|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **ANNEX A** | | | | | | | | | | | | | | | |
| **STATEMENT OF ACOUNT** | | | | | | | | | | | | | | | |
| **SOA REFERENCE NO.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | |
|  |  | |  | |  | |  | |  | |  | |  | |  |
| Republic of the Philippines  Province of Cavite  CITY OF GENERAL TRIAS  OFFICE OF THE CITY HEALTH OFFICER  **GEN. TRIAS CHO ANIMAL BITE TREATMENT CENTER** | | | | | | | | | | | | | | | |
| **HOSPITAL RD., BRGY. PINAGTIPUNAN, GEN. TRIAS, CAVITE** | | | | | | | | | | | | | | | |
| **TEL. NO: (046) 509-5289** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **PATIENT NAME : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE & TIME ADMITTED 08:00AM/PM \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | |
| **ADDRESS : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE & TIME ADMITTED:12:00AM/PM \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | |
| **FINAL DIGNOSIS : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CATEGORY III FIRST CASE RATE : 90375 T14.1 W5\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | |
| **OTHER DIGNOSIS : 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SECOND CASE RATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(IF APPLICABLE)** | | | | | | | | | | | | | | | |
| **SUMMARY OF FEES** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **PARTICULARS** | | **ACTUAL CHARGES** | | **AMOUNT OF DISCOUNTS** | | | | | | **PHILHEALTH BENEFITS** | | | | |  |
|  |
|  | |  | |  | |  | | **PLACE √ \_\_\_\_\_ PCSO \_\_\_\_\_DSWD \_\_\_\_\_\_DOH \_\_\_\_\_\_HMO OTHERS: \_\_\_\_\_\_\_\_\_** | |  | |  | |  |  |
|  | | **VAT EXEMPT** | | **SENIOR CITIZEN / PWD** | | **FIRST CASE RATE AMOUNT** | | **SECOND CASE RATE AMOUNT** | | **OUT OF POCKET OF PATIENT** |
| **HCI FEES** | |  | |  | |  | |  | | **₱2700 . 00** | |  | |  |  |
| **ROOM & BOARD** | |  | |  | |  | |  | |  | |  | |  |  |
| **DRUGS & MEDICINE** | |  | |  | |  | |  | |  | |  | |  |  |
| **( ERIG EQUINE ANTI RABIES SERUM )** | | **PHP\_\_\_\_\_\_\_\_\_\_.00** | |  |
| **ANTI RABIES VACCINE (INACTIVATED)** | | **PHP 2600.00** | |  |
| **LABORATORY & DIAGNOSTIC** | | **N/A** | |  | |  | |  | |  | |  | |  |  |
| **OPERATING ROOM FEE** | | **N/A** | |  | |  | |  | |  | |  | |  |  |
| **SUPPLIES** | |  | |  | |  | |  | |  | |  | |  |  |
| **OTHERS PLS. SPECIFY** | | **N/A** | |  | |  | |  | |  | |  | |  |  |
| **SUBTOTAL** | | **PHP\_\_\_\_\_\_\_\_\_\_.00** | | **N/A** | | **N/A** | | **N/A** | | **PHP\_\_\_\_\_\_\_.00** | | **N/A** | |  |  |
| **PROFESSIONAL FEE/S** | |  | |  | |  | |  | |  | |  | |  |  |
| **1 . RUTH S. PUNZALAN M.D** | |  | |  | |  | |  | | **PHP 300 .00** | |  | |  |  |
| **2** | |  | |  | |  | |  | |  | |  | |  |  |
| **SUB TOTAL** | | **PHP\_\_\_\_\_\_\_\_\_\_.00** | | **N/A** | | **N/A** | | **N/A** | | **PHP\_\_\_\_\_\_\_.00** | | **N/A** | | **PHP\_\_\_\_\_\_\_\_.00** |  |
| **TOTAL** | | **PHP\_\_\_\_\_\_\_\_\_\_.00** | | **N/A** | | **N/A** | | **N/A** | | **PHP\_\_\_\_\_\_\_.00** | | **N/A** | | **PHP\_\_\_\_\_\_\_\_.00** |  |
| **PREPARED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CONFORME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | |
| **BILLