

## APPLICATION FOR ACCREDITATION NON-HOSPITAL HEALTH FACILITY FOR THE MATERNITY CARE PACKAGE

(Date)

**THE PRESIDENT**  
**Philippine Health Insurance Corporation**  
**Pasig City, Philippines**

**SIR:**

I, \_\_\_\_\_, Filipino, of legal age, \_\_\_\_\_ with address at \_\_\_\_\_  
(Position/Designation)

\_\_\_\_\_ and the duly authorized representative to act for and in behalf of

\_\_\_\_\_, hereby applies for accreditation under Sec. 16 L of R.A. 7875 and its Implementing  
(Health Care Institution)  
**Rules and Regulations thereto. For this purpose, I hereby submit the following pertinent information and documentary requirements.**

Name of Health Facility: _____		Type of Health Facility: _____	
Complete Address: _____			
Telephone No. _____		Zip Code _____	
Fax No: _____		E-mail Address: _____	
Date Established: _____		Director/Owner _____	
Nature of Ownership: <input type="checkbox"/> Government		<input type="checkbox"/> Private	
Type of Application: <input type="checkbox"/> Initial		<input type="checkbox"/> Renewal <input type="checkbox"/> Re-accreditation	
<b>I. CLINIC FACILITIES</b>			
<b>1. General Infrastructure</b>			
<input type="checkbox"/> Space for large and clear sign bearing name of the Health Facility	<input type="checkbox"/> Additional sign indicating it is a PhilHealth provider	<input type="checkbox"/> Space for large sign enumerating the service components of the Maternity Care Package	<input type="checkbox"/> Generally clean environment
<input type="checkbox"/> Fire safety provision	<input type="checkbox"/> Sufficient seats for patients in a well ventilated area	<input type="checkbox"/> Adequate lighting/electric supply	<input type="checkbox"/> Adequate clean water supply
<input type="checkbox"/> Covered garbage containers with color-coded segregation	<input type="checkbox"/> Separate receptacle for disposing pointed/sharp objects	<input type="checkbox"/> Private consultation/examination room or cubicle	<input type="checkbox"/> Examination table with clean linen
	<input type="checkbox"/> Delivery room with delivery table	<input type="checkbox"/> Recovery area with bed/s	<input type="checkbox"/> Area for cleaning/resuscitation of newborn
	<input type="checkbox"/> Toilet facility	<input type="checkbox"/> Area for cleaning of instruments	<input type="checkbox"/> Cleaning supplies for the facility and clinical instruments
<b>2. Basic Consultation and Delivery Room Equipment:</b>			
<input type="checkbox"/> Alligator forceps 10"	<input type="checkbox"/> Ambu bag (adult)	<input type="checkbox"/> Ambu bag (pedit)	<input type="checkbox"/> Bassinet/newborn carrier
<input type="checkbox"/> BP Apparatus	<input type="checkbox"/> Delivery table	<input type="checkbox"/> Electric Stove	<input type="checkbox"/> Foot stool
<input type="checkbox"/> Gooseneck lamp (2)	<input type="checkbox"/> Haemostatic straight forceps	<input type="checkbox"/> Instrument cabinet	<input type="checkbox"/> Instrument table
<input type="checkbox"/> IV Stand	<input type="checkbox"/> Jar with stainless cover	<input type="checkbox"/> Jar without cover	<input type="checkbox"/> Kelly pad
<input type="checkbox"/> Needle holder	<input type="checkbox"/> Ovum forceps	<input type="checkbox"/> Oxygen guage/regulator	<input type="checkbox"/> Oxygen tank (5 lbs. minimum)
<input type="checkbox"/> Pail	<input type="checkbox"/> Pick up forceps	<input type="checkbox"/> Portable emergency light or flashlight	<input type="checkbox"/> Rubber suction bulb syringe
<input type="checkbox"/> Suction apparatus	<input type="checkbox"/> Surgical scissors (straight)	<input type="checkbox"/> Tenaculum forceps	<input type="checkbox"/> Tissue forceps 6" (regular)
<input type="checkbox"/> Uterine forceps 10"	<input type="checkbox"/> Uterine sound 12"	<input type="checkbox"/> Vaginal speculum	<input type="checkbox"/> Wall clock with second hand
<input type="checkbox"/> Weighing scale (adult)	<input type="checkbox"/> Weighing scale (infant)	<input type="checkbox"/> Straight forceps 10"	
<b>3. Standard Supplies:</b>			
<input type="checkbox"/> 70 % Isopropyl Alcohol	<input type="checkbox"/> Bed sheets	<input type="checkbox"/> Butterfly set (G19)	<input type="checkbox"/> D5LR
<input type="checkbox"/> Disposable syringes w/ needles	<input type="checkbox"/> DR Gown/scrub suit	<input type="checkbox"/> IV Tubing	<input type="checkbox"/> Linen for bassinet/newborn carrier
<input type="checkbox"/> Nasal Cannula	<input type="checkbox"/> Plaster	<input type="checkbox"/> Plastic apron	<input type="checkbox"/> Povidone iodine
<input type="checkbox"/> Soaking/sterilizing solution	<input type="checkbox"/> Sterile absorbable suture with/without needle	<input type="checkbox"/> Sterile cord clips/ties for baby	<input type="checkbox"/> Sterile cotton balls
<input type="checkbox"/> Sterile cotton pledgets	<input type="checkbox"/> Sterile cutting needle	<input type="checkbox"/> Sterile drapes	<input type="checkbox"/> Sterile gauze
<input type="checkbox"/> Sterile gloves	<input type="checkbox"/> Sterile round needle	<input type="checkbox"/> Surgical cap	<input type="checkbox"/> Surgical masks
<input type="checkbox"/> Surgical masks	<input type="checkbox"/> Tape measure	<input type="checkbox"/> Thermometer (oral)	<input type="checkbox"/> Thermometer (rectal)
<input type="checkbox"/> Xylocaine/Lidocaine	<input type="checkbox"/> Methergin	<input type="checkbox"/> Tetanus toxoid	<input type="checkbox"/> Erythromycin ophthalmic ointment (0.5%)
<input type="checkbox"/> Vitamin K Ampule	<input type="checkbox"/> Progesterone only pills	<input type="checkbox"/> D-Medroxyprogesterone acetate(DMPA)	<input type="checkbox"/> Intrauterine Device (copper T)
<b>4. Means of Transport for Conduction of Patients:</b>			
<input type="checkbox"/> Transport vehicle for patient's use	<input type="checkbox"/> Contract with providers of such ambulance services		

**5. Standard FP-MCH Records/Reports/Materials:**

Consultations/Admissions logbook       Patient's Clinical Record       Printed materials/posters for patient education

Referral Forms

**II. CLINIC STAFF**

	Name	PRC No.	Validity	Signature
Provider (Midwife/Physician)				
Provider (Midwife/Physician)				
Provider (Midwife/Physician)				
Partner OB Physician				
Partner Pedia Physician				
Clinic Aide				

**III. SERVICE CAPABILITY**

Prenatal Consultation       Delivery       Postnatal including FP

**IV. QUALITY ASSURANCE ACTIVITIES (optional for initial accreditation)**

Mission/Vision       Human resource development

Clinical standard operating procedures (SOP) of performance and referral       Satisfaction surveys for employees and patients

Records Management       Compliance to monitoring and evaluation activities of PHIC

**I hereby declare under penalties of perjury that the answers given are true and correct to the best of my knowledge and belief.**

\_\_\_\_\_

**Date Accomplished**

\_\_\_\_\_

**Owner**

Res. Cert. No. \_\_\_\_\_

Issued at: \_\_\_\_\_

Issued on: \_\_\_\_\_

**Status of Application:**

Approved       Deferred       Denied

Date:      Date:      Date:

**Date Received at CO:** \_\_\_\_\_

**Date Received at PRO:** \_\_\_\_\_

**Checklist of Requirements for Non-Hospital Health Facility for Maternity Care Package**

<input type="checkbox"/> PhilHealth application form properly accomplished and notarized	<input type="checkbox"/> MOA with a physician
<input type="checkbox"/> Mayor's permits and Proofs of operation for a minimum period of three (3) years	<input type="checkbox"/> Transport vehicle or MOA with a vehicle owner
<input type="checkbox"/> Patients' records	<input type="checkbox"/> Current photographs of clinic façade and other facilities
<input type="checkbox"/> Sworn testimonies from the parish priest, other religious or community leaders	<input type="checkbox"/> Current photographs of complete Clinic Staff
<input type="checkbox"/> Tax returns of the facility for the past three (3) years	<input type="checkbox"/> Complete list of staff with respective designations
<input type="checkbox"/> Identification of precursor health facility	<input type="checkbox"/> List of equipment and supplies
<input type="checkbox"/> Accreditation Fee (P1500.00) by postal money order payable only to Philippine Health Insurance Corporation or cash paid directly to the cashier. The accreditation fee is non-refundable.	<input type="checkbox"/> List of available drugs in the clinic
<input type="checkbox"/> MOA with hospital of higher category to admit referred cases	<input type="checkbox"/> Current standard operating procedure
	<input type="checkbox"/> PhilHealth RF1
	<input type="checkbox"/> Quality Assurance activities
	<input type="checkbox"/> Location Map

**Checklist of Requirements for Renewal of Accreditation of Non-Hospital Health Facility for the Maternity Care Package**

PhilHealth application form properly accomplished and notarized       PhilHealth RF1

Accreditation Fee (P1000.00) by postal money order payable only to Philippine Health Insurance Corporation or cash paid directly to the cashier. The accreditation fee is non-refundable.

