

IMPLEMENTING RULES AND REGULATIONS

of the

National Health Insurance Act of 1995
(Republic Act 7875 as Amended by Republic Act 9241)

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Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION

Subject: **Implementing Rules and Regulations of the National Health Insurance Act of 1995
(Republic Act No. 7875 As Amended by Republic Act No. 9241)**

Title I - GUIDING PRINCIPLES

SECTION 1. Declaration of Principles and Policies

Section 11, Article XIII of the 1987 Constitution of the Republic of the Philippines declares that the State shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all the people at affordable cost. Priority for the needs of the underprivileged, sick, elderly, disabled, women and children shall be recognized. Likewise, it shall be the policy of the State to provide free medical care to paupers.

In the pursuit of a National Health Insurance Program (NHIP), this Implementing Rules and Regulations shall adopt the following guiding principles:

- a. **Allocation of National Resources for Health** – The NHIP shall underscore the importance for government to give priority to health as a strategy for bringing about faster economic development and improving quality of life;
- b. **Universality** – The NHIP shall provide all citizens with the mechanism to gain financial access to health services, in combination with other government health programs. The NHIP shall give the highest priority to achieving coverage of the entire population with at least a basic minimum package of health insurance benefits;
- c. **Equity** – The NHIP shall provide for uniform basic benefits. Access to care must be a function of a person's health needs rather than ability to pay;
- d. **Responsiveness** – The NHIP shall adequately meet the needs for personal health services at various stages of a member's life;
- e. **Social Solidarity** – The NHIP shall be guided by community spirit. It must enhance risk sharing among income groups, age groups, and persons of differing health status, and residing in different geographic areas;
- f. **Effectiveness** – The NHIP shall balance economical use of resources with quality of care;
- g. **Innovation** – The NHIP shall adapt to changes in medical technology, health service organizations, health care provider payment systems, scopes of professional practice, and other trends in the health sector. It must be cognizant of the appropriate roles and respective strengths of the public and private sectors in health care, including people's organizations and community-based health care organizations;
- h. **Devolution** – The NHIP shall be implemented in consultation with local government units, subject to the overall policy directions set by the National Government;
- i. **Fiduciary Responsibility** – The NHIP shall provide effective stewardship, funds management, and maintenance of reserves;

- j. **Informed Choice** – The NHIP shall encourage members to choose from among accredited health care providers. The Corporation's local offices shall objectively apprise its members of the full range of providers involved in the NHIP and of the services and privileges to which they are entitled as members. This explanation, which the members may use as a guide in selecting the appropriate and most suitable provider, shall be given in clear and simple Filipino and in the local languages that are comprehensible to the member;
- k. **Maximum Community Participation** – The NHIP shall build on existing community initiatives for its organization and human resource requirements;
- l. **Compulsory Coverage** – All citizens of the Philippines shall be required to enroll in the NHIP in order to avoid adverse selection and social inequity;
- m. **Cost-Sharing** – The NHIP shall continuously evaluate its cost-sharing schedule to ensure that costs borne by the members are fair and equitable and that the charges by health care providers are reasonable;
- n. **Professional Responsibility of Health Care Providers** – The NHIP shall assure that all participating health care providers are responsible and accountable in all their dealings with the Corporation and its members;
- o. **Public Health Services** – The Government shall be responsible for providing public health services for all groups such as women, children, indigenous people, displaced communities and communities in environmentally endangered areas, while the NHIP shall focus on the provision of personal health services. Preventive and promotive health services are essential for reducing the need and spending for personal health services;
- p. **Quality of Services** – The NHIP shall promote the improvement in the quality of health services provided through the institutionalization of programs of quality assurance at all levels of the health service delivery system. The satisfaction of the community, as well as individual beneficiaries, shall be a determinant of the quality of service delivery;
- q. **Cost Containment** – The NHIP shall incorporate features of cost containment in its design and operations and provide viable means of helping the people pay for health care services; and,
- r. **Care for the Indigent** – The Government shall be responsible for providing a basic package of needed personal health services to indigents through premium subsidy or through direct service provision until such time that the NHIP is fully implemented.

SECTION 2. General Objectives - This Implementing Rules and Regulations seeks to:

- a. provide all citizens of the Philippines with the mechanism to gain financial access to health services;
- b. establish the NHIP to serve as the means to help the people pay for health care services; and
- c. prioritize and accelerate the provision of health services to all Filipinos, especially that segment of the population who cannot afford these services.

Title II – DEFINITION OF TERMS

SECTION 3. Definition of Terms - For the purposes of this Implementing Rules and Regulations, the terms below shall be defined as follows:

- a. **Accreditation** – a process whereby the qualifications and capabilities of health care providers are verified in accordance with the guidelines, standards and procedures set by the Corporation for the purpose of

conferring upon them the privilege of participating in the NHIP and assuring that health care services rendered by them are of the desired and expected quality. Accreditation shall be any of the following:

1. **Initial Accreditation** – the accreditation given to a health care provider following the initial application or following an application treated as if it is an initial application, as provided for in this Rules.
 2. **Renewal Accreditation** – the accreditation given to a health care provider before the expiration of a previous accreditation in accordance with the provisions of this Rules.
 3. **Re-accreditation** – the accreditation given a health care provider following the expiration beyond the prescriptive period or denial of a previous accreditation, or following a change of ownership or location, or upgrading of capabilities of an institutional health care provider.
 4. **Reinstatement of Accreditation** – the restoration of accreditation following a suspension of an accreditation after compliance with the requirements, conditions and corrections imposed by the Corporation.
 5. **Provisional Accreditation** – the accreditation granted to an institutional health care provider applying for renewal while compliance with standards/requirements set by the Corporation are being completed for a period determined by the Corporation.
- b. **Accredited Collecting Agent** – a private individual or juridical entity accredited by the Corporation to receive premium contributions from members.
- c. **Act** – Republic Act No. 7875, otherwise known as the National Health Insurance Act of 1995, as amended by Republic Act No. 9241.
- d. **Benefit Package** – services that the NHIP offers to members, subject to the classification and qualifications provided for in this Rules.
- e. **Board** – the Board of Directors of the Philippine Health Insurance Corporation.
- f. **Capitation** – a payment mechanism where a fixed rate, whether per person, family, household, or group, is negotiated with a health care provider who shall be responsible for delivering or arranging for the delivery of health services required by the covered person under the conditions of a health care provider contract.
- g. **Clinical Practice Guidelines (CPG)** – systematically developed statements based on best evidence, intended to assist practitioners in making decisions about appropriate management of specific clinical conditions or diseases.
- h. **Complaint** - any case filed against a health care provider or member where the health care provider is charged with failure to comply with the warranties of accreditation or with the commission of any of the offenses enumerated in this Rules, or where the member is charged with the commission of fraudulent act/s or gross negligence in connection with his/her coverage and/or entitlement to benefits under the NHIP or any of the offenses enumerated in Title VII on Offenses and Penalties under this Rules.
- i. **Corporation** – the Philippine Health Insurance Corporation (PHIC or PhilHealth) which is mandated by law to administer the NHIP.

- j. **Coverage** – the entitlement of an individual, as a member or as a qualified dependent, to the benefits of the NHIP.
- k. **Dependent** – the legal dependents of a member who are the:
 - 1. legitimate spouse who is not a member;
 - 2. unmarried and unemployed legitimate, legitimated, acknowledged and illegitimate children as appearing in the birth certificate, and legally adopted or stepchildren below twenty-one (21) years of age;
 - 3. children who are twenty-one (21) years old or above but suffering from congenital disability, either physical or mental, or any disability acquired that renders them totally dependent on the member for support;
 - 4. parents who are sixty (60) years old or above, not otherwise an enrolled member, whose monthly income is below an amount to be determined by the Corporation in accordance with the guiding principles set forth in the Act.
- l. **Diagnostic Procedure** – any procedure to identify a disease or condition through analysis and examination.
- m. **Emergency** – an unforeseen combination of circumstances which calls for immediate action to preserve the life of a person or to preserve the sight of one or both eyes; the hearing of one or both ears; or one or two limbs at or above the ankle or wrist.
- n. **Employee** – any person who performs services for an employer in which either or both mental and physical efforts are used and who receives compensation for such services, the performance of which is under an employer-employee relationship.
- o. **Employer** – a natural or juridical person who employs the services of an employee.
- p. **Enrollment** – the process determined by the Corporation to enlist individuals as members or dependents covered by the NHIP.
- q. **Family** – a group of persons usually living together and composed of the head and other persons related to the head by blood, marriage and adoption.
- r. **Fee-for-Service** – a health care payment system in which health care providers receive a payment for each unit of service.
- s. **Global Budget** – an approach in the purchase of medical services by which health care providers negotiate the cost of providing a specific package of medical benefits based solely on a pre-determined and fixed budget as determined by the Corporation.
- t. **Government Service Insurance System (GSIS)** – the Government Service Insurance System created under Commonwealth Act No. 186, as amended by Republic Act 8291, otherwise known as the New GSIS Act of 1997.
- u. **Grievance** – a ground for complaint as provided for in this Rules by a member, dependent or health care provider who believes he/she has been aggrieved by any decision of the implementors of the NHIP. The complaint can also be filed against a member and/or health care provider by any person or by the Corporation.

v. **Gross Negligence** – the utter lack of care and diligence expected of a reasonable person as evidence by how the respondent is indifferent or oblivious to the danger of the injury to the person or property of others.

w. **Health Care Provider** – refers to:

1. A health care institution, which is duly licensed and/or accredited, devoted primarily to the maintenance and operation of facilities for health promotion, prevention, diagnosis, treatment and care of individuals suffering from illness, disease, injury, disability or deformity, drug addiction or in need of obstetrical or other medical and nursing care.

It shall also be construed as any institution, building or place where there are installed beds, cribs or bassinets for twenty-four (24) hour use or longer by patients in the treatment of disease, injuries, deformities or abnormal physical and mental states, maternity cases or sanitarial care; or infirmaries, nurseries, dispensaries, rehabilitation centers and such other similar names by which they may be designated; or,

2. A health care professional, who is any doctor of medicine, nurse, midwife, dentist, pharmacist or other health care professional or practitioner duly licensed to practice in the Philippines and accredited by the Corporation; or,
3. A health maintenance organization (HMO), which is an entity that provides, offers or arranges for coverage of designated health services needed by plan members for a fixed-pre-paid premium; or,
4. A preferred provider organization (PPO), which is a network of providers whose services are available to enrollees at lower cost than the services of non-network providers. PPO enrollees may choose any network provider at any time.
5. A community-based health care organization (CBHCO), which is an association of members of the community organized for the purpose of improving the health status of that community through preventive, promotive and curative health services.

x. **Health Education Package** – a set of informational services such as training and instruction on disease prevention, health promotion, rehabilitation and other health education packages that may be determined by the Corporation. These shall be made available by health care providers to an individual to provide him/her and his/her family with knowledge about his/her illness and its treatment, the means available to prevent the recurrence or aggravation of such illness and to promote health in general.

y. **Health Insurance Arbiter (Arbiter)** – an official of the Corporation who has been appointed or designated as such to hear and decide complaints filed against accredited health care providers and enrolled members.

z. **Health Technology** – health resource that includes drugs, devices, equipment, medical, diagnostic and surgical procedures as well as organizational, administrative and support systems.

aa. **Home Care and Medical Rehabilitation Services** – skilled nursing care, which members get in their homes/clinics for the treatment of an illness or injury that severely affects their activities or daily living. Home care and rehabilitation services include hospice or palliative care for people who are terminally ill but does not include custodial and non-skilled personal care.

bb. **Hospital Extension or Branches** – a licensed hospital facility of any category situated in another location that is owned and operated by a second or third level government or private referral hospital.

- cc. **Household Help** – a person working in a private household for pay, in cash or in kind such as domestic helper, household cook, gardener, family driver.
- dd. **Land-Based OFW** – an Overseas Filipino Worker as defined herein who is other than a sea-based OFW.
- ee. **Late Remittance** – PhilHealth premium contribution remittances made by employers after the prescribed period as provided in Section 20 (b) of this Rules.
- ff. **Local Government Premium Subsidy** – the counterpart premium that the local governments shall provide for indigents and partly paying members enrolled by the local government units where they reside.
- gg. **Local Government Units (LGUs)** – provinces, cities, municipalities, and barangays where an enrolled member resides.
- hh. **Means Test** – the protocol administered at the barangay level to determine the ability of individuals and households to pay varying levels of contributions to the NHIP, ranging from those whose contributions should be totally subsidized by the government, to those who can afford to subsidize part but not all of the required contributions, and to those who can afford to pay.
- ii. **Mechanism for Feedback** – the processes devised to inform both the Corporation and the health care providers of the data and results of the performance monitoring and outcomes assessment processes.
- jj. **Medicare** – the health insurance program initially implemented under Republic Act No. 6111 as repealed by Republic Act No. 7875, otherwise known as the National Health Insurance Act of 1995, as amended.
- kk. **Member** – any person whose premium contributions have been regularly paid to the NHIP. He/she may be a paying member, an indigent member, a privately sponsored member, or a pensioner/retiree member. Members of the NHIP are categorized as follows:

1. **Paying member**

1.1 Government Employee – an employee of the government, whether regular, casual or contractual, who renders services in any of the government branches, military or police force, political subdivisions, agencies or instrumentalities, including government-owned and-controlled corporations, financial institutions with original charter, Constitutional Commissions, and is occupying either an elective or appointive position, regardless of status of appointment.

1.2 Private Sector Employee – an employee who renders services in any of the following:

- 1.2.1 Corporations, partnerships, or single proprietorships, nongovernment organizations, cooperatives, non-profit organizations, social, civic, or professional or charitable institutions, organized and based in the Philippines;
- 1.2.2 Foreign corporations, business organizations, nongovernment organizations based in the Philippines;
- 1.2.3 Foreign governments or international organizations with quasi-state status based in the Philippines which entered into an agreement with the Corporation to cover their Filipino employees in the NHIP;
- 1.2.4 Foreign business organizations based abroad with agreement with the Corporation to cover their Filipino employees in the NHIP;
- 1.2.5 Household employers.

1.3 Individually-Paying Member – a member who is other than an employed member, an indigent member, or a retiree-member, who pays the required contribution or whose

contribution is being paid by another individual or private entity according to the rules as may be prescribed by the Corporation.

2. **Indigent Member** - a person who has no visible means of income or whose income is insufficient for the subsistence of the family, as identified based on specific criteria set by the Corporation in accordance with the guiding principles set forth in Article I of the Act.
 3. **Privately-Sponsored Member** – any person/individual whose premium contribution is being paid for by charitable organizations, duly registered associations, CBHCOs, cooperatives, private non-profit health insurance organizations or an individual through a defined criteria set by the Corporation.
 4. **Retiree-Member** – refers to:
 - 4.1 a member of the GSIS or SSS who has reached the age of retirement or who has retired on account of disability prior to the effectivity of the Act on March 4, 1995; or
 - 4.2 a pensioner of the GSIS or SSS prior to the effectivity of the Act on March 4, 1995; or
 - 4.3 a member who has reached the age of retirement as provided for by law and has paid at least 120 monthly premium contributions.
- ll. **National Contribution Subsidy** – the counterpart premium contribution that the National Government, through the Corporation, shall provide to indigents who are enrolled in the NHIP.
- mm. **National Health Insurance Program (NHIP)** – a compulsory health insurance program of the government as instituted pursuant to the National Health Insurance Act of 1995 (Republic Act No. 7875), as amended by Republic Act No. 9241, which shall provide universal health insurance coverage and ensure affordable, acceptable, available and accessible health care services for all citizens of the Philippines.
- nn. **Outcomes Assessment** – the process of monitoring and review of outcomes resulting from the health care services rendered by accredited providers. Information that can result from an outcome assessment includes knowledge and attitude changes, short-term or intermediate behavior shifts, reduction of morbidity and mortality, satisfaction of patients with care and cost, among others.
- oo. **Out-Patient Clinic** – an institution or facility with a basic team providing health services such as diagnostic consultation, examination, treatment, surgery and rehabilitation on an out-patient basis.
- pp. **Overseas or Migrant Filipino Worker** – any person, eighteen (18) years of age or above as provided in RA 8042, otherwise known as the Migrant Workers and Overseas Filipinos Act of 1995, who is to be engaged, or is engaged or has been engaged in a remunerated activity in a state of which the worker is not a legal resident.
- qq. **Overseas Workers' Welfare Administration (OWWA)** - the Overseas Workers' Welfare Administration created by Presidential Decree No. 1694, as amended.
- rr. **Peer Review** – a process by which the quality of health care provided to NHIP members or the performance of a health care professional is reviewed by professional colleagues of comparable training and experience either within the professional organization or hospital or within the Corporation itself when commissioned by the Corporation to undertake the same. The results of the said review can be utilized as basis for quality interventions and/or payment or non-payment of claims.
- ss. **Performance Monitoring** – an ongoing measurement of a variety of indicators of health care quality in the health field to identify opportunities for improvement in health care delivery.

- tt. **PhilHealth Bed** – private and government hospital beds set aside for NHIP members as may be prescribed by the Corporation.
- uu. **PhilHealth Employer Number (PEN)** – the permanent and unique number issued by the Corporation to registered employers.
- vv. **PhilHealth Identification Number (PIN)** - the permanent and unique number issued by the Corporation to its members.
- ww. **PhilHealth Identification Card** – the document issued by the Corporation to members and dependents upon their enrollment to serve as the instrument for proper identification, eligibility verification and utilization recording.
- xx. **PhilHealth Office** - the head office and other offices established by the Corporation in every province and chartered city, or wherever it is deemed practicable. Other offices can be a regional office, service office, or service desk.
- yy. **Philippine Medical Care Commission (PMCC)** – the Philippine Medical Care Commission created under Republic Act No. 6111 as repealed by RA 7875, as amended.
- zz. **Philippine National Drug Formulary (PNDF)** – the essential drugs list of the Philippines which is prepared by the Department of Health (DOH) in consultation with experts and specialists from organized professional medical societies, the academe and the pharmaceutical industry, and which is updated regularly.
- aaa. **Policy Review and Formulation** – the process of continuous research, development and evaluation of program policies that address health needs and ensure delivery of quality and cost-effective health services.
- bbb. **Portability** – the enablement of a member to avail of program benefits in an area outside the jurisdiction of the member's PhilHealth office.
- ccc. **Premium Contribution or Premium Payment** – the amount paid to the NHIP by or in behalf of a member, based on salaries or wages, on household earnings and assets, or on scheduled level of premium subsidy.
- ddd. **Prescription Drug** – a drug which has been approved by the Bureau of Food and Drugs (BFAD) and which can only be dispensed pursuant to a prescription order from a provider who is duly licensed to do so.
- eee. **Program Implementor** – any official and/or employee of the Corporation who, in the general conduct of the operations and management functions of the Corporation, is charged with the implementation of the NHIP and the enforcement of the provisions of the NHI Act of 1995 as amended by RA 9241, this Rules, and other administrative issuances related thereto, including officials and employees of other institutions who are duly authorized by virtue of a Memorandum of Agreement (MOA) to exercise any of the powers vested in the Corporation to implement the NHIP.
- fff. **Prosecutor** – an employee of the Corporation who is given the power and authority to conduct fact-finding investigation on complaints filed by any person or the Corporation against health care providers and/or members and to file and prosecute such complaints with the Health Insurance Arbiter (HIA).

- ggg. Quality Assurance** – a formal set of activities to review and ensure the quality of services provided. It includes quality assessment and corrective actions to remedy any deficiency identified in the quality of patient care, administrative and support services.
- hhh. Recidivist** – any health care provider who at the time of trial for an offense has been previously convicted by final judgment for any offense under this Rules.
- iii. Residence** – the place where a member actually lives.
- jjj. Salary** – the basic monthly compensation paid regularly for services rendered.
- kkk. Sea-Based OFW** – any person who is employed or engaged in any capacity on board a seagoing ship navigating the foreign seas other than a government ship used for military or non-commercial purposes. The definition shall include fishermen, cruise ship personnel and those serving a foreign maritime mobile offshore and drilling units.
- III. Self-Employed** – a person who works for himself/herself and is therefore both employee and employer at the same time.
- mmm. Social Security System (SSS)** – the Social Security System created under Republic Act. No. 1161, as amended by Republic Act No. 8282, otherwise known as the Social Security Act of 1997.
- nnn. Sufficient Regularity of Premium Contribution** – the payment of premium contribution of at least nine (9) months within the twelve-month period immediately prior to the month of availment.
- ooo. Therapeutic Committee** – the committee created by DOH Administrative Order No. 51 s. 1998. It shall be the highest professional body in a health care institution for drug-related issues and shall exert genuine influence in the use of drugs.
- ppp. Treatment Procedure** – any method used to remove or alleviate the signs and symptoms and/or causes of a disease.
- qqq. Utilization Review** - a formal review of health resource utilization or of the appropriateness of health care services on a prospective, concurrent, or retrospective basis.
- rrr. Wage** – the price of labor as income to the employee and as cost to the employer.

Title III – MEMBERSHIP AND CONTRIBUTIONS

Rule I COVERAGE

SECTION 4. Objective – It is the main objective of the NHIP to provide all Filipinos with the mechanism to gain financial access to quality health care services within the first 15 years of its implementation. Coverage of the employed members in the government and private sectors, individually-paying, retirees, and indigent families shall be ensured.

SECTION 5. Nature and Scope - The NHIP shall cover the following members and their dependents:

1. Employed
 - 1.1 Government Sector
 - 1.2 Private Sector to include household help and sea-based OFWs

2. Individually-Paying
 - 2.1 Self-Employed
 - All self-employed professionals
 - Partners and single proprietors of businesses
 - Actors and actresses, directors, scriptwriters and news correspondents who do not fall within the definition of the term “employee” in Section 3n of this Rules
 - Professional athletes, coaches, trainers and jockeys, and
 - Individual farmers and fisherfolks
 - 2.2 Land-based OFWs
 - 2.3 Privately sponsored/employed to include employers/employees of international organizations and foreign governments based in the Philippines
 - 2.4 Others including but not limited to the following:
 - Individuals who are separated from employment
 - Parents who are not qualified as legal dependents, indigents or retirees/pensioners
 - Children who are not qualified as legal dependents
 - Unemployed persons who are not qualified as indigents
 - Citizens of the Philippines residing in other countries
 - Citizens of other countries residing and/or working in the Philippines
3. Enrolled Indigents
4. Retiree-Members
 - 4.1 Old-age retirees and pensioners of the GSIS, including uniformed and non-uniformed personnel of the Armed Forces of the Philippines (AFP), Philippine National Police (PNP), Bureau of Fire Protection (BFP) and the Bureau of Jail Management and Penology (BJMP) who have reached the compulsory age of retirement before June 24, 1997, and retirees under Presidential Decree 408;
 - 4.2 GSIS disability pensioners prior to March 4, 1995;
 - 4.3 SSS pensioners prior to March 4, 1995:
 - 4.3.1 SSS permanent total disability pensioners;
 - 4.3.2 SSS death/survivorship pensioners;
 - 4.4 SSS old-age retirees/pensioners;
 - 4.5 Uniformed members of the AFP, PNP, BFP and BJMP who have reached the compulsory age of retirement on or after June 24, 1997, being the effectivity date of RA 8291 which excluded said individuals in the compulsory membership of the GSIS;
 - 4.6 Retirees and pensioners who are members of the judiciary;
 - 4.7 Retirees who are members of Constitutional Commissions and other constitutional offices;
 - 4.8 Former employees of the government and/or private sectors who have accumulated/paid at least 120 monthly premium contributions as provided for by law but separated from employment before reaching sixty (60) years old and thereafter have reached age sixty (60);
 - 4.9 Former employees of the government and/or private sectors who were separated from employment without completing 120 monthly premium contributions but continued to pay their premium

payment as individually-paying members (IPM) until completion of the required 120 monthly premium contributions and have reached age sixty (60) as provided for by law;

4.10 Individually-paying members (IPM), including SSS self-employed and voluntary members, who continued paying premium contributions to PhilHealth, have reached age sixty (60) and have met the required 120 monthly premium contributions as provided for by law; and

4.11 Retired underground mine workers who have reached the age of retirement as provided for by law and have met the minimum required premium contributions.

SECTION 6. Activities - To achieve its objectives, the Corporation shall undertake the following activities:

- a. Require the enrollment of the employed in the government and private sectors, sea-based OFWs, retirees/pensioners, and individually-paying members;
- b. Coordinate with LGUs and other stakeholders for the implementation of the government subsidy program for indigent families or the Indigent Program in their areas;
- c. Develop mechanisms for the participation of CBHCOs, HMOs, PPOs, cooperatives and other organized groups in the NHIP;
- d. Encourage associations, charitable institutions, cooperatives, private non-profit health insurance organizations/associations or individuals to mobilize funds for the enrollment of as many persons who cannot afford to pay premium contribution;
- e. Establish an efficient premium collection mechanism;
- f. Establish and maintain an updated membership and contribution database; and
- g. Undertake intensive information, education and communication (IEC), and marketing activities.

Rule II

GENERAL PROVISIONS CONCERNING ALL MEMBERS

SECTION 7. PhilHealth Identification Card – The PhilHealth Identification Card shall contain vital information which will be the basis of the member's identification, eligibility for availment of program services and other transactions with the Corporation. The issuance of the PhilHealth Identification Card shall be accompanied by a clear explanation of the enrollee's rights, privileges and obligations as a member.

A member shall be assigned a permanent and unique PhilHealth Identification Number (PIN) contained in the PhilHealth Identification Card.

SECTION 8. Replacement of Lost PhilHealth Identification Card – In case of loss, the PhilHealth Identification Card shall be replaced upon submission of an affidavit of loss, with cost chargeable to the member. A member applying for a replacement of the PhilHealth Identification Card for reasons other than loss shall be required to surrender the existing identification card.

SECTION 9. Requirements for Membership Registration – A person intending to register with the NHIP, regardless of membership category, shall submit to the Corporation the appropriate and properly accomplished membership registration form and any of the following documents:

- a. Birth Certificate;
- b. Baptismal Certificate;
- c. GSIS/SSS Member's ID;
- d. Passport;
- e. Any other valid ID/document acceptable to the Corporation.

Likewise, any person who is required by law to secure a Tax Identification Number (TIN) shall declare the same in his/her application for registration in the NHIP. In addition to the above requirement, retirees and

pensioners shall submit the approved retirement documents.

The registrant may submit a photocopy of the above-mentioned documents but the original/certified true copy should be presented for validation, if required by the Corporation.

SECTION 10. Requirements for Declaration of Dependents – Registrants who are declaring dependent/s shall also submit the following supporting document/s, whichever is/are applicable:

- a. Marriage Contract/Marriage Certificate – for dependent spouse;
- b. Birth/Baptismal Certificate – for dependent legitimate, illegitimate, legitimated children;
- c. Court Order on Adoption – for dependent adopted children;
- d. Birth/baptismal certificate of the member and dependent parents – for dependent parents;
- e. Marriage Contract of the parent and stepfather/stepmother and birth certificate of the dependent stepchildren – for dependent stepchildren;
- f. Joint affidavit of two (2) disinterested persons and other relevant information (date of birth, etc.) attesting to the fact of the relationship of the dependents to the supposed members except declaration of spouse;
- g. Certificate from the Department of Social Welfare and Development (DSWD) or Punong Barangay attesting to the fact of the relationship of the dependents to the supposed members;
- h. Any other valid ID or document acceptable to the Corporation.

The registrant may submit a photocopy of the above-mentioned documents but the original/certified true copy should likewise be presented for validation, if required by the Corporation.

The Corporation may prescribe a separate rule on the requirements for declaration of dependents of indigent members as may be warranted.

SECTION 11. Member Data Amendment/Revision – A member may request revision/amendment in the data previously furnished the Corporation by filling up the proper form and submitting documents to substantiate the same. The nature of this request may be any of the following:

- a. Correction/Change of Name – submit affidavit or Birth Certificate;
- b. Correction of Date of Birth – submit Birth Certificate;
- c. Change of Civil Status – submit Marriage Contract/Court Declaration on Nullity of Marriage/Death Certificate/Court Resolution for Presumptive Death;
- d. New/Additional/Change of Dependent/s – submit birth certificate of the dependent/Court Order on Adoption;
- e. Change of address - properly accomplished Member Data Amendment Form (M2).

SECTION 12. Effectivity – Membership in the NHIP shall take effect upon enrollment and payment of the required premium contribution.

SECTION 13. Remittance of Premium Contribution – Remittance of premium contribution shall be made to PhilHealth Offices or to any of the accredited collecting agents.

Rule III

SPECIFIC PROVISIONS CONCERNING EMPLOYED MEMBERS AND EMPLOYERS

SECTION 14. Government and Private Sector Employees – All government and private sector employees, including household help and sea-based OFWs, are compulsory members of the NHIP.

All officers and uniformed and non-uniformed personnel of the AFP, PNP, BJMP and BFP who entered the service after the effectivity of Republic Act No. 8291, otherwise known as the new GSIS Act, on June 24, 1997, are likewise compulsory members of the NHIP.

SECTION 15. Registration of Employers – All government and private sector employers are required to register with the Corporation and each shall be issued a permanent PhilHealth Employer Number (PEN). However, branches/regional offices and sub-units are required to register with the Corporation separately from their central/main offices.

Private sector employers, including employers of household help, who have registered with the SSS prior to July 1, 1999, are considered automatically registered. They shall be required to update their records with the Corporation.

SECTION 16. Requirements for Registration of Employers – All government agencies are required to submit the employer registration form while all private sector employers are required to submit the same together with their business permit/license to operate and/or any of the following, whichever is applicable:

1. For single proprietorships – Department of Trade and Industry (DTI) registration;
2. For partnerships and corporations – Securities and Exchange Commission (SEC) registration;
3. For foundations and other non-profit organizations – SEC registration;
4. For cooperatives – Cooperative Development Authority (CDA) registration;
5. For backyard industries/ventures and micro-business enterprises – Barangay Certification and/or Mayor's Permit.

SECTION 17. Employer Data Amendment/Revision – An employer may request revision/amendment in the data previously furnished the Corporation by accomplishing an amendment form and submitting documents to substantiate the same. The nature of this request may be any of the following:

- a. Correction/change of business name/legal personality – submit certificate of filing of business name with the DTI or Articles of Partnership/Incorporation;
- b. Temporary suspension of operation – if due to:
 1. Bankruptcy – submit
 - Financial Statement, or
 - Income Tax Return, or
 - Board Resolution
 2. Separation of employee/s - submit
 - Latest submitted prescribed PhilHealth form
 - Separation paper of last employee
 3. Fire/Demolition – submit
 - Certification from the Fire Department of the municipality or city; or
 - Certification from the concerned municipality or city government
 4. And such other fortuitous events as defined by law
- c. Termination/dissolution –
 1. For single proprietorship – submit:
 - approved application for business retirement by the Municipal Treasurer's Office
 - Death Certificate in case the owner dies to be submitted by a legal representative
 2. For partnership or corporation – submit Deed of Dissolution approved by SEC or Minutes of the Meeting certified by the corporate secretary
 3. For cooperatives – Certificate/Order of Dissolution/Cancellation issued by the CDA
 4. Under fortuitous events as defined by law – submit applicable documents as determined by the Corporation;
- d. Merger – submit Deed of Merger/Merger Agreement duly certified by SEC or Memorandum of Agreement filed with SEC;
- e. Change of ownership – submit Deed of Sale/Transfer/Assignment;

- f. Resumption of operation – submit prescribed PhilHealth form reporting newly-hired or re-hired employees. In case of closure due to fortuitous events, submit applicable documents as determined by the Corporation.

SECTION 18. Obligations of the Employer – All government and private employers are required to register their employees with the Corporation and shall be issued a permanent and unique PhilHealth Identification Number.

It is likewise the obligation of the employer to report to the Corporation its newly-hired employees within thirty (30) calendar days from assumption to office.

Further, the employer has the obligation to give notice to the Corporation of an employee's separation within thirty (30) calendar days from separation. Failure to remit the premium contribution shall make the employer liable for reimbursement of payment for a properly filed claim in case the separated employee or the dependent/s avail of NHIP benefits, without prejudice to the imposition of other penalties provided for in this Rules.

Every employer shall likewise keep true and accurate work records for such period and containing such information as the Corporation may prescribe. Such records shall be open for inspection by the Corporation or its authorized representatives.

SECTION 19. Schedule of Premium Contributions – The schedule of premium contributions shall be determined by the Corporation on the basis of applicable actuarial studies to be issued to members and employers in the government and private sectors through a PhilHealth circular. *Provided*, that the amount of premium shall not exceed three percent (3%) of the members' respective monthly salaries to be shared equally by the employer and employee.

SECTION 20. Payment of NHIP Premium Contributions –

- a. The member's monthly contribution shall be deducted and withheld automatically by the employer from the former's salary, wage or earnings. The employer's counterpart in the payment of contribution shall not in any manner be charged to the employee.
- b. The monthly premium contribution of employed members shall be remitted by the employer on or before the tenth (10th) calendar day of the month following the applicable month for which the payment is due and applicable.
- c. The remittance of premium contribution by the employer shall be supported by a Quarterly Remittance List to be submitted to the Corporation not later than fifteen (15) calendar days after the end of each calendar quarter.

The failure of the employer to remit the required contribution and to submit the required remittance list shall make the employer liable for reimbursement of payment of a properly filed claim in case the concerned employee or his/her dependent/s avails of NHIP benefits, without prejudice to the imposition of other penalties as provided for in this Rules.

- d. For government agencies, it shall be mandatory and compulsory for the employers to include the payment of contributions in their annual appropriations. The use of said funds other than for the purpose of remitting NHIP contributions will hold the erring government employers liable under the pertinent provisions of the Revised Penal Code.

- e. Failure and/or refusal of the employer to deduct or remit the complete employees' and employer's premium contribution shall not be a basis for denial of a properly filed claim. In such a case, the Corporation shall be entitled to reimbursement of claims paid from the erring or negligent employer, without prejudice to the latter's prosecution and other liabilities, as may hereafter be provided by this Rules.
- f. The last complete record of monthly contributions paid by the employer or the average of the monthly contributions paid during the past three (3) years as of the date of filing of the action for collection shall be presumed to be the monthly contributions payable by and due from the employer to the Corporation for each of the unpaid month, unless contradicted and overcome by other evidence: *Provided*, that the Corporation shall not be barred from determining and collecting the true and correct contributions due it even after full payment pursuant to this provision, nor shall the employer be relieved of his/her liability under Section 44 of RA 7875.

SECTION 21. Remittance of Premiums of Employed Members With No Earnings – Employees realizing no income for particular month/s due to non-rendition of service such as those who are on leave without pay or on extended leave but who have active employment status, including members engaged in seasonal employment, shall continue to pay premiums to the NHIP to ensure continuous entitlement to benefits.

Rule IV SPECIFIC PROVISIONS CONCERNING INDIGENT MEMBERS

SECTION 22. Negotiation with LGUs – The Corporation shall initiate the signing of a Memorandum of Agreement (MOA) with LGUs and with other concerned parties, if applicable, for the implementation of the Indigent Program in their areas.

SECTION 23. Identification of Indigent Members - The identification of indigent members shall be undertaken through the conduct of a social research survey, referred to as the means test, to determine the current socio-economic and health profile of the indigent sector in each LGU. The Community-Based Information System – Minimum Basic Needs (CBIS-MBN) approach administered at the barangay level by the City/Municipal Social Welfare and Development Office (C/MSWDO) and/or the Barangay shall be interphased with the means test protocol. The Corporation, however, reserves the right to adopt other means test mechanisms as it may deem appropriate.

The LGU and the Corporation shall give priority to the enrollment of the elderly, disabled, orphans and paupers in the Program, especially when premium donors are involved.

SECTION 24. Annual Evaluation of the List of Indigents - The list of indigent members shall be evaluated every year through a procedure prescribed by the Corporation in coordination with the concerned LGU.

SECTION 25. Grounds for Revocation/Cancellation of Membership – Membership in the Indigent Program can be revoked/cancelled by the Corporation for any of the following reasons:

- a. Non-compliance by the indigent member or any of the dependents with NHIP rules and regulations; or
- b. Employment of the member resulting to change in membership status, or an increase in the family income above the poverty threshold.

SECTION 26. Replacement of Revoked/Cancelled Membership - The LGU may propose for the replacement of the indigent member whose membership was revoked/cancelled during the membership year. The “replacement member” should also be certified by the Local SWDO and/or Barangay Official.

SECTION 27. Continuation of Coverage in Case of Death of Member – In case of death of the member, the dependents of the deceased indigent member shall continue to avail of NHIP benefits for the unexpired portion of the coverage.

The LGU and/or the premium donor may extend membership beyond the unexpired portion of the coverage to orphans of deceased members until such time that the orphans are in legal custody or guardianship of the state.

SECTION 28. Premium-Sharing Schedule for the Indigent Program – The premium contribution subsidy for indigent families shall be shared by the National Government and the LGUs as follows:

<i>Year</i>	<i>City</i>	<i>Municipality</i>	
	<i>1st-6th Class</i>	<i>1st-3rd Class</i>	<i>4th-6th Class</i>
1 st year	50-50	50-50	90-10
2 nd year			90-10
3 rd year			85-15
4 th year			80-20
5 th year			75-25
6 th year			70-30
7 th year			65-35
8 th year			60-40
9 th year			55-45
10 th year			50-50

- The city/municipal classification and the barangay classification in case of component barangays of cities shall be used in the determination of counterpart local government subsidy. It shall also be used as basis of counterpart sharing for any barangay-initiated enrollment, until such time that the Department of Finance (DOF) prescribes the income classification of barangays;
- The determination of LGU premium contribution shall in no case deprive 4th to 6th class municipalities the intended National Government subsidy;
- Any change in the income classification of the municipality shall be implemented prospectively and shall not infringe the right of the municipality to the agreed premium-sharing at the time the Memorandum of Agreement (MOA) was executed;
- The LGU premium contribution subsidy shall be remitted in accordance with the pertinent provisions of the MOA entered into by and between the Corporation and the LGU concerned and/or premium donors. A premium donor under the partial subsidy scheme may either be a government agency, a local/foreign private entity/organization, charitable organization, cooperative, or an individual person;
- The LGU premium contribution of 4th, 5th, and 6th class municipalities shall be progressively increased. However, the LGU premium contribution of 4th, 5th, and 6th class municipalities shall be made equal to that of the National Government only when they shall have been upgraded to 1st, 2nd, or 3rd class municipalities.

SECTION 29. Partial Subsidy Scheme – The partial subsidy scheme may be adopted for indigents who are proposed to be enrolled by the LGU or premium donor/s but do not qualify for full subsidy under the means test rules. The premium share of a partially subsidized member is based on the ability to pay a portion of the annual NHIP premium as determined by the Corporation.

Rule V
SPECIFIC PROVISIONS CONCERNING INDIVIDUALLY PAYING MEMBERS

SECTION 30. Self-Employed – All self-employed shall be required to enroll with the NHIP.

All self-employed and voluntary-paying members of the SSS who are already enrolled in the Medicare Program I/NHIP before July 1, 1999, are deemed automatically registered. However, they shall be required to update their membership records with the Corporation.

SECTION 31. Land-Based Overseas Filipino Workers – All land-based OFWs shall be required to enroll as individually-paying members. However, they are also required to present appropriate documents as proof of their status as OFWs.

SECTION 32. Venue for Enrollment – Enrollment for membership as individually-paying member shall be made through PhilHealth Offices or through some other mechanisms as may be prescribed by the Corporation.

SECTION 33. Cessation of Membership From Employed Sector or Indigent Program - A member of the NHIP separated from employment or whose membership coverage from the Indigent Program has ceased should pay the required premium as an Individually-Paying Member (IPM) to ensure continuous entitlement to benefits.

SECTION 34. Non-Entitlement to Benefits– An IPM whose premium contributions for at least three (3) months have not been paid within the immediate six (6) months prior to first day of his/her availment shall not be entitled to avail of the benefits of the Program.

SECTION 35. Retroactive Payment of Premium Contribution – An IPM who has missed/unpaid premium contribution and has established sufficient regularity of premium payment shall be allowed to retroactively pay within one month immediately following the missed period. *Provided*, that such member can show proof that he/she contributed thereto with sufficient regularity.

SECTION 36. Premium Contribution Schedule – The premium contribution of individually-paying members shall be at a rate prescribed by the Corporation and shall be paid quarterly, semi-annually, or annually. Land-based OFWs enrolled with the NHIP shall pay an annual contribution in an amount prescribed by the Corporation.

Rule VI
SPECIFIC PROVISION CONCERNING RETIREE-MEMBERS

SECTION 37. Employment of a Retiree-Member - A retiree-member who gains regular employment shall resume paying the required monthly premium contribution until finally separated from service.

Title IV – BENEFIT ENTITLEMENTS

Rule VII
BENEFITS

SECTION 38. Objective - The NHIP aims to provide its members with a responsive benefit package. In view of this, the Corporation shall continuously endeavor to improve its benefit package to meet the needs of its members.

SECTION 39. Activities — To achieve the above objective, the Corporation shall undertake the following activities:

- a. Introduce additional benefit items while improving those already being provided;
- b. Develop the appropriate provider payment mechanisms; and
- c. Continuously improve the system for benefit availments.

SECTION 40. Benefit Package — The benefits under the NHIP shall consist of the following:

- a. In-patient hospital care
 1. Room and board
 2. Services of health care professionals
 3. Diagnostic, laboratory, and other medical examination services
 4. Use of surgical or medical equipment and facilities
 5. Prescription drugs and biologicals;
- b. Out-patient care
 1. Services of health care professionals
 2. Diagnostic, laboratory and other medical services
 3. Use of surgical or medical equipment and facilities
 4. Personal preventive services
 5. Prescription drugs and biologicals;
- c. Health education packages;
- d. Emergency and transfer services; and
- e. Such other health care services that the Corporation determines to be appropriate and cost-effective.

The benefit package for confinement of members and their dependents shall not exceed the benefit package provided by the Corporation.

The Board shall cause the inclusion of all the benefits provided in the Act after these have been pilot-tested to determine their viability, impact on costs and acceptability to providers and members.

SECTION 41. Exclusions – Expenses for the following services shall not be covered by the NHIP except when the Corporation, after actuarial studies, recommends their inclusion subject to the approval of the Board:

- a. Fifth and subsequent normal obstetrical deliveries;
- b. Non-prescription drugs and devices;
- c. Alcohol abuse or dependency treatment;
- d. Cosmetic surgery;
- e. Optometric services; and
- f. Cost-ineffective procedures as defined by the Corporation.

Provided, that such actuarial studies must be done within a period of three (3) years, and then periodically reviewed, to determine the financial sustainability of including the foregoing personal health services in the benefit package provided for under Section 10 of the NHI Act (RA 7875) as amended.

SECTION 42. Entitlement to Benefits - A member whose premium contributions for at least three (3) months have been paid within the six (6) months prior to the first day of his or his dependents' availment, shall be entitled to the benefits of the Program: *Provided*, that such member can show that he contributed thereto with sufficient regularity, as evidenced in their health insurance ID card: and *Provided further*, that he is not currently subject to legal penalties as provided for in Section 44 of RA 7875.

The following need not pay the monthly contributions to be entitled to the Program's benefits:

1. Retirees and pensioners of the SSS and GSIS prior to the effectivity of the NHI Act of 1995;

2. Members who reach the age of retirement as provided for by law and have paid at least one hundred twenty (120) monthly contributions; and
3. Enrolled indigents.

SECTION 43. Requirements for the Availment of Benefits – To avail of NHIP benefits, a member must present the PhilHealth Identification Card/Certificate and/or any other proof of membership and contribution.

SECTION 44. Benefits of Members and their Dependents Confined Abroad – Members and/or their dependents shall be eligible to avail of benefits for confinement/s outside the country: *Provided*, that the conditions for entitlement under this Rules are met and the following requirements are submitted within one hundred eighty (180) calendar days from the date of discharge:

- a. Official receipt or any proof of payment and/or statement of account from the health care institution where the member/dependent was confined; and
- b. Certification of the attending physician as to the final diagnosis, period of confinement and services rendered.

The benefits to be granted shall be paid in the equivalent local rate based on the tertiary hospital category or the applicable case payment rate and the specialist's rate for professional fee.

SECTION 45. Benefits of Survivors of Deceased SSS Pensioners – Qualified dependents of deceased SSS members and who consequently became SSS survivorship pensioners prior to the effectivity of the Act on March 4, 1995, shall continue to be entitled to the benefits of the NHIP.

Rule VIII PAYMENT OF CLAIMS

SECTION 46. Payment Mechanisms – Payment of a health care provider shall be made through any of the following mechanisms:

- a. Fee for service;
- b. Capitation payment to health care professionals and institutions or networks of the same including HMOs, cooperatives, and other legally formed health service groups based on capitation rate guidelines set by the Corporation;
- c. Such other mechanisms as may hereafter be determined by the Corporation.

SECTION 47. Fee for Service Guidelines on Claims Payment –

- a. The health care provider shall file the claim using the prescribed PhilHealth claim forms.
- b. All claims for payment of services rendered shall be filed within sixty (60) calendar days from the date of discharge of the patient.

If the claim is sent through mail or courier, the date of mailing as stamped by the post office of origin or date received by the courier service shall be considered as the date of filing.

If the delay in the filing of claims is due to natural calamities or other fortuitous events, the health care provider shall be accorded an extension period of sixty (60) calendar days.

If the delay in the filing of claim is caused by the health care provider and the Medicare benefits had already been deducted, the claim will not be paid. If the benefits are not yet deducted, it will be paid to the member chargeable to the future claims of the health care provider.

Claims returned for completion of requirements should be re-filed within sixty (60) calendar days from receipt of notice based on the date the returned claims were received by the health care institution or member, as stamped on the envelope or the receipt issued by the postal/courier service if sent through mail, or on the claims as stamped by the Corporation in case of personally filed claims. The date of re-filing shall be the mailing date as stamped on the envelope or the receipt issued by the postal/courier service if the claim is sent through mail, or on the date stamped by the Corporation in case of personally filed claims.

- c. The health care provider shall determine in good faith the member's eligibility and substantial compliance with the requirements for availment set forth by the Corporation. It shall deduct from the total charges all expenses reimbursable by the Corporation upon discharge of the patient. The payment of NHIP benefits shall be made directly to the health care provider.

In exceptional cases, if the member fails to submit the requirements which only he/she can provide within the prescribed period, the Corporation may deny payment of the claim of the member but not the claim of the health care provider who acted in good faith, as may be determined by the Corporation.

- d. Health care institutions are not allowed to charge for PhilHealth forms and processing fees from the member when claiming reimbursement from the Corporation.
- e. Direct payment to the member is allowed only in the following cases:
 - 1. The member or dependent was confined abroad;
 - 2. Drugs, medicines and other medical supplies bought and used as well as diagnostic and therapeutic procedures done on the member or dependent within the confinement period and supported with official receipts. However, in cases of chemotherapy, dialysis and other similar cases as may be determined by the Corporation, drugs, medicines and other medical supplies purchased prior to confinement but used specifically for the procedure will be reimbursed.
 - 3. Full payment was made by the member because of failure to submit the required documents. In this case, the health care provider shall issue an official receipt or waiver in favor of the member;
 - 4. The member paid professional fees directly with official receipts issued by the attending physician showing total amount of professional fees chargeable against the entire period of confinement. In this case, the health care provider shall have the responsibility of informing the member of the existence of this payment option and shall issue an official receipt or waiver in favor of the member.
- f. The Corporation may deny or reduce any benefit provided herein when the claims are attended by any of the following circumstances:
 - 1. Over-utilization of services;
 - 2. Unnecessary diagnostic and therapeutic procedures and intervention;
 - 3. Irrational medication and prescriptions;
 - 4. Fraudulent, false or incorrect information as determined by the appropriate office;
 - 5. Gross, unjustified deviations from currently accepted standards of practice and/or treatment protocols;
 - 6. Inappropriate referral practices;
 - 7. Use of fake, adulterated or misbranded pharmaceuticals, or unregistered drugs; or
 - 8. Use of drugs other than those recognized in the latest PNDF and those for which exemptions were granted by the Board.

Drugs and medicines that are de-listed by the DOH through the BFAD because of failure to satisfy the eligibility standards/registration criteria and cause adverse drug reaction shall also be used as reference guide in parallel with the prescribed edition of the PNDF.

Further, the Corporation may deny or reduce payment of claims when the claimant fails without justifiable cause to comply with the pertinent provisions of the law and its implementing rules and regulations.

When the claim is reduced or denied, the amount thus reduced or denied shall not be charged directly or indirectly to the member.

- g. All claim applications for drugs and medicines shall be in generic terminology in conformity with DOH Administrative Order No. 62 s. 1989, "Rules and Regulations to Implement Prescribing Requirements Under the Generics Act of 1988."

The health care provider must specify the generic name, the strength and the preparation of each drug and medicine administered to the member/dependent with the corresponding price charges therefor. Otherwise, the claim shall be returned for compliance.

- h. Primary hospitals are required to submit a copy of PhilHealth Claim Form 3 of patients in connection with their claims. Otherwise, such claims shall be returned for completion.
- i. Secondary and tertiary hospitals may be required, on a case-to-case basis, to submit PhilHealth Claim Form 3 and/or clinical records and other documents such as statement of accounts, itemized billing statement and medication sheets in order to facilitate processing of claims.
- j. When the claims filed by a health care institution indicate that its bed occupancy rate exceeds its accredited bed capacity, such claims should be accompanied by a justification in writing. Otherwise, the same shall not be processed.
- k. Any operation performed beyond the accredited capability of the accredited health care institution shall be considered a violation and a claim for such shall be denied by the Corporation, except when the same is done in an emergency case or when referral to a higher category health care institution is physically impossible. Primary care hospitals shall be compensated only for simple surgical operations as determined by the Corporation.
- l. All claims for services filed by a health care institution after its category is downgraded/upgraded pursuant to this Rules shall be paid based on rates for such downgraded/upgraded category, as determined by the Corporation. In cases wherein the effectivity of change in category of the provider falls during the confinement period of a member, the payment of claims shall be computed based on the higher category.
- m. Professional fees for services rendered by salaried health care providers may be retained by the health care institution in which the services are rendered for pooling and distribution among health personnel. The manner of distributing the professional fees is left to the discretion of the health care institution.
- n. Public health care institutions shall retain charges paid for use of facilities. Such revenues shall be kept in a trust fund and shall be used to defray operating costs to maintain or upgrade equipment, plant or facility and to maintain or improve the quality of service in the public sector except for remuneration of personnel services.
- o. All claims, except those under investigation, shall be acted upon within sixty (60) calendar days from receipt of the Corporation.
- p. Hospital confinements of less than twenty-four (24) hours shall only be compensated under the following instances:
 - 1. when the patient died;

2. when the patient is transferred to another health care institution; or
 3. in emergency cases as defined by the Corporation.
- q. Claims of members confined in a non-accredited health care institution shall be compensated; *Provided*, that all of the following conditions are met:
1. the health care institution has a current DOH license;
 2. the case is emergency as determined by the Corporation; and
 3. when physical transfer/referral to an accredited health care institution is impossible as determined by the Corporation.

If the above conditions are met, hospital charges, drugs, medicines and medical supplies purchased by the member and the professional fees of health care professionals shall be reimbursed by the Corporation. *Provided*, that official receipts are submitted together with the claim. When filed, such claims should include the complete clinical chart and/or clinical summary/abstract of the patient.

All claims of health care institutions that are not accredited by the Corporation and not licensed/accredited/cleared to operate by the DOH shall not be paid.

- r. Health care institutions must give indigent members preferential access to their social welfare funds, which may be used to augment the benefit package provided, in case of insufficiency to fully cover all confinement charges.
- s. Physicians must not charge over and above the professional fees provided by the NHIP for members admitted to a PhilHealth bed.

SECTION 48. Reimbursement Limits for Drugs and Medicines – The Board shall provide for a process to determine the price index of drugs and medicines included in the PNDF and reimbursable by the Corporation. Based on the indices, the Board may from time to time set the allowable percentage mark-up in the prices of drugs and medicines charged by health care providers on members. Reimbursement shall only be made for drugs and medicines within the allowable mark-up price.

SECTION 49. Capitation Arrangement – All capitation arrangement shall be covered by a MOA by and between the Corporation and the concerned accredited health care provider.

Title V – ACCREDITATION AND QUALITY ASSURANCE

Rule IX QUALITY ASSURANCE OF THE NHIP

SECTION 50. Objective – The Corporation shall implement a Quality Assurance Program applicable to all health care providers for the delivery of health services nationwide. This program shall ensure that the health services rendered to the members by accredited health care providers are of the quality necessary to achieve the desired health outcomes and member satisfaction.

SECTION 51. Activities – To achieve the above objective, the Corporation shall undertake the following activities:

- a. Verify, through the accreditation process, the qualification and capabilities of health care providers for the purpose of conferring upon them the privilege of participating in the NHIP and assuring that the health care services they render meet the desired and expected quality;

- b. Monitor on a periodic basis, the services rendered to members by health care providers through a process of utilization review and patient satisfaction review or index;
- c. Monitor and review, through outcomes assessment, the outcomes resulting from the health care services rendered by health care providers both from the standpoint of effects on health and member satisfaction;
- d. Initiate and impose changes and corrective actions based on the results of performance monitoring and outcomes assessment to ensure quality health service by using mechanisms for feedback and change;
- e. Formulate and review program policies on health insurance based on data gathered from the conduct of the above activities, to ensure quality health services;
- f. Translate and implement quality assurance standards in the medical evaluation of claim applications for reimbursement of services rendered to members; and
- g. Undertake studies/researches that would gauge the effectiveness of the program.

Rule X ACCREDITATION

SECTION 52. Health Care Providers – The following health care providers shall be accredited before they can participate in the NHIP:

- a. Institutional Health Care Providers
 - Hospitals
 - Out-Patient Clinics
 - Health Maintenance Organizations (HMOs)
 - Preferred Provider Organizations (PPOs)
 - Community-Based Health Care Organizations (CBHCOs)
 - Other institutional health care providers licensed by the DOH
- b. Independent Health Care Professionals
 - Physicians
 - Dentists
 - Nurses
 - Midwives
 - Pharmacists
 - Other duly licensed health care professionals

Health care professionals under the employment of accredited institutional health care providers must be accredited individually when receiving from the NHIP separate reimbursement for rendering health services, whether or not such services are rendered independent of their institutions.

SECTION 53. General Accreditation Requirements and Conditions – The following requirements shall apply to all health care providers in appropriate cases:

- a. Health care institutions must have been operating for at least three (3) years prior to initial application for accreditation as defined in the succeeding section, with a good track record in the provision of health care services within the same period: *Provided*, that a health care provider which has not operated for at least three (3) years may likewise apply and qualify for accreditation if it complies with all other accreditation requirements and further meets any of the following conditions:

1. Its managing health care professional has had a working experience in another accredited health care institution for at least three (3) years;
 2. It operates as a tertiary facility or its equivalent;
 3. It operates in a local government unit where the accredited health care provider cannot adequately or fully service its population; and
 4. Other conditions as may be determined by the Corporation.
- b. Health care institutions must have the human resources, equipment, physical structure and other requirements in conformity with the standards of the relevant facility, as determined by the Corporation;
 - c. All personnel of the health care institution must be members of the NHIP;
 - d. Physicians and other health care professional must submit a Certificate of Good Standing from their respective recognized national associations. In addition, specialists must submit a Certificate of Good Standing from their respective specialty societies which are duly recognized by the Corporation in accordance with its established standards and criteria;
 - e. Health care providers must have their own ongoing formal program of quality assurance that satisfy the Corporation's standards;
 - f. They must adopt all referral protocols, practice guidelines, payment mechanisms, health resource sharing arrangements of the NHIP and other accepted standards of practice;
 - g. They must recognize and respect the rights of patients;
 - h. They must comply with all information system requirements including but not limited to reporting mechanisms established by the Corporation and maintenance of accurate records of all patients, services rendered and health outcomes resulting from such services, and health expenditures on patient care and continuous patient education;
 - i. They must accept any and all corrective actions to be prescribed by the Corporation to ensure quality of services;
 - j. They must allow the Corporation to inspect and secure reproduction of certified true copies of their medical and financial records and to visit, enter and inspect their respective premises and facilities, consistent with Section 16 m) of RA 7875;
 - k. The health care professionals must be members of the NHIP;
 - l. Health care providers must comply at all times with all the requirements and provisions of RA 7875, as amended by RA 9241, this Rules and other administrative issuances of the Corporation; and
 - m. Any other requirements that may be determined by the Corporation.

SECTION 54. Three-Year Operation Requirement - The date of reckoning of the three-year operation requirement shall be the effectivity date of either the initial license, clearance to operate, accreditation certificate, or other proof of operation issued by the Department of Health or other pertinent government agencies if applicable.

Hospitals that have temporarily stopped operation due to upgrading, expansion, change of ownership or any other causes shall have their length of operation computed on a cumulative basis from the date of the initial operation of the former hospital.

Transfer of location for the purpose of upgrading, expansion, or for any other reason acceptable to the Corporation, whether within or outside the same municipality, city or province, shall be subject to the provisions of Section 67c of this Rules and shall comply with the DOH guidelines on licensing.

Extensions or branches of accredited hospitals in another location shall be required a separate accreditation but shall not be covered by the three-year operation requirement. Moreover, the hospital extension or branches should be owned and operated by a second or third level government or private referral hospital or its equivalent. However, the original hospital should have been accredited for at least two (2) years.

Industrial hospitals or clinics that cater exclusively to employees and their dependents within the Special Economic Zones shall be eligible for accreditation: *Provided*, that the Special Economic Zones are allowed to operate such hospital or clinic by the special law or charter governing or creating them.

SECTION 55. Specific Accreditation Requirements and Conditions for Hospitals – In addition to the general requirements and conditions prescribed in this Rules, hospitals shall comply with the following specific requirements and conditions for accreditation:

- a. It must be licensed by the DOH;
- b. It must comply at all times with the provisions of Republic Act 4226, otherwise known as “The Hospital Licensure Act,” and its prevailing Implementing Rules and Regulations as well as other applicable administrative issuances;
- c. It must be a member in good standing of any national association of licensed hospitals in the Philippines duly recognized by the Corporation in accordance with its established standards and criteria;
- d. All secondary hospitals must establish a Therapeutic Committee and other committees that will ensure rational drug use; and
- e. All tertiary hospitals must establish Therapeutics and Infection Control Committees and other committees that will ensure rational drug use.

SECTION 56. Accreditation Requirements for Out-Patient Clinics - The Corporation shall prescribe the requirements and conditions for the accreditation of out-patient clinics that will support the provision of services which these facilities are accredited for.

SECTION 57. Specific Accreditation Requirements and Conditions for HMOs and PPOs – In addition to the general requirements and conditions prescribed in this Rules, HMOs and PPOs shall comply with the following specific requirements and conditions for accreditation as a direct provider of health care services to individual members or to an affiliate of accredited health care institutions:

- a. It must have a Clearance to Operate from the DOH in accordance with the provisions of Executive Order No. 119 and pertinent DOH issuances;
- b. It must be duly registered with the SEC;
- c. Its laboratory, x-ray and diagnostic facilities, if any, must comply with all the rules, regulations and licensing requirements of the DOH; and
- d. A corporate HMO must be a member in good standing of any national association of HMOs in the Philippines cleared to operate in the Philippines in accordance with subsection (a) hereof, duly recognized by the Corporation in accordance with its established standards and criteria.

A cooperative HMO must be a member of good standing of any regional or national federation of cooperatives, and must be duly recognized by the Corporation in accordance with its established standards and criteria.

SECTION 58. Specific Accreditation Requirements and Conditions for CBHCOs - In addition to the general requirements and conditions prescribed in this Rules, CBHCOs shall comply with the following specific requirements and conditions for accreditation as a direct provider of health care services to members:

- a. It must be organized, owned and/or managed by an association of members of the community for the purpose of improving the health status of the community through preventive, promotive and curative health services;
- b. It must be duly registered with the SEC and/or with the CDA; and
- c. Its laboratory, x-ray and diagnostic facilities, if any, must comply with all the rules, regulations and licensing requirements of the DOH.

SECTION 59. Accreditation Requirements for HMOs, PPOs, and CBHCOs As Financial Intermediaries – The Corporation shall prescribe the requirements and conditions for the accreditation of HMOs, PPOs, and CBHCOs as financial intermediaries.

SECTION 60. Specific Accreditation Requirements and Conditions for Physicians – In addition to the general requirements and conditions in this Rules, physicians shall comply with the following specific requirements and conditions:

- a. The physicians must be duly licensed to practice medicine in the Philippines by the Professional Regulation Commission (PRC);
- b. They must be PhilHealth members with qualifying premium contributions;
- c. Physicians must submit a Certificate of Good Standing from their respective national associations which is duly recognized by the Corporation in accordance with its established standards and criteria;
- d. They must abide by the Code of Ethics as prescribed under Section 24, Paragraph 12 of the Medical Act of 1959, as amended;
- e. They must comply with practice guidelines or protocols, peer review and payment mechanisms of the NHIP;
- f. They must not charge members over and above the professional fees provided by the NHIP for members admitted to a PhilHealth bed; and
- g. They must comply with any other requirements that may be determined by the Corporation.

