ACEMC-PHI-04-01-01

WAIVER ON PHILHEALTH

PHILIPPINE HEALTH INSURANCE CORPORATION IS IMPLEMENTING THE NEW PHILHEALTH CIRCULAR
"ALL CASE RATES"
Case Rate – Fixed rate or amount of Philhealth benefit for a specific illness/case.

I, ✓___________________________, Member/patient/Authorized Representative, understand and agree that Philhealth benefits are granted only to members and dependents who has the following:

- Submitted complete set of requirements. (on or before the date of discharge.)
  For more other concerns please consult the Philhealth section.
- Case is compensable according to Limited List given by Philhealth:

  Medical Case Rates - based on Final Diagnosis given by the Attending Physician.
  (Final Diagnosis is given only when the patient is for discharge.)
  -must have admitted strictly 24 hours for medical case only.
  Surgical Case Rates - based on Surgical Procedures undergone by the Surgeon or Attending Physician.

That I acknowledge that I have given the right whether or not use Philhealth insurance (excluded if other insurance (HMO) are required to use Philhealth). I understand further that I am financially responsible for all hospital charges whether or not covered by Philhealth Insurance.

Philhealth benefits are NOT granted to members and dependents for the following reasons:

- Philhealth Members has lack of qualified contribution.
- Case is not compensable/covered.
- Physicians are not accredited by Philhealth Insurance
- The patient was admitted less than 24 bhours (for medical case only.)
- The patient has reached the maximum (45 day) confinement allowable per calendar year.
- Case Rate is same with the previous confinement. (before 3 months)
- Transferring patient to other hospitals with lower or same level of hospital as ACEMC.

That I understand further that if my field claims are returned to the hospital or denied by the Philhealth Insurance. I am willingly to comply and give my full cooperation to provide necessary additional requirements needed.

I understand and agree that failure that to comply may lead to invalidation of claims and I am fully responsible to pay the Philhealth coverage that being deducted to me.

That for the waiver for admission was read and explained to me, and I was not forced nor coerced when I signed the same. I hereby acknowledge that I fully understood and agreed to abide with the hospital policies institution.

Signed:
✓____________________________
Date: ✓__________________
Time: ✓__________________
Contact No.✓____________________
Relationship to the Member/Patient✓__________________

Interpreted:
____
Date: __________________
Time: __________________