Statement of Account

HCP Logo

SOA Reference No: _____

Name of Health Care Provider
Address
Contact No/s.

Print Name: _____ Age: _____
Address: _____
Final Diagnosis (ICD-10/RVS): _____
Other Diagnosis (ICD-10/RVS): 1._____
2._____
3._____

Date and Time Admitted: _____
Date and Time Discharged: _____

Summary of Fees

Fee Particulars	Amount	Mandatory 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	-	-	-	-
Total	21,500.00	(4,300.00)	(6,500.00)	(2,000.00)	8,700.00

Professional Fees

Physician Accreditation Number (check appropriate term with accre)	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
Total						27,000.00

Itemized Charges

Service Date	Item Name	Unit of Measurement	Price	Quantity	Amount
6/30/2021	Gloves	Box	373.00	2	746.00
7/1/2021	N95 Face Mask	Box	246.00	2	492.00
Total					1,238.00

MASTER COPY
11/17/23
DC:

Prepared by:

_____
Billing Clerk/Accountant
(Signature over printed name)
Date Signed: _____
Contact No.: _____

Conforme:

_____
Patient/ Representative
(Signature over printed name)
Relationship of representative to patient

_____
Date Signed: _____
Contact No.: _____