SECTION 61. Specific Accreditation Requirements and Conditions for Other Health Care Professionals (Dentists, Nurses, Midwives, Pharmacists and other licensed health care professionals) – In addition to the general requirements and conditions in this Rules, dentists, nurses, midwives, pharmacists and other duly licensed health care professionals shall comply with the following specific requirements and conditions:

- a. They must be licensed to practice their profession by the PRC;
- b. They must be PhilHealth members with qualifying premium contributions;

- c. They must be a member in good standing of any national association of licensed practitioners of their profession in the Philippines duly recognized by the Corporation in accordance with its established standards and criteria;
- d. They must not charge members over and above the professional fees provided by the NHIP for members admitted to a PhilHealth bed;
- e. They must follow all practice guidelines or protocols, peer review and payment mechanisms of the NHIP; and
- f. They must comply with any other requirements that may be determined by the Corporation.

SECTION 62. Types of Accreditation – Accreditation shall be of the following types:

- a. Initial
- b. Renewal
- c. Re-accreditation
- d. Reinstatement
- e. Provisional

SECTION 63. Accreditation of Institutional Health Care Providers –

- a. The Corporation shall determine the period of accreditation and reserves the right to issue or deny accreditation after an evaluation of the capability and integrity of the health care provider.
- b. The Corporation shall determine the required documents to be submitted to comply with the requirements and conditions for accreditation. Such documents shall be subject to verification and authentication at the discretion of the Corporation.
- c. Institutional health care providers shall be visited and inspected as often and as necessary to determine compliance with the requirements and conditions for accreditation.
- d. The Corporation shall impose an accreditation fee and such other fees at rates prescribed by the President and CEO.
- e. The Corporation may limit accreditation to a specific number of beds for hospitals as well as to specific health care services and surgical operations for other institutional health care providers.
- f. Inspection and initial evaluation of application for accreditation shall be decentralized to the PhilHealth Offices. Their recommendation shall be forwarded to the Accreditation Committee for decision subject to the approval by the President and CEO.
- g. The decision of the President and CEO on all matters pertaining to accreditation shall be final and executory, unless a motion for reconsideration is filed with the Accreditation Committee within thirty (30) calendar days from receipt of such a decision. Only one motion for reconsideration shall be entertained. If the last day falls on a Saturday, Sunday, legal holiday or a declared non-working day due to *force majeure*, the motion may be filed on the next working day.

In case the motion for reconsideration is denied, an appeal may be filed with the Board within fifteen (15) calendar days from receipt.

- h. Revocation of an accreditation is permanent. It shall operate to disqualify the health care providers from obtaining another accreditation in their own name, under a different name, or through another person,

whether natural or juridical. If the facilities of the revoked institutional health care provider are transferred either by sale or lease or such other modes of conveyance, such will be treated as an application for initial accreditation. For this purpose, the three-year in operation rule shall be reckoned from the new owner's/transferee's/lessee's first license, clearance to operate, accreditation certification or other proof of operation issued by other government agency.

- i. Accreditation shall take effect prospectively. Claims for services before the effectivity of accreditation and after the expiration of accreditation shall be denied.
- j. For renewal of accreditation, applications shall be filed within thirty (30) calendar days before the ninety (90) calendar days prior to the expiration of the existing accreditation. In case of incomplete submission of the requirements, the application shall be returned for completion by the health care provider who should refile the same within thirty (30) calendar days from receipt thereof.
- k. Even after accreditation has been granted, the Corporation may decide to downgrade the category of an institutional health care provider, reduce bed capacity or suspend the accreditation due to adverse findings and reports.
- l. A provisional accreditation may be granted for a period as may be determined by the Corporation.

SECTION 64. Accreditation of Health Care Professionals –

- a. The Corporation shall determine the period of accreditation and reserves the right to issue or deny accreditation after an evaluation of the capability and integrity of the health care professional.
- b. The Corporation shall determine the documents to be submitted to comply with the requirements and conditions for accreditation. Such documents shall be subject to verification and authentication at the discretion of the Corporation.
- c. The Corporation shall impose an accreditation fee and such other fees at rates prescribed by the President and CEO.
- d. The Corporation may limit accreditation to health care professionals performing specific health care services, as applicable, depending on training, experience, capability, and specialty certification.
- e. Application for initial accreditation of health care professionals shall be approved by the President and CEO.
- f. A revocation of accreditation is permanent.
- g. Accreditation shall take effect prospectively.
- h. For renewal of accreditation, applications shall be filed within thirty (30) calendar days before the ninety (90) calendar days prior to the expiration of the existing accreditation. In case of incomplete submission of the requirements, the application shall be returned for completion by the health care professional who should refile the same within thirty (30) calendar days from receipt thereof.

SECTION 65. Initial Accreditation –

- a. Accreditation shall be given to qualified health care providers who are applying for the first time.
- b. The accreditation shall take effect upon approval of the application.

SECTION 66. Renewal of Accreditation –

- a. Accreditation shall be renewed after compliance with the requirements and conditions set forth in this Rules.
- b. A health care provider under suspension cannot apply for renewal of accreditation unless such suspension has been lifted and all requirements, conditions and corrective actions set by the Corporation have been complied with.

SECTION 67. Re-Accreditation –

- a. A health care provider whose previous accreditation has lapsed or whose subsequent application was denied may apply for re-accreditation.
- b. An institutional health care provider in good standing, but whose ownership has changed, must apply for re-accreditation within ninety (90) calendar days from actual change of ownership, subject to the provisions of this Rules.
- c. An institutional health care provider in good standing which intends to transfer location must first secure a license to operate from the DOH for the new facility prior to the date of transfer and apply for re-accreditation within ninety (90) calendar days from the date of transfer subject to the provisions of this Rules. Beyond this period, the accreditation shall automatically lapse and all claims filed with the Corporation shall not be paid.

The health care provider must inform the Corporation in writing of the planned transfer indicating therein the exact date of transfer and address of the new site. The ninety (90) - day grace period shall not apply to the new site if it is not licensed.

- d. Where the accreditation lapsed due to the voluntary act of a health care provider to evade the consequences of a previous violation or adverse findings indicating fraud, as determined by the Corporation, the application for re-accreditation shall be denied.
- e. Re-accreditation shall also be given to a health care provider who:
 - acquires new skills;
 - qualifies as a specialist; and
 - upgrades or downgrades its facilities in the case of institutional health care providers.
- f. The re-accreditation shall take effect upon approval of the application.

SECTION 68. Reinstatement of Accreditation – Accreditation that has been suspended may be reinstated after all requirements and conditions set by the Corporation have been complied with.

SECTION 69. Process of Accreditation of Institutional Health Care Providers –

- a. The institutional health care provider shall apply for accreditation by submitting the duly accomplished forms and documents required and upon payment of the required fees.
- b. An inspection shall be conducted within sixty (60) calendar days upon receipt of the complete application.
- c. A decision shall be made within a reasonable period of time from receipt of the application.

- d. A Certificate of Accreditation shall be issued to the institutional health care provider upon approval of the application.

SECTION 70. Process of Accreditation for Health Care Professionals –

- a. A health care professional shall apply for accreditation by submitting the duly accomplished forms and documents required and upon payment of the required fees.
- b. The completed application shall be processed and validated by the Corporation.
- c. A decision shall be made within thirty (30) calendar days from date of receipt of complete application.
- d. An Accreditation Card shall be issued to the health care professional upon approval of the application.

SECTION 71. Grounds for Denial/Non-Reinstatement of Accreditation – The following shall be the grounds for the denial/non-reinstatement of accreditation:

- a. non-compliance with any or all of the requirements and conditions of accreditation;
- b. revocation, non-renewal or non-issuance of license/accreditation/clearance to operate or practice of the health care provider by the DOH, PRC or government regulatory office or institution;
- c. conviction due to fraudulent acts as determined by the Corporation until such time that the decision is reversed or modified by the Board or Appellate Court;
- d. change in the ownership, management or any form of transfer either by lease, mortgage or any other conveyance of a health care institution for the purpose of evading the consequences of fraud or violations previously committed after a thorough investigation;
- e. non-compliance with the safeguards provided under this Rules; and
- f. such other grounds as the Corporation may determine.

SECTION 72. Certificate of Accreditation of Institutional Health Care Providers – The Certificate of Accreditation shall contain an accreditation number and shall be publicly displayed in a prominent and visible place in the health care provider's office or place of practice. The certificate shall be replaced upon each renewal. In case of revocation of accreditation, the health care provider shall be required to surrender the certificate.

All accredited health care institutions shall likewise put up conspicuous signs indicating that they are PhilHealth accredited, of size and dimension as the Corporation may hereafter determine. It shall be placed outside the facility preferably beside the spot where the facility's name is written. If, for any reason, the accreditation of the institution is revoked or suspended, the Corporation reserves the right to place another sign indicating the same.

**Rule XI
NATIONAL ASSOCIATIONS OF PROVIDERS**

SECTION 73. Identification and Recognition of National Associations – The Corporation shall identify and recognize national associations of health care providers for the purpose of assuring quality health care. The Corporation may recognize national associations for provider groups that meet the criteria for recognition set forth in this Rules.

SECTION 74. Criteria for Recognition – The Corporation shall use the following criteria in recognizing such national associations:

- a. The association must be in active operation;
- b. It must be national in scope and must have a significant number of members throughout the country;
- c. It must possess a juridical personality;
- d. It must undertake a continuing professional education program or its equivalent and require from its members minimum number of units or hours of attendance to the program for a particular period; and
- e. It must cooperate with the Corporation in the implementation of quality assurance programs and in the investigation, discipline, and imposition of penalties to erring accredited members of the association.

SECTION 75. Cooperation Between the Corporation and the Recognized National Associations – The Corporation shall coordinate closely with the recognized national associations to encourage and ensure cooperation from the provider-members as well as to promote compliance with the requirements and conditions for participation in the NHIP.

Rule XII

PERFORMANCE MONITORING OF HEALTH CARE PROVIDERS

SECTION 76. Objective – The Corporation shall develop and implement a performance monitoring system for all health care providers which shall provide safeguards against:

- a. over- and under-utilization of services;
- b. unnecessary diagnostic and therapeutic procedures and interventions;
- c. irrational drug use;
- d. inappropriate referral practices;
- e. gross, unjustified deviations from currently accepted practice guidelines or treatment protocols;
- f. use of fake, adulterated or misbranded pharmaceuticals or unregistered drugs;
- g. use of drugs other than those recognized in the PNDF and those for which exemptions were granted by the Board; and
- h. withholding/denial of benefits/services to members and dependents.

The practices enumerated above are grounds for suspension, revocation, denial of accreditation and/or filing of a criminal complaint with the proper courts if so warranted, without prejudice to the reduction or denial of claims as provided in this Rules.

SECTION 77. Monitoring System – To achieve the above objective, the monitoring system shall include, among others, the following activities:

- a. Periodic inspection of facilities and offices;
- b. Gathering of utilization data from services rendered by all health care providers who shall be required to submit mandatory reports thereon;
- c. Periodic review of these data for purposes of determining quality and cost effectiveness as well as adherence to practice guidelines by health care providers;
- d. Utilization review;
- e. Peer review;
- f. Periodic assessment of the performance of all health care providers; and
- g. Submission of Mandatory Monthly Hospital Reports and other reportorial requirements, as determined by the Corporation.

Rule XIII OUTCOMES ASSESSMENT

SECTION 78. System of Outcomes Assessment – The Corporation shall implement a system of assessing outcomes of services rendered by health care providers to include the following:

- a. Review of mortality and morbidity rates, post-surgical infection rates and other health outcome indicators;
- b. Undertaking of outcomes research projects; and
- c. Client satisfaction surveys.

A periodic report of outcomes assessment shall be submitted to the President and to the Board.

Rule XIV MECHANISM FOR FEEDBACK

SECTION 79. Mechanism for Feedback – A mechanism aimed at improving quality of service shall be established by the Corporation to periodically inform health care providers, program administrators and the public of the performance of accredited health care providers. The Corporation shall make known to the general public information on the performance of accredited health care providers, including the release of names of those of good standing as well as those whose accreditation has been suspended or revoked by the Corporation.

In pursuit of informed choice as enunciated in the Act, feedback reports shall include information on the amount reimbursed by the Corporation vis-à-vis the actual charges billed by the accredited health care provider.

Rule XV TECHNOLOGY ASSESSMENT

SECTION 80. Assessment of Health Technology – The Corporation shall assess the advantage and appropriateness of health technology consistent with actual needs and current standards of medical practice and ethics and with national health objectives.

In this regard, the Corporation may require specific types of health care providers to upgrade their facilities, equipment and manpower complement as a prerequisite to accreditation.

Rule XVI POLICY FORMULATION AND REVIEW

SECTION 81. Policy Formulation – In formulating and designing policies to pursue the principles and objectives of the NHIP, the Corporation shall utilize and incorporate data, results, reports and other information derived from the conduct of the preceding formal set of activities to ensure quality health care.

SECTION 82. Policy Review – The Corporation shall continuously evaluate and validate the relevance, efficacy and acceptability of existing NHIP policies in the light of the outcomes and results derived from the conduct of the Quality Assurance Program.

SECTION 83. Remedial Measures – As the need arises and based on data obtained from performance monitoring, remedial measures shall be imposed by the Corporation on particular health care providers found to be deficient in the delivery of cost-efficient and quality services.

Rule XVII
QUALITY ASSURANCE OF HEALTH CARE PROVIDERS

SECTION 84. Requisite for Accreditation – A formal ongoing quality assurance program shall be a requisite for accreditation of health care providers.

SECTION 85. Objectives – The objectives of the program shall be to:

- a. ensure that health care professionals of the accredited health care institution possess the proper training and credentials to render quality health care services to members of the NHIP;
- b. work towards the promotion of uniform health care standards throughout the country; and
- c. ensure appropriateness of medical procedures and administration of drugs and medicines consistent with generally accepted standards of medical practice and ethics.

SECTION 86. Activities – The program shall include, among others, the following activities:

- a. The proper review of credentials of individual health care professionals working in the health care institution;
- b. The provision of referral and practice guidelines for the health care providers;
- c. A utilization review and monitoring scheme for the performance of health care providers;
- d. A measurement of health outcomes and patient satisfaction including mortality, morbidity, infection rates and other related activities;
- e. A data gathering and retrieval system from the health and financial records to support performance monitoring and outcomes measurement activities;
- f. A system of peer review and feedback to the health care professionals and mechanism for change in practice patterns as needed;
- g. The appointment of a specific person responsible for quality assurance in the institution;
- h. The implementation of remedial measures to correct defects identified in the health system;
- i. A documentation of regular meetings for members of quality circles or Quality Assurance Committee; and
- j. The documentation of processes developed, evaluated and improved.

SECTION 87. Monitoring and Verification – The Corporation shall periodically monitor and verify compliance with this requisite during inspection of the health care provider and may require submission of periodic reports as a means of monitoring compliance.

SECTION 88. Penalties for Violations – Violation of the requisites provided in Rule XVII shall constitute breach of warranties of accreditation.

Title VI – RULES OF PROCEDURE OF THE CORPORATION

Rule XVIII
TITLE AND CONSTRUCTION

SECTION 89. Title of the Rules – This Rules shall be known as the Rules of Procedure of the Corporation.

