Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
ACCREDITATION DEPARTMENT
12th Floor City State Centre Bldg., 709 Shaw Blvd. Oranbo, Pasig City
Tel No. 637-62-65 Trunk line 637-99-99 loc 1215, 1216, Telefax. 637-25-27
E-mail: Accre@philhealth.gov.ph

CHECKLIST OF REQUIREMENTS FOR HOSPITAL ACCREDITATION (PRIMARY)

NAME OF HOSPITAL:_____

ADDRESS:_____

_____ **1. PhilHealth application form properly accomplished.**
_____ **2. Duly notarized Warranties of Accreditation.**
_____ **3. DOH License issued 2002.**
_____ **4. PHA / PHAP Certificate of Membership issued 2002.**
_____ **5. List of functional / serviceable equipment signed by Medical Director / Administrator (Annex A).**
_____ **6. List of current hospital's bed rates (Annex B).**
_____ **7. List of current hospital service charges (Annex C).**
_____ **8. Ancillary Licenses issued / revalidated 2001 - 2002.**
a.) Laboratory License (optional)
b.) X-ray License (optional)
c.) Hospital Pharmacy License (optional)
NOTE: ***If a certain ancillary service is present, it should comply with the requirements.***
_____ **9. Certificate of affiliation for Laboratory and X-ray License issued 2002.**
_____ **10. List of available emergency drugs.**
_____ **11. Complete list of hospital staff with respective designation indicating position as full time or part time (Annex D).**
_____ **12. Accreditation fee of P1,000.00 for Primary Hospitals by postal money order payable to Philippine Health Insurance Corporation or cash paid directly to cashier and / or photocopy of OR from PRO.**
_____ **13. Ongoing Quality Assurance Program.**
_____ **14. Photocopy of Remittance Form I (RF1) for the last quarter.**
_____ **15. Updated Health Certificate of Kitchen personnel.**
_____ **16. Fire Safety Permit for 2002.**

Additional Requirements for Initial Accreditation:

_____ **1. Current photographs of hospital façade, ER, Laboratory, Pharmacy, X-ray (optional), DR, Recovery Room, Isolation Room, CR, Records, Business Office, Nurses Station, CSS and other available hospital facilities.**
_____ **2. Current photograph of complete hospital staff.**
_____ **3. Current standard operating procedures.**
_____ **4. SEC License / DTI certificate / CDA certificate.**
_____ **5. DOH licenses of three (3) previous successive years or Mayor's Permit.**

DOCUMENTS SUBMITTED TO PRO:
Region: _____
Date Received: _____
Received By: _____
Date Refiled: _____

TO PHILHEALTH CENTRAL OFFICE:
Date Received: _____
Received By: _____
Received and Assessed By: _____

PRO staff are advised to strictly indicate the above data.

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PhilHealth ACCREDITATION FORM **1 P**
APPLICATION FOR ACCREDITATION (PRIMARY)

_____, 20___

THE PRESIDENT
Philippine Health Insurance Corporation
Pasig City, Philippines

SIR :

I, _____, Filipino of legal age, _____ with address
(Position / Designation)

at _____ and the duly authorized representative to act for and in behalf of _____, hereby applies for accreditation under
(Health Care Institution)

Sec. 16 L of R.A. 7875 and its Implementing Rules and Regulations thereto. For this purpose, I hereby submit the following pertinent information and documentary requirements.

PART I - GENERAL INFORMATION

Name of Hospital : _____

Complete Address : _____ Postal Code : _____

PhilHealth Code No. : _____ Tel No.: _____ Fax No.: _____

Date established : _____ Date of Last Accreditation : _____

Chief / Medical Director : _____ Administrator : _____

DOH License No. _____ valid from _____ to _____ issued on _____, 20__

Ownership / Management

( )	**Single Proprietorship**	**( )**	**Cooperative**
( )	**Corporation**	**( )**	**Foundation**
( )	**National Government**	**( )**	**Local Government**

Others, specify _____

A. PHYSICAL PLANT & ENVIRONMENT

1. Building

( )	**Concrete**	**( )**	**Old structure**
( )	**Semi-concrete**	**( )**	**Renovated**
( )	**Wood**	**( )**	**New structure**

2. Sanitation and Safety Standard

a. Water supply _____
b. Electric Power _____
Stand by generator ( ) Yes ( ) No
c. Sewage Disposal
Solid waste by _____

Liquid waste by _____
Pathological waste by _____

d. Fire escape ( ) Yes ( ) No
e. Fire extinguisher ( ) Yes ( ) No
f. Toilet facilites ( ) Yes ( ) No

3. Has there been any change in ownership or management ?
( ) Yes ( ) No If yes, when ? _____

4. Has the Health Care Institution transferred to another location ?
( ) Yes ( ) No If yes, where ? _____
(complete address)

5. Has there been any change in category or authorized bed capacity since last accreditation ?
( ) Yes ( ) No If yes, when ? _____ **What ?** _____

B. HOSPITAL BEDS Submit complete list of hospital's bed per room and current rates. (See Annex B)

C. MANPOWER COMPLEMENT (Indicate the Number)

	Full Time	Part Time	Visiting
1. Medical Service			
a. Consultants:			
General Surgery	_____	_____	_____
Sub-surgical Specialty	_____	_____	_____
OB-Gyn	_____	_____	_____
Pediatrics	_____	_____	_____
Internal Medicine	_____	_____	_____
Pathology	_____	_____	_____
Radiology	_____	_____	_____
Dental	_____	_____	_____
Others _____	_____	_____	_____
b. Residents	_____	_____	_____
2. Nursing Service			
a. Registered Nurse	_____	_____	_____
b. Registered Midwives	_____	_____	_____
c. Nursing Aides	_____	_____	_____
3. Pharmacist (optional)	_____	_____	_____
4. Laboratory & X-ray (optional)			
a. Medical Technologist	_____	_____	_____
b. X-ray Technologist	_____	_____	_____
5. Dentist	_____	_____	_____
6. Cook / Food Handlers	_____	_____	_____
7. Administrative Service	_____	_____	_____
8. Others	_____	_____	_____

NOTE : Submit complete list of hospital personnel. (See Annex D)

D. CLINICAL FACILITIES

( ) Emergency room
( ) Doctor's / Consultation office
( ) Clinical laboratory (optional)
Laboratory Lic. No. _____ **valid from** _____ **to** _____
Affiliation ( ) Yes ( ) No If yes, specify _____
- Laboratory Lic. No. _____ **valid from** _____ **to** _____

( ) **X-ray facility (optional)**
X-ray Lic. No. _____ valid from _____ to _____
Affiliation ( ) Yes ( ) No If yes, specify _____
- X-ray Lic. No. _____ valid from _____ to _____

( ) **Pharmacy (optional)**
Pharmacy Lic. No. _____ valid from _____ to _____

( ) **Dental room**
( ) **Drug room**
( ) **Labor room**
( ) **Delivery room**
( ) **Recovery room**
( ) **Medical Records room**
( ) **Kitchen**
( ) **Others, please specify _____**

E. EQUIPMENT **Submit complete list of existing <u>functional or serviceable</u> equipment under each facility. (Please see Annex A)**

F. CLINICAL SERVICE

( ) **General Medicine**
( ) **OB - Gyn (if with DR)**
( ) **Others, specify _____**

G. RECORDS

( ) **Admission & discharge records**
[ ] Prescribed logbook (Follow PhilHealth Cir. No. 56 s.1999, No. 38 s.2000 & No. 7 s.2002) **[ ] Computerized**

Case No.	Admission Date & Time	Name of Patient	Age	Sex	Address	Membership	Admitting Diagnosis	Final Diagnosis	Attending Physician	Disposition	Disposition Date & Time

( ) **Patient's chart**
( ) **Laboratory logbook (optional)**

Case No.	Name of Patient	Age	Sex	Type of Examination	Date of Examination

( ) **X-ray logbook (optional)**

Case No.	Name of Patient	Age	Sex	Type of Examination	Date of Examination

( ) **OPD logbook**
( ) **Outpatient surgical logbook (Minor surgery)**
( ) **Mandatory monthly hospital reports**

H. QUALITY ASSURANCE PROGRAM OF THE INSTITUTION

1. **Plan**
2. **Mission and Vision**
3. **Personnel Responsible for the Program**
4. **Activities**
5. **Minutes of Meeting**