?											
4. Is the data same as in RAW PDF (as provided by the HCI provider)?											





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CRITERIA	CYCLE # _____				CYCLE # _____				CYCLE # _____		
	P	F	Remarks		P	F	Remarks		P	F	Remarks
<b><u>V. CF 4</u></b>											
1. Does the system has data entry for the Height and Weight and requires to have a value?											
2. Does the system has data entry for Systolic and Diastolic for patient?											
3. Does the system able to use '1' as value for Systolic and Diastolic (1/1) for patients where BP are not available or not required and '2' for palpatory (2/2)											
4. Does the system able to use the additional library code for no medicine record?											
<b><u>VI. Data Migration</u></b>											
1. Was the system able to export all HCI data compliant to the encrypted eClaims migration format?											
2. Was the system able to import the eClaims migration file?											



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		P	F	Remarks		P	F	Remarks		P	F	Remarks
<b>B</b>	<b><u>PROCESS REQUIREMENT</u></b>											
	<b>I. <u>eSOA</u></b>											
	1. Did the system successfully generated eSOA in XML format?											
	2. Did the system successfully uploaded the encrypted eSOA XML data?											
	3. Did the system successfully attached the encrypted eSOA XML data to the claim?											
	<b>II. QR Code</b>											
	1. Does the the system able to scan and read the QR code of member?											
	2. Did the system retrieve the QR tracking?											
	3. Did the system populate the CF 1 data entry fields using the data returned by the API?	4.										



## SOFTWARE SOLUTION VALIDATION TEST FORM

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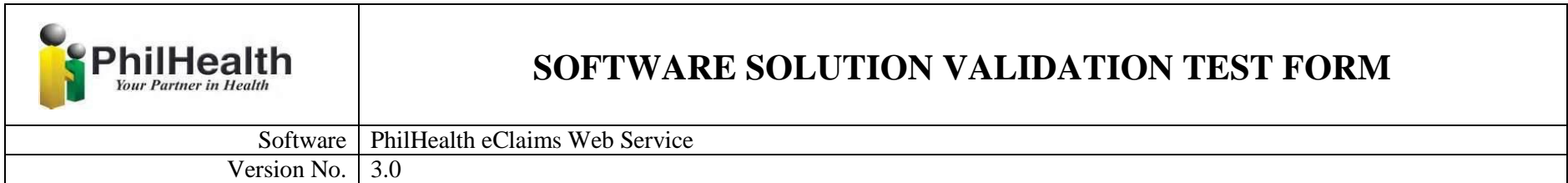
CRITERIA	CYCLE # _____				CYCLE # _____				CYCLE # _____		
	P	F	Remarks		P	F	Remarks		P	F	Remarks
<b>III. Claim Form 5 (CF 5)</b>											
1. Did the system generate CF5?											
2. Did the system allowed PhilHealth to view and validate uploaded CF5 XML?											
<b>IV. Claim Form 4 (CF4)</b>											
1. Did the system uploaded CF4 XML (with screenshot as proof)?											
<b>C Controls and Validations</b>											
<b>I. QR Code</b>											
1. Was the member data was displayed upon confirmation of the member in the confirmation dialogue box?											
2. Was the system able to display a notification indicating whether the member has cancelled or declined the authorization for data sharing?											

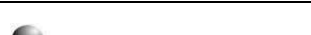


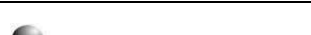
## SOFTWARE SOLUTION VALIDATION TEST FORM


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CRITERIA	CYCLE # _____				CYCLE # _____				CYCLE # _____		
	P	F	Remarks		P	F	Remarks		P	F	Remarks
3. Was the system was able to display a notification if the member has a pending action (denied/approved) onsharing of member information?											
4. Did the system displayed a notification if the transaction has expired after 5 minutes from the time of approval of the member?											
<b>II. CF 5</b>											
1. Did the system displayed warning errors and major errors?											
2. Did the system displayed c5 validation result?											
<b><u>STAGE 2 (for PhilHealth Central Office Use)</u></b>											
<b>D <u>ENCRYPTED FILE</u></b>											
1. Are the URLs of the encrypted PDF and XML files accessible to PHILHEALTH via a web browser?											



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 <b>PhilHealth</b> <i>Your Partner in Health</i>	<h1>SOFTWARE SOLUTION VALIDATION TEST FORM</h1>
Software	PhilHealth eClaims Web Service
Version No.	3.0

[illegible]


**Note:**

## Part I

- All criteria are required to be tested / evaluated.

## Part II

- CF4 and eClaims Cloud Storage API, Data Migration modules are required to be tested/evaluated.
- CF5 module and eSOA module can be jointly or separately applied for certification. (PA 2024-0032)

 <b>PhilHealth</b> <i>Your Partner in Health</i>	<h2>SOFTWARE SOLUTION VALIDATION TEST FORM</h2>
Software Version No.	PhilHealth eClaims Web Service 3.0

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

Cycle # _____  _____ Signature above Name _____ Position	Cycle # _____  _____ Signature above Name _____ Position	Cycle # _____  _____ Signature above Name _____ Position
_____ Signature above Name _____ Position	_____ Signature above Name _____ Position	_____ Signature above Name _____ Position
_____ Signature above Name _____ Position	_____ Signature above Name _____ Position	_____ Signature above Name _____ Position


 <b>PhilHealth</b> Your Partner in Health	<h2>SOFTWARE SOLUTION VALIDATION TEST FORM</h2>
Software Version No.	PhilHealth eClaims Web Service 3.0

Fig. 1 (PC 2023-0004)

**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/RV5): \_\_\_\_\_ Date and Time Discharged: \_\_\_\_\_  
Other Diagnosis (ICD-10/RV5): 1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

**Summary of Fees**

Fee Particulars	Amount	Mandatory Discount	PhilHealth	Other Funding Sources	Balance
Room and Board	3,000.00	-	-	-	-
Drugs and Medicines	3,500.00	-	-	-	-
Laboratory and Diagnostics	4,000.00	-	-	-	-
Operating Room Fees	2,000.00	-	-	-	-
Medical Supplies	2,000.00	-	-	-	-
<b>Total</b>	<b>21,500.00</b>	<b>(4,000.00)</b>	<b>(8,500.00)</b>	<b>(2,000.00)</b>	<b>8,700.00</b>

**Professional Fees**

Physician/Healthcare Provider Name (check appropriate acronym)	Physician Name	Amount	Discount	PhilHealth	Other Funding Sources	Balance
123456	Dr. Juan dela Cruz	15,500.00	(3,750.00)	-	-	11,750.00
654321	Dr. Angel Santos	21,000.00	(4,000.00)	(2,000.00)	(3,000.00)	12,000.00
<b>Total</b>						<b>23,750.00</b>

**Itemized Charges**

Service Date	Item Name	Unit of Measurement	Price	Quantity	Amount
8/30/2023	Gloves	Box	375.00	2	750.00
7/1/2023	N95 Face Mask	Box	240.00	2	480.00
<b>Total</b>					<b>1,230.00</b>

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

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

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