SECTION 90. Applicability – This Rules shall apply to all cases brought before the Corporation.

SECTION 91. Construction – This Rules shall be liberally construed to carry out the objectives of RA 7875, as amended by RA 9241, and to assist the parties in obtaining an expeditious and inexpensive resolution of any case arising under the said Act.

SECTION 92. Suppletory Application of the Rules of Court and Jurisprudence - In the absence of any applicable provisions in this Rules, the pertinent provisions of the Rules of Court of the Philippines and

prevailing jurisprudence may be applied in a suppletory character to all cases brought before the Corporation in the interest of expeditious resolution of these cases.

Rule XIX

POWERS OF THE CORPORATION

SECTION 93. Powers of the Corporation, the Board and the President and CEO - The powers vested in the Corporation by RA 7875, particularly Sections 16 and 17 of Article IV and Article IX, shall be exercised by the Board as the policy-making and quasi-judicial body and by the President as the Chief Executive Officer of the Corporation.

SECTION 94. Board as Quasi-Judicial Body - The Board, as a quasi-judicial body, may sit *en banc* or in divisions in all cases brought before it for review.

As provided for in RA 7875, as amended by RA 9241, the Board is composed of thirteen (13) members, as follows:

The Secretary of Health;
The Secretary of Labor and Employment or his representative;
The Secretary of the Interior and Local Government or his representative;
The Secretary of Social Welfare and Development or his representative;
The President of the Corporation;
A representative of the labor sector;
A representative of employers;
The SSS Administrator or his representative;
The GSIS General Manager or his representative;
The Vice-Chairperson for the basic sector of the National Anti-Poverty Commission or his representative;
A representative of Filipino Overseas Workers;
A representative of the self-employed sector; and
A representative of the health care providers to be endorsed by the national associations of health care institutions and medical health professionals

The Secretary of Health shall be the ex-officio Chairperson of the Board while the President and CEO shall be the Vice Chairperson.

SECTION 95. Quorum and Votes Required - When sitting *en banc* or in divisions, the concurrence of the majority of all the members thereof shall be required to render a decision in all cases.

Rule XX

THE PROSECUTORS AND THE ARBITERS OF THE CORPORATION

SECTION 96. Jurisdiction and Qualifications of the Prosecutors and the Arbiters of the Corporation – Prosecutors of the Corporation shall have the power and authority to conduct fact-finding investigation on complaints filed by any person or by the Corporation against health care providers and/or members, and if a *prima facie* case exists, to file and prosecute the complaint before the Arbiter. The Prosecutor may also administer oath in accordance with Chapter X, Section 41, paragraph 2 of Executive Order No. 292. A Prosecutor must be a *bona fide* member of the Philippine Bar and must have been engaged in the practice of law for at least three (3) years prior to appointment.

Arbiters shall exercise original and exclusive jurisdiction over all complaints filed with the Corporation in accordance with the Act and this Rules. They shall have the power to administer oaths, issue subpoenas, (*Ad Testificandum* and *Duces Tecum*) and such other powers vested in them by the Act and this Rules. An Arbiter

must be a *bona fide* member of the Philippine Bar and must have been engaged in the practice of law for at least three (3) years prior to appointment.

SECTION 97. Assignment of Prosecutors and Arbiters - The Prosecutor and the Arbiter may be assigned to more than one PhilHealth Office, as the interest of the service may require.

Rule XXI GROUNDS AND VENUE

SECTION 98. Grounds for a Complaint Against a Health Care Provider - A complaint against a health care provider may be filed on any of the following grounds:

- a. Failure to comply with the warranties of accreditation;
- b. Commission of any of the offenses enumerated in Title VII, on Offenses and Penalties, of this Rules.

SECTION 99. Grounds for a Complaint Against a Member – A complaint against a member may be filed on any of the following grounds:

- a. Commission of any fraudulent act;
- b. Gross negligence in connection with the member's coverage and/or entitlement to benefits under the NHIP;
- c. Commission of any of the offenses enumerated in Title VII, on Offenses and Penalties, of this Rules.

SECTION 100. Venue – Any complaint against a health care provider may be filed with the PhilHealth Office where the respondent health care provider is located or where the complainant resides at the election of the complainant.

Rule XXII FILING OF A COMPLAINT

SECTION 101. Who May File - Any person may file a complaint in writing against a health care provider and/or a member. The Corporation, *motu proprio*, may file a complaint brought to its attention by any of its departments, offices or units.

SECTION 102. The Corporation as an Indispensable Party - In every case where the complainant is a private person, the Corporation shall join the complainant as an indispensable party in the complaint.

Rule XXIII ACTION ON A COMPLAINT

SECTION 103. Duty of the Prosecutor - After receipt of a complaint, the Prosecutor may, from an examination of the allegations therein and such evidence as may be attached thereto, dismiss a case outright on the ground of lack of jurisdiction over the subject matter or failure to state a cause of action. Outright dismissal based on the latter ground shall be without prejudice to a subsequent refiling of the complaint.

If no ground for dismissal is found, the Prosecutor shall forthwith issue the corresponding directive to the respondent health care provider/s and/or member directing the respondent/s to file their answer within five (5) calendar days from receipt, with a notice that unless the respondent/s so answers, the case shall be resolved based on available record. If from an examination of the complaint and the evidence a *prima facie* case is found to exist, the Prosecutor shall then file and prosecute the complaint with the Arbiter.

SECTION 104. Caption and Title - The complaint shall be filed in accordance with the following caption:

**REPUBLIC OF THE PHILIPPINES
PHILIPPINE HEALTH INSURANCE CORPORATION
(PLACE)**

Complainant/s
-versus-

PHIC Case No. _____

Respondent/s
x- -----x

SECTION 105. Contents of Complaint - A complaint shall contain, among others, the following:

- a. The name/s and address/es of the complainant/s;
- b. The name/s and address/es of the respondent/s health care provider/s;
- c. A clear and concise statement of the cause/s of action. If the cause of action is the failure to comply with the warranties of accreditation, the particular warranties not complied with shall be indicated. If the cause of action is the commission of any offense enumerated by this Rules, such offense shall be indicated, together with a narration of how the offense was committed;
- d. The relief/s sought.

All pertinent papers or documents in support of the complaint must be attached whenever possible.

SECTION 106. Docket Number - A complaint shall be filed with a duly designated Docket Clerk of the Corporation. Said clerk shall assign to the complaint a docket number in the order of the date and time of filing thereof, after which the clerk shall immediately endorse the complaint to the Arbiter for appropriate action.

SECTION 107. Service of Summons - Upon the filing of the complaint, the Arbiter shall then issue the summons to the respondent/s directing them to file their answers with a notice that unless the respondent/s so answers, the complainant/s will take judgment by default and demand from said Arbiter the relief/s applied for. A copy of the complaint with the supporting documents shall be attached to the original copy of the summons.

Service of summons shall be made either personally or by registered mail.

- a. Personal Service – The summons shall be served by handing a copy thereof to the respondent in person, or if the respondent refuses to receive it, by tendering it.

If the respondent cannot be served within a reasonable time as provided for in the preceding paragraph, service may be effected (a) by leaving a copy of the summons at the respondent’s residence with some person of suitable age and discretion residing therein, or (b) by leaving a copy at respondent’s office or regular place of business with some competent person in charge thereof.

When persons associated in business are sued under a common name, service may be effected upon all the respondents by serving upon any one of them, or upon the person in charge of the office or place of business maintained in the common name. But such service shall not bind individually any person whose connection with the association has, upon due notice, been severed before the action was brought.

Service upon a corporation or a partnership may be made on the President, Manager, Secretary, Cashier, Agent or any of its Directors.

b. Service by Registered Mail - If service is not made personally, service by registered mail shall be required.

SECTION 108. Proof of Service - The proof of service of the directive/summons shall be made in writing by the server who shall set forth the manner, place, and date of service and shall specify any papers which have been served with the process and the name of the person who received the same.

Service by registered mail may be proved by a certificate of the server showing that a copy of the summons and papers attached thereto, enclosed in an envelope and addressed to the defendant, with postage prepaid, has been mailed to which certificate the registry receipt and return card shall be attached.

SECTION 109. Answer - Within fifteen (15) calendar days from service of the summons and a copy of the complaint, respondent shall file a verified answer and serve a copy thereof to the complainant. Affirmative and negative defenses not pleaded therein shall be deemed waived except for lack of jurisdiction over the subject matter. Failure to specifically deny any of the material allegations in the complaint shall be deemed an admission thereof.

No motion to dismiss shall be entertained, except one filed on the ground of lack of jurisdiction over the subject matter, or failure to state a cause of action.

SECTION 110. Default - Should the respondent/s fail to answer the complaint within the period above provided, the Arbiter may, *motu proprio*, or on motion of the complainant/s, render judgment as may be warranted by the facts alleged in the complaint and limited to what is prayed for therein.

SECTION 111. Affidavits and Position Papers - After an answer is filed and the issues are joined, the Arbiter shall require the parties to simultaneously submit their respective position papers within fifteen (15) calendar days from receipt of the order. The position paper shall contain a brief statement of their positions setting forth the law and the facts relied upon them, including the affidavits of the witnesses and other evidence on the factual issues defined therein.

SECTION 112. Rendition of Judgment - After receipt of the affidavits and position papers, or the expiration of the period for filing the same, the Arbiter shall render judgment, not later than thirty (30) calendar days from the date the case is submitted for resolution. However, should the Arbiter find it necessary to conduct a formal hearing, an order to that effect shall be issued, setting the date or dates therefor and specifying the witnesses who will be called to testify therein, which shall be terminated as soon as possible.

Final orders or judgment of the Arbiter shall be served either personally or by registered mail.

SECTION 113. Procedure of Trial - Whenever the conduct of a hearing is deemed necessary by the Arbiter, the affidavits submitted by the parties shall constitute the testimonies of the witnesses who executed the same. Witnesses who testify may be subjected to clarificatory questions by the Arbiter. No witness shall be allowed to testify unless an affidavit was previously submitted to the Arbiter.

SECTION 114. Role of Arbiter in Proceedings - The Arbiter shall:

- a. personally conduct the hearings and determine the order of presentation of evidence by the parties;
- b. take full control of the proceedings and may ask clarificatory questions to the parties and their witnesses with respect to the matters at issue; and
- c. limit the presentation of evidence to matters relevant to the issue/s.

SECTION 115. Powers of the Arbiter - The Arbiter shall:

- a. conduct proceedings or any part thereof in public or in executive session;
- b. adjourn hearings to any time and place;
- c. refer technical matters or accounts to an expert and to accept the reports as evidence;

- d. direct parties to be joined or excluded from the proceedings;
- e. give such directions as may be deemed necessary or expedient in the resolution of the dispute at hand;
- f. summon the parties to a controversy;
- g. issue subpoenas requiring attendance and testimony of witnesses or the production of documents and other material/s necessary;
- h. administer oaths; and
- i. certify official acts.

Whenever a person, without lawful excuse, fails or refuses to make an oath or to produce documents for examination or gives testimony, in disobedience to a lawful subpoena issued by the Arbiter, the latter may invoke the aid of the Regional Trial Court within whose territorial jurisdiction the case is being heard, pursuant to Section 14, Chapter 3, Book VII of the Revised Administrative Code. The Court may punish contumacy or refusal as contempt.

SECTION 116. Non-Appearance of Parties at Hearings - When the complainant/s fail/s to appear at the trial on two (2) successive occasions, despite due notice thereof, the Arbiter may *motu proprio* or upon motion of the respondent/s, dismiss the case without prejudice. Said complainant/s may, by proper motion and upon submission of proper justification, ask for a reopening of the case within sixty (60) calendar days after the resolution is received. Dismissal of the case for the second time for the same reason shall have the effect of adjudication upon the merits.

The withdrawal or desistance of a complainant shall not bar the Arbiter from proceeding with the hearing of the complaint against the respondent. The Arbiter shall act on the complaint as may be merited by the results of the hearing and impose such penalties on the erring respondent as may be deemed appropriate.

SECTION 117. Postponement of Hearing - The parties and their counsel or representative appearing before an Arbiter shall be prepared for continuous hearing. Postponements or continuances of hearing shall be allowed by the Arbiter only upon meritorious grounds and subject always to the requirement of expeditious disposition of a case.

SECTION 118. Records of Proceedings - Except when any or both of the parties request that the proceeding be duly transcribed, the proceedings before an Arbiter need not be recorded by stenographers. The Arbiter shall make a written summary of the proceedings, including the substance of the evidence presented, in consultation with the parties. The written summary shall be signed by the parties and shall form part of the records.

SECTION 119. Contents of Decisions - The decision of the Arbiter shall be clear and concise and shall include a brief statement of the:

- a. facts of the case;
- b. issue/s involved;
- c. applicable laws or rules;
- d. conclusions and the reasons therefor; and
- e. specific remedy or relief granted.

The decision of the Arbiter shall be immediately executory, unless an appeal is made to the Board pursuant to Section 123 of this Rules.

Rule XXIV
REVIEW BY THE BOARD

SECTION 120. Jurisdiction - The Board shall have exclusive appellate jurisdiction to review decisions of the Arbiter in complaints filed under the Act and this Rules on any of the following grounds:

- a. The existence of a *prima facie* evidence of abuse of discretion on the part of the Arbiter, due to a misappreciation of facts or misapplication of law, or both;
- b. The decision was secured through fraud or coercion, including graft and corruption;
- c. The appeal is grounded on the questions of law;
- d. Serious errors in the finding of facts which if not corrected, would cause grave or irreparable damage or injury to the appellant.

SECTION 121. Filing of Appeal – The appeal shall be filed with the Arbiter before whom the case was heard and decided by submitting seven (7) legibly typewritten copies.

SECTION 122. Appeal Fee – The appellant shall pay an appeal fee in an amount as may be determined by the Corporation except when the appellant is the Corporation or a member of the Indigent Program. The official receipt of such payment shall be attached to the records of the case. No appeal shall be entertained without the payment of the appeal fee.

SECTION 123. Period of Appeal - A decision of an Arbiter in a complaint, filed against a health care provider or a member, shall be final and executory unless appealed to the Board within fifteen (15) calendar days from receipt of such decision. If such day falls on a Saturday, Sunday, holiday, or declared a non-working day due to *force majeure*, the last day to perfect the appeal shall be the next working day.

SECTION 124. Who May File an Appeal – Any party to the complaint, including the Corporation, may appeal from a judgment of the Arbiter.

SECTION 125. No Extension of Appeal Period – No motion or request for extension of the period within which to file an appeal shall be allowed.

SECTION 126. Perfection of Appeal – An appeal shall be under oath with proof of payment of the required appeal fee. It shall be accompanied by a Memorandum of Appeal. A mere notice of appeal without complying with the aforesaid requisites shall not stop the running of the period for perfecting an appeal.

SECTION 127. Memorandum of Appeal of Appellant – A Memorandum of Appeal shall state the grounds relied upon and the arguments in support thereof, the relief prayed for, and a statement of the date when the appellant received the appealed decision and proof of service on the other party of such appeal.

SECTION 128. Answer or Reply of Appellee – The appellee shall file the answer or reply to appellant's Memorandum of Appeal not later than fifteen (15) calendar days from receipt thereof. Failure on the part of the appellee who was properly furnished with a copy of the appeal to file the answer or reply within the said period may be construed as a waiver to file the same.

