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

Accreditation Number / Name of Accredited Health Care Professional / Date Signed	Details
Accreditation No.: 15041-240001-5-3 ON, LIFE G. Signature Over Printed Name Date Signed: 04-07-2025 (Month-Day-Year)	☐ No Co-pay on top of PhilHealth Benefit ☑ with Co-pay on top of PhilHealth Benefit P 650.00
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	6,000.00
Total Professional Fees	350.00
Grand Total	6,350.00

☐ 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				Amount P ____ 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)				Amount P 650.00 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: 04-10-2025 (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: 04-07-2025 (Month-Day-Year)