# WARRANTIES OF ACCREDITATION FOR OUT PATIENT CLINICS FOR THE MATERNITY CARE PACKAGE

## 1. ELIGIBILITY

- 1.1 That it is in operation for at least three (3) years.
- 1.2 That it is affiliated with a PHIC accredited secondary hospital;
- 1.3 That it has the human resources, equipment, physical structure and other requirements in conformity with standards established by the Corporation;
- 1.4 That it has an ongoing quality assurance activity;
- 1.5 That it has at most three (3) accredited midwives.

## 2. COMPLIANCE TO PERTINENT LAWS

- 2.1 That the aforementioned health care institution shall in the course of its participation with the NHI Program by virtue of its accreditation comply with the provisions of the National Health Insurance Law (RA 7875), its Implementing Rules and Regulations, and all administrative orders of the corporation;
- 2.2 That it shall accept the formal program of quality assurance, payment mechanism and utilization review of the NHI Program;
- 2.3 That its personnel shall strictly adhere and comply at all times with the Codes of Ethics of their respective professions and other medical related professions of the Philippines.

## 3. CLINICAL SERVICES

- 3.1 That the aforementioned health care institution shall guarantee safe, adequate and standard maternal care for all patients seeking maternal care; and shall exercise observance of public health measures in case of communicable disease;
- 3.2 That it shall adopt referral protocols, strictly follow guidelines and health resource sharing arrangements of the Program;
- 3.3 That it shall extend without delay chargeable benefits due qualified members and beneficiaries;
- 3.4 That it shall not engage in unethical and illegal solicitation of patients for purposes of compensability under the NHI program;
- 3.5 That it shall maintain serviceable equipment and facilities and required personnel.

## 4. CLINICAL RECORDS AND PREPARATION OF CLAIMS

- 4.1 That the aforementioned health care institution shall maintain and accomplish at all times accurate chronological records of all patients, services rendered, health outcomes resulting from such services and health expenditures on patient care;
- 4.2 That it shall keep neat and systematic records file in a safe but accessible place for easy retrieval;
- 4.3 That it shall undertake measures to enter only true and correct data in all patients' records and in the preparation of claims and ensure the filing of legitimate claims within the sixty (60) calendar days after the patient's discharge;
- 4.4 That I, acting on behalf of this institution, together with the concerned personnel, shall take full responsibility for any omission or commission in the preparation of claims and in the entry of clinical records.

## 5. MANAGEMENT INFORMATION SYSTEM

- 5.1 That the aforementioned health care institution shall give proper information of its accreditation status by posting the PhilHealth certificate of accreditation in a very conspicuous place in the said institution;
- 5.2 That it shall post at its billing section updated information of the Program's benefits and procedural requirements and make available the necessary forms for patient's use;
- 5.3 That it shall inform the Department of Health all reportable cases confined in the aforementioned institution;
- 5.4 That it shall immediately inform the PhilHealth in writing of any of the following changes in the institution's 1) location, 2) ownership or management, or 3) closure or temporary cessation of the outpatient clinic for the MC Package operation.

## 6. OUTPATIENT CLINIC INSPECTION / VISITATION / INVESTIGATION

- 6.1 That the aforementioned health care institution recognizes the authority of the PhilHealth and its duly authorized representative or agents deputized by PhilHealth to conduct inspection, visitation or investigation of the institution at anytime;
- 6.2 That it shall cooperate in the inspection / visitation / investigation by making ready and available all clinic records (medical & financial) and other pertinent documents;
- 6.3 That it shall obey without delay summon, subpoena or subpoena duces tecum from the Corporation or Local Health Insurance Office.

Finally, the undersigned hereby affirms that the PhilHealth, by virtue of its power under RA 7875 may suspend or revoke the accreditation of this institution if found to have violated any of the provisions of the National Health Insurance Act, or its Implementing Rules and Regulations and any of these Warranties of Accreditation.

WITNESS MY HAND AND SEAL, this \_\_\_\_\_ day of \_\_\_\_\_ 200\_ at \_\_\_\_\_.

\_\_\_\_\_  
**Administrator/Provider**  
(Signature over printed name)

Notary Public  
Until \_\_\_\_\_  
PTR No. \_\_\_\_\_  
Issued at \_\_\_\_\_  
Issued on \_\_\_\_\_

Doc. No. \_\_\_\_\_  
Book No. \_\_\_\_\_  
Page No. \_\_\_\_\_  
Series of 200\_\_