SECTION 129. Transmittal of the Records of the Case on Appeal – The Arbiter shall transmit the entire records of the case to the Board within five (5) calendar days from receipt of the appeal.

SECTION 130. Functions of the Clerk of the Board – The Corporate Secretary shall act as the Clerk of the Board and shall assign one of its personnel to perform the following functions:

- a. Receive all papers required to be filed with the Board in connection with any petition pending therewith and to stamp the date and hour of the filing thereof; and

b. Keep such book as may be necessary for recording all the proceedings of the Board and its decisions.

SECTION 131. Decision of the Board – The Board shall resolve the appeal within sixty (60) calendar days from receipt of the entire records of the case.

SECTION 132. Assignment of An Appeal to a Member of the Board – All appeals received by the Board shall be assigned by the Chairman to the Members on an equal basis. The Member assigned to the case shall write the decision after the same is reached in consultation with the other members. A certification to this effect signed by the Chairman of the Board shall be issued and a copy thereof attached to the record of the case and served upon the parties.

SECTION 133. Inhibition – Any Member may inhibit himself from the consideration and resolution of any case/matter before the Board and shall so state in writing the legal or justifiable grounds therefor.

SECTION 134. Form of Decision - The decision of the Board shall state clearly and distinctly the findings of facts, issues and conclusions of law on which it is based and the relief/s granted, if any.

Rule XXV

APPEAL TO THE COURT OF APPEALS

SECTION 135. Board Decision Reviewable by the Court of Appeals - Final orders and decisions of the Board may be reviewed by the Court of Appeals in accordance with the provisions of the Revised Administrative Circular No. 1-95 issued by the Supreme Court on May 17, 1995, pursuant to Republic Act No. 7902, approved February 23, 1995, expanding the jurisdiction of the Court of Appeals.

Rule XXVI

EXECUTION OF A DECISION

SECTION 136. Execution of Decision - Any decision of an Arbiter or of the Board in a complaint filed against a health care provider or member after the same shall have become final and executory shall be executed by the concerned official of the Corporation. If necessary, it may be enforced and executed in the same manner as decisions of the Regional Trial Court. The Board shall have the power to issue to the City or Provincial Sheriff or the Sheriff whom it may appoint such needed writs of execution. Any person who shall fail or refuse to comply with such decision, or writ, after being required to do so shall, upon application by the Board, be punished by the proper court for contempt.

The decision of the Board shall immediately be executory even pending appeal when the public interest so requires.

Title VII – OFFENSES AND PENALTIES

Rule XXVII

GENERAL PROVISIONS

SECTION 137. Mitigating and Aggravating Circumstances - The following circumstances shall affect the gravity of the violation and the liability of the erring health care provider, member, and employer:

- a. **Mitigating Circumstances** – The following circumstances shall mitigate the liability of the respondent:
- voluntary admission of guilt;
 - good track record;
 - first offense.

- b. **Aggravating Circumstances** – The following circumstances shall aggravate the liability of the respondent:
- Previous conviction of an offense, as provided for in this Rules;
 - Connivance and/or conspiracy to facilitate the commission of the violation;
 - Gross negligence.

Being an officer or employee of the Corporation when the offense was committed, if used to facilitate or cover up the commission of the offense, shall be considered an aggravating circumstance.

SECTION 138. Application of Circumstances in the Imposition of Penalties –

- a. The presence of mitigating circumstance without any aggravating circumstance shall limit the imposable penalty to its minimum.
- b. When there is neither mitigating nor aggravating circumstance, the imposable penalty shall be between the minimum and the maximum of the applicable penalty for the offense committed, at the discretion of the Corporation. The same shall apply when both mitigating and aggravating circumstances are present.
- c. The presence of any aggravating circumstance without the mitigating circumstance shall increase the penalty of the offense to its maximum.

SECTION 139. Common Provisions - All penalties for offenses committed by health care providers and members shall carry with them denial of payment of claim/s in question and/or refund to the Corporation, if already paid.

The penalty of suspension shall be for a period of three (3) months to the whole term of accreditation. If the penalty of suspension imposed against a health care provider exceeds the validity of the current accreditation, the renewal or the re-accreditation of the latter shall not be acted upon until the full term of the suspension imposed has been served or lifted. For this purpose, the period covering the expiration of accreditation and the start of the effectivity of the renewal and/or re-accreditation shall be considered as part or continuation of the suspension. Suspension shall be carried out by the temporary cessation of the benefits or privileges under the NHIP.

Should the aggregate period of suspension to be imposed upon the provider on account of two or more violations exceed twenty-four (24) months, the maximum imposable fine shall be exacted.

In all cases wherein a decision is rendered against a health care provider, the DOH, PRC and/or other concerned agencies shall be furnished with a copy of the same for information and/or appropriate action.

A notice of suspension for the information of members shall be posted in the institution concerned indicating the period of suspension in such form and manner to be prescribed by the Corporation.

A notice of suspension of benefits of a member shall be provided to all accredited institutional health care providers.

A health care provider who at the time of trial for an offense enumerated herein shall have been previously convicted by final judgment for any offense under this Rules may no longer be accredited as participant of the NHIP.

Rule XXVIII
OFFENSES OF INSTITUTIONAL HEALTH CARE PROVIDERS

SECTION 140. Padding of Claims - Any health care provider who, for the purpose of claiming payment from the NHIP, files a claim for benefits which are in excess of the benefits actually provided by adding drugs, medicines, supplies, procedures and services, shall be punished by a fine of not less than Ten Thousand

Pesos (P10,000) but not more than Fifty Thousand Pesos (P50,000). In addition, its accreditation shall be revoked or suspended from three (3) months to the whole term of accreditation.

SECTION 141. Claims for Non-Admitted Patients – This is committed by any health care provider who, for the purpose of claiming payment for non-admitted patients from the NHIP, files a claim by:

- a. making it appear that the patient is actually confined in the health care institution; or
- b. using such other machinations that would result in claims for non-admitted patients.

The foregoing offenses shall be penalized by a fine of not less than Ten Thousand Pesos (P10,000) but not more than Fifty Thousand Pesos (P50,000). In addition, its accreditation shall be revoked or suspended from three (3) months to the whole term of accreditation.

SECTION 142. Extending Period of Confinement – This is committed by any health care provider who, for the purpose of claiming payment from the NHIP, files a claim with extended period of confinement by:

- a. increasing the period of actual confinement of any patient;
- b. continuously charting entries in the Doctor's Order, Nurse's Notes and Observation despite actual discharge or absence of the patients;
- c. using such other machinations that would result in the unnecessary extension of confinement.

The foregoing offenses shall be penalized by a fine of not less than Ten Thousand Pesos (P10,000) but not more than Fifty Thousand Pesos (P50,000). In addition, its accreditation shall be revoked or suspended from three (3) months to the whole term of accreditation.

SECTION 143. Post-dating of Claims - Any health care provider who, for purposes of claiming payment from the NHIP, files a claim for payment of services rendered not within sixty (60) calendar days from the date of discharge of the patient or such other prescriptive periods as the Corporation may issue but makes it appear so by changing, erasing, adding to the period of confinement or in any manner altering dates so as to conform with the adopted prescriptive period, shall suffer a fine of not less than Ten Thousand Pesos (P10,000) but not more than Fifty Thousand Pesos (P50,000) and suspension of accreditation for three (3) months to the whole term of accreditation.

SECTION 144. Misrepresentation by Furnishing False or Incorrect Information - Any health care provider shall be liable for fraudulent practice when, for the purpose of participation in the NHIP or claiming payment therefrom, it furnishes false or incorrect information concerning any matter required by RA 7875 and this Rules. It shall be penalized with a fine of not less than Ten Thousand Pesos (P10,000) but not more than Fifty Thousand Pesos (P50,000) and suspension of accreditation for three (3) months to the whole term of accreditation.

Where such misrepresentation leads to damage to the Corporation, the penalty shall be revocation of accreditation.

SECTION 145. Filing of Multiple Claims - Any health care provider who, for the purpose of claiming payment from the NHIP, files two or more claims for a patient for the same confinement or illness, or makes it appear that the patient had been confined for two or more times and/or for two or more different illnesses shall be punished by a fine of not less than Ten Thousand Pesos (P10,000) but not more than Fifty Thousand Pesos (P50,000). In addition, its accreditation shall be revoked or suspended from three (3) months to the whole term of accreditation.

SECTION 146. Unjustified Admission Beyond Accredited Bed Capacity - Any health care institution which, for the purpose of claiming payment from the NHIP, files claims for patients confined in excess of the accredited bed capacity at any given time without justification in the form and manner prescribed by the

Corporation shall suffer a fine of not less than Ten Thousand Pesos (P10,000) but not more than Fifty Thousand Pesos (P50,000) and suspension of accreditation for three (3) months to the whole term of accreditation.

SECTION 147. Unauthorized Operations Beyond Service Capability - Any primary hospital which performs a surgical operation beyond its authorized capability shall suffer a fine of not less than Ten Thousand Pesos (P10,000) but not more than Fifty Thousand Pesos (P50,000) and suspension of accreditation for three (3) months to the whole term of accreditation; except, when the operation is done in an emergency to save life and referral to a higher category provider is physically impossible.

SECTION 148. Fabrication or Possession of Fabricated Forms and Supporting Documents - Any health care provider who is found preparing claims with misrepresentations or false entries, or to be in possession of claim forms and other documents with false entries, shall suffer a fine of not less than Ten Thousand Pesos (P10,000) but not more than Fifty Thousand Pesos (50,000) and suspension of accreditation for three (3) months to the whole term of accreditation.

SECTION 149. Other Fraudulent Acts - Any health care provider shall also be liable for the following fraudulent acts:

- a. Making it appear that the patient suffered from a compensable illness or underwent a compensable procedure;
- b. Failure or refusal to give benefits due to qualified members/dependents;
- c. Charging qualified patients for medicines and/or services which are legally chargeable to and covered by the NHIP;
- d. Failure or refusal to refund to the member the payment received from the NHIP when the hospital charges and professional fees are fully paid in advance by the member within a period of thirty (30) days from the date of receipt of refund check from the Corporation;
- e. Failure or refusal to accomplish and submit the required forms in connection with letter d.;
- f. Failure or refusal to provide the members with the required forms for direct filing of claims, billing statements, official receipts and other documents required/necessary for filing of claims;
- g. Deliberate failure or refusal to comply with the requirements of RA 7875 and this Rules.

Said health care provider shall be penalized by a fine of not less than Ten Thousand Pesos (P10,000) but not more than Fifty Thousand Pesos (P50,000). In addition, its accreditation shall be revoked or suspended from three (3) months to the whole term of accreditation.

SECTION 150. Breach of the Warranties of Accreditation - Any institutional health care provider who commits any breach of the warranties of accreditation shall suffer a fine of not less than Ten Thousand Pesos (P10,000) but not more than Fifty Thousand Pesos (P50,000). In addition, its accreditation shall be revoked or suspended from three (3) months to the whole term of accreditation.

SECTION 151. Criminal Liability - In addition, a criminal complaint shall be filed against the officials of the erring institutional health care providers before the appropriate Office of the Prosecutor for violations of these rules and/or the Revised Penal Code.

Rule XXIX

OFFENSES OF HEALTH CARE PROFESSIONALS

SECTION 152. Misrepresentation by False or Incorrect Information - Any health care professional shall be liable for fraudulent practice when, for purposes of participation in the NHIP or claiming payment from the Corporation, furnishes false or incorrect information concerning any matter required by RA 7875 as amended and this Rules shall suffer a fine of not less than Ten Thousand Pesos (P10,000) but not more than Fifty Thousand Pesos (P50,000). The said professional shall likewise be suspended from participation in the

NHIP for not less than one (1) year but not more than three (3) years or the accreditation shall be revoked.

SECTION 153. Breach of the Warranties of Accreditation - Any health care professional found to have committed any breach of the warranties of accreditation shall suffer a fine of not less than Ten Thousand Pesos (P10,000) but not more than Fifty Thousand Pesos (P50,000) and for not less than six (6) months but not more than three (3) years suspension from participation in the NHIP.

SECTION 154. Other Violations - Any other willful or negligent act or omission of the health care professional in violation of RA 7875 as amended and this Rules which tends to undermine or defeat the objectives of the NHIP shall be dealt with in accordance with Section 44 of RA 7875.

SECTION 155. Criminal Liability - In addition, a criminal complaint shall be filed against erring health care professionals before the appropriate Office of the Prosecutor for violations of these rules and/or the Revised Penal Code.

Rule XXX OFFENSES OF MEMBERS

SECTION 156. Fraudulent Acts - Any member who, for purposes of claiming NHIP benefits or entitlement thereto, shall commit any of the offenses provided for in Sections 140 to 149, 152 and 154 hereof, independently or in connivance with the health care provider, shall suffer a fine of Five Thousand Pesos (P5,000) and suspension from availment of NHIP benefits for not less than three (3) months but not more than six (6) months.

SECTION 157. Criminal Liability – In addition, a criminal complaint shall be filed against the member before the Office of the Prosecutor for the above violations which carry a penalty of imprisonment of not less than six (6) months but not more than one (1) year.

Rule XXXI OFFENSES OF OFFICERS AND EMPLOYEES OF THE CORPORATION

SECTION 158. Infidelity in the Custody of Property – This offense is committed by any officer or employee of the Corporation who:

- a. receives or keeps funds or property belonging, payable or deliverable to the Corporation, or who shall appropriate the same; or
- b. shall take or misappropriate such property or fund wholly or partially; or
- c. shall consent, or through abandonment or negligence, shall permit any other persons to take such property or funds wholly or partially.

The officer or employee found liable for misappropriation of funds or property shall suffer imprisonment of not less than six (6) years but not more than twelve (12) years and a fine of not less than Ten Thousand Pesos (P10,000) but not more than Twenty Thousand Pesos (P20,000).

Any shortage of funds or loss of the property upon audit shall be deemed *prima facie* evidence of the offense.

SECTION 159. Other Violations Involving Funds - All other violations involving funds of the Corporation shall be governed by the applicable provisions of the Revised Penal Code or other laws, taking into consideration the provisions under this Rules on collection, remittances, and investment of funds.

SECTION 160. Connivance - Any officer or employee of the Corporation who shall connive, conspire, agree, plot, scheme, contrive or collude with any health care provider or any member, or through gross negligence or imprudence shall facilitate or consent to commission of the same offenses enumerated in this

Rules shall be prosecuted under applicable penal laws, rules and regulations, without prejudice to the filing of appropriate administrative action with the appropriate agency.

Rule XXXII OFFENSES OF EMPLOYERS

SECTION 161. Failure or Refusal to Deduct Contributions - Any employer or officer who fails or refuses to deduct contributions from the employee's compensation shall be penalized depending on the violation as specified below. The fine shall be in addition to the outstanding applicable contribution receivable from the employer and shall be multiplied by the total number of employees of the firm.

Violations	Fines
1. Did not or refuses to deduct contributions for all or certain number of employees	
▪ Three (3) months or less of employee's contributions	P500
▪ More than three (3) months but less than six (6) months of employee's contributions	P625
▪ More than six (6) months but less than nine (9) months of employee's contributions	P750
▪ More than nine (9) months but less than twelve (12) months of employee's contributions	P875
▪ More than twelve (12) months of employee's contributions	P1,000
2. Did not deduct the right amount	
▪ Three (3) months or less of employee's contributions	P500
▪ More than three (3) months but less than six (6) months of employee's contributions	P625
▪ More than six (6) months but less than nine (9) months of employee's contributions	P750
▪ More than nine (9) months but less than twelve (12) months of employee's contributions	P875
▪ More than twelve (12) months of employee's contributions	P1,000
3. Combination of 1 & 2	

SECTION 162. Failure/Refusal to Remit Contributions – Any employer or officer authorized to collect contributions who, after collecting or deducting the monthly contributions due from his/its employees, fails or refuses to remit said contributions to the Corporation within thirty (30) days from the date they become due shall be presumed to have misappropriated such contribution and shall suffer the penalties hereunder indicated and those provided for in Article 315, par 1 (b) of the Revised Penal Code on Swindling. The fine shall be in addition to the outstanding applicable contribution receivable from the employer and shall be multiplied by the total number of employees of the firm.

Violations	Fines
▪ Three (3) months or less of employee's contributions	P500
▪ More than three (3) months but less than six (6) months of employee's contributions	P625
▪ More than six (6) months but less than nine (9) months of employee's contributions	P750
▪ More than nine (9) months but less than twelve (12) months of employee's contributions	P875
▪ More than twelve (12) months of employee's contributions	P1,000

SECTION 163. Unlawful Deductions - Any employer or officer who shall deduct directly or indirectly from the compensation of the covered employees or otherwise recover from them their own contribution on behalf of such employees shall be punished by imprisonment not exceeding one (1) year or a fine not exceeding One Thousand Pesos (P1,000) multiplied by the total number of employees employed by the firm, or both fine and imprisonment, at the discretion of the Court.

SECTION 164. Institution as Offender - If any of the acts or omissions provided in the preceding section be committed by an association, partnership, corporation or any other institution, its managing directors or partners or president or general manager and/or any other persons responsible for the commission of the said act shall be liable for the penalties provided for in this Rules and other laws for the offense.

Rule XXXIII FINAL PROVISIONS

SECTION 165. Prosecution of Offenses - Offenses defined under Rules XXXI and XXXII hereof, shall be prosecuted in regular courts of justice of competent jurisdiction without prejudice to administrative action that may be instituted by the Corporation under existing laws.

SECTION 166. Filing of Complaint - The filing of complaint before the Corporation shall not bar a separate independent criminal action before any board, office, tribunal or court against the erring health care provider or member, and vice versa.

SECTION 167. Execution of Penalty - When an institutional health care provider ceases operation or an independent health care professional stops his/her practice before serving the suspension, execution of penalty shall be deferred, to be implemented when the same owner or medical director opens or operates a new institution irrespective of the name or location, or when the health care provider practices again. *Provided*, that the dispositive part of the resolution requiring payment of fines, reimbursement of paid claim or denial of payment shall be immediately executory.

A spouse or relative within the second degree of consanguinity or affinity of the owner or medical director shall be presumed to be the alter ego of such owner or medical director for the above purposes.

Despite the cessation of operation or practice of a health care provider while the complaint is being heard, the proceeding shall continue until rendition of judgment for the purpose of determining future relationships between the Corporation and the erring provider.

SECTION 168. Applicability of This Rules - Complaints already filed with and under deliberation by appropriate bodies of the Corporation prior to the effectivity of this Rules shall be governed in accordance with the previous rules.

Title VIII – ADMINISTRATIVE REMEDIES

Rule XXXIV COMMON PROVISIONS

SECTION 169. Jurisdiction - The Corporation, through the Grievance and Appeals Review Committee (GARC) and the Board, shall hear and decide all grievances filed by any accredited health care provider or by any member against any program implementor. The Corporation shall likewise act on all protests against administrative decisions involving payments of charges, fees or claims, subject to the procedures hereafter provided.

SECTION 170. Grievance and Protests Not Covered - Any action of a program implementor which can be the basis of an administrative or criminal complaint or charge under the jurisdiction of the Office of the Ombudsman, the Sandiganbayan, Civil Service Commission, or the regular courts of justice is neither a grievance nor a protest covered by this Rules and shall be dealt with in accordance with applicable laws.

Rule XXXV GRIEVANCE AGAINST PROGRAM IMPLEMENTORS

SECTION 171. Grounds for Grievances - The following acts shall constitute valid grounds for grievance:

- a. Any violation of the rights of patients;
- b. Willful neglect of duty resulting in the loss or non-availment of benefits by members or their dependents;
- c. Unjustifiable delay in actions on claims;
- d. Delay in the processing of claims that extends beyond the prescribed period; and
- e. Any other act or omission that tends to undermine or defeat the purposes of the Act and this Rules.

SECTION 172. Who May File - Any aggrieved health care provider or member may file a verified complaint for grievance.

SECTION 173. Venue - A grievance covered by this Rules may be filed with the PhilHealth Office where the aggrieved health care provider is located or where the member resides.

SECTION 174. Contents of Grievance - All complaints for grievance shall contain, among others, the following:

- a. Name/s and address/es of the aggrieved party/ies;
- b. Name/s and address/es of respondent program implementor/s;
- c. A clear and concise statement of the aggrieved party's cause/s of action, citing the specific ground relied upon and the acts or omissions complained of which constitute the same; and
- d. The relief/s sought.

The complaint shall be verified and accompanied by affidavits of the complainant and the witnesses as well as other supporting documents, in such number of copies as there are respondents, plus two (2) copies for the official file. The said affidavits shall be sworn to before any official authorized to administer oath who shall certify that the affiant/s has been personally examined and is satisfied that the affiant/s voluntarily executed and understood their affidavits.

SECTION 175. Investigation - Upon the filing of a complaint for grievance, the GARC, through the Protests And Appeals Review Department (PARD), shall conduct an inquiry to determine whether there is sufficient ground to engender a well-founded belief that a grievance cognizable by the GARC has been committed by a program implementor and that prosecution and adjudication of the case by the GARC is necessary to give the aggrieved party redress.

SECTION 176. Duty of the Investigating Officer - If the PARD finds cause for the aggrieved party to prosecute the case with the GARC, a resolution shall be prepared by the PARD certifying under oath that the aggrieved party and the witnesses have been personally examined by the PARD, that there is reasonable ground to believe that a valid cause for grievance exists, that the respondent implementor has probably committed the same, and that the respondent implementor has been informed of the complaint and has been given an opportunity to submit controverting evidence. Otherwise, the PARD shall recommend the dismissal of the complaint.

In the former case, the PARD shall forward the resolution, together with the records of the case, including the verified complaint and answer, the affidavits, counter-affidavits and supporting evidence submitted by the parties to the GARC.

Rule XXXVI THE GRIEVANCE AND APPEALS REVIEW COMMITTEE

SECTION 177. Grievance and Appeals Review Committee (GARC) - The Grievance and Appeals Review Committee (GARC) shall be composed of the President and Chief Executive Officer as the Presiding Officer and four (4) other members, upon recommendation by the Presiding Officer for confirmation by the Board, through which it shall hear and decide all actions for grievance. The Board, through the GARC, shall likewise exercise jurisdiction to review the action of the Corporation dismissing the grievance against the program implementor upon a verified petition of the aggrieved party. The GARC shall be convened upon certification or endorsement by the PARD or upon filing of the petition, as the case may be, and shall continue to meet as a body until a decision thereon is rendered. The PARD shall act as the investigating arm of the GARC.

SECTION 178. Quorum and Votes Required – Three (3) members of the GARC shall constitute a quorum to deliberate on and decide any case brought before it. In all cases, the concurrence of at least three (3) members of the GARC which shall include the President as the Presiding Officer shall be necessary to reach a decision, resolution, order or ruling.

SECTION 179. Preliminary Determination - Upon the endorsement of the grievance, the GARC, after consideration of the allegations thereof, may dismiss a case outright due to lack of verification, failure to state a cause of action, or any other valid ground for the dismissal of the grievance after consultation with the Board, or proceed to hear and determine the case.

If the respondent implementor failed to submit the verified answer, counter-affidavits and other supporting documents in the proceeding before the Corporation, the respondent implementor shall be required to file the same with the GARC within five (5) calendar days from the service of summons. Summons may be served in accordance with the provisions of this Rules.

SECTION 180. Judgment by Default - Should the respondent implementor fail to answer within the reglementary five (5) calendar-day period provided in the immediately preceding section, the GARC, *motu proprio*, or upon motion of the aggrieved party, shall render judgment as may be warranted by the facts on record and limited to what is prayed for in the complaint for grievance.

SECTION 181. Position Papers - After an answer is filed and the issues are joined, the GARC shall require the parties to submit, within ten (10) calendar days from receipt of the order, a brief statement of their respective positions setting forth the law and the facts relied upon by them. In the event the GARC finds, upon consideration of the pleadings, records of the proceeding before the Corporation and position statements submitted by the parties, that a judgment may be rendered thereon without need of a formal hearing, it may proceed to render judgment not later than ten (10) calendar days from submission of the position papers by the parties.

SECTION 182. Clarificatory Hearing - In cases where the GARC deems it necessary to hold a hearing to clarify specific factual matters before rendering judgment, it shall set the case for hearing for the said purpose. At such hearing, witnesses whose affidavits were previously submitted may be asked clarificatory questions by the proponent and by the GARC and may be cross-examined by the adverse party. The order setting the case for hearing shall specify the witnesses who will be called to testify, and the matters on which their examination will deal. The hearing shall be terminated within fifteen (15) calendar days, and the case decided by the GARC within fifteen (15) calendar days from such termination.

SECTION 183. Contents of the Decision - Decisions of the GARC shall be clear and concise and shall include brief statements of the facts of the case, the issue/s involved, the applicable law/s or rule/s, conclusions and reasons therefor, and specific reliefs granted.

SECTION 184. Finality of Judgment - The decision of the GARC shall become final and executory fifteen (15) calendar days after notice thereof was given to the parties, unless an appeal is filed with the Board within the same period, in accordance with the procedure set forth in this Rules.

SECTION 185. Administrative Sanctions – Upon finding of guilt, the GARC may censure, reprimand, or suspend the respondent implementor from office, depending on the gravity of the offense: *Provided*, that the suspension shall not exceed thirty (30) days.

SECTION 186. Degree of Proof - In all its proceedings the GARC and the Board shall not be bound by the technical rules of evidence: *Provided, however*, that the Rules of Court shall apply with suppletory effect.

SECTION 187. Powers of the GARC - The GARC can administer oaths, certify to official acts and issue subpoena *ad testificandum* to compel the attendance and testimony of witness, and subpoena *duces tecum* to enjoin the production of books, papers and other records pertinent to the case. Any act of contumacy shall be dealt with in accordance with Section 14, Chapter 3, Book VII of the Revised Administrative Code.

Rule XXXVII REVIEW OF GARC DECISION

SECTION 188. Jurisdiction - The Board, *en banc*, shall have exclusive appellate jurisdiction to review decisions of the GARC in grievances filed under the Act and this Rules.

SECTION 189. Period to File Petition for Review - A Petition for Review shall be filed within a non-extendible period of fifteen (15) calendar days from receipt of the decision of the GARC.

SECTION 190. Who May File Petition for Review - Any of the parties in a complaint for grievance decided by the GARC may file a Petition for Review.

SECTION 191. Decision of the Board - The Board shall resolve the petition within thirty (30) calendar days from receipt of the Petition for Review and the records of the case.

Rule XXXVIII ADMINISTRATIVE PROTESTS

SECTION 192. Jurisdiction – The Chief Operating Officer (COO), through the Claims Review Department (CRD), shall act on all administrative protests filed by health care providers and members against decisions pertaining to processing and payment of claims.

SECTION 193. Claims Subject to Protest - Claims that were either denied or reduced may be the subject of a protest before the CRD.

SECTION 194. Form - The protest must be in writing, duly signed by the protestant and addressed to the COO. It must be accompanied by supporting documents and filed not later than sixty (60) calendar days from receipt of written notice of denial/reduction.

SECTION 195. Procedure Before the CRD - Upon receipt of the protest, the CRD may either return the same, where the period of filing a protest has lapsed, or give it due course. The CRD may require submission of additional documents or affidavits pertinent to a just resolution of the protest. Thereafter, it shall notify concerned parties of the protest and request their comments on the allegations therein.

SECTION 196. Action on Claims - After thorough deliberation, the CRD shall recommend to the COO any of the following actions on the protest, as appropriate:

- a. The denial of the protest if the claims are invalid or without merit in the light of existing laws, pertinent circulars and orders of the Corporation;
- b. The grant of the protest if the claims are found to be valid and meritorious and to direct the payment thereof;
- c. The prosecution of the parties responsible therefor before the appropriate administrative body or competent court where there is a finding of violation of laws, rules and regulations;
- d. Such other actions as are just or equitable under the circumstances.

The COO may adopt, modify or reject the recommendation of the CRD in whole or in part. Forthwith, the COO shall issue an order resolving the protest, citing the facts and the law or rules on which the same is based. The decision of the COO shall be final and executory, unless appealed to the Board through the PARD in accordance with the procedures above stated.

Under the aforementioned provisions, the CRD and PARD shall exercise their respective functions until such time that the offices under the re-engineered organizational structure are put in place, or until the Board declares otherwise.

Title IX - TRANSITORY PROVISIONS

SECTION 197. PhilHealth Number Card – Members of the NHIP can temporarily use their PhilHealth Number Card which shall serve as the basis for availment of services until such time that they are issued a PhilHealth Identification Card. OWWA Medicare members can use their Eligibility Certificate (EC) in the availment of benefits.

SECTION 198. SSS Employer ID Number – Private sector employers including household employers who have registered with the SSS prior to July 1, 1999, can temporarily use their SSS Employer ID Number until such time they are issued a permanent PhilHealth Employer Number (PEN).

Title X – MISCELLANEOUS PROVISIONS

SECTION 199. Repealing Clause - All PhilHealth circulars, orders and memoranda inconsistent with the provisions of this Rules are hereby considered repealed or amended.

SECTION 200. Separability Clause - In the event any provision of this Rules or the Act or the application of such provision to any person or circumstance is declared invalid, the remainder of this Rules or the application of said provisions to other persons or circumstance shall not be affected by such declaration.

SECTION 201. Promulgation and Effectivity - The Board shall promulgate this Rules in at least two (2) national newspapers of general circulation. It shall take effect on July 1, 2004.

Done in Pasig City, Philippines, this 18th of March 2004.

(SGD.) **MANUEL M. DAYRIT, M.D., M.Sc**

Chairperson
Secretary, Department of Health

(SGD.) **FRANCISCO T. DUQUE, III, M.D., M.Sc**

Vice-Chairperson
President & CEO, Philippine Health Insurance Corporation

(SGD.) **CORAZON J. SOLIMAN**

Member
Secretary, Department of Social Welfare and Development

(SGD.) **JOSE D. LINA, JR.**

Member
Secretary, Department of the Interior and Local Government

(SGD.) **PATRICIA A. STO. TOMAS**

Member
Secretary, Department of Labor and Employment

(abstain)

ARLYN GRACE V. GUICO

Member
Representative, Health Care Providers' Sector

(SGD.) **MA. ASUNCION E. VILLANUEVA**

Member
Representative, Self-Employed Sector

(SGD.) **GREGORIO C. DEL PRADO**

Member
Representative, Labor Sector

WINSTON F. GARCIA

Member
President & General Manager, Government Service Insurance System

(SGD.) **CORAZON S. DELA PAZ**

Member
President & CEO, Social Security System

This IRR has been approved as per PhilHealth Board Resolution Nos. 661 & 692 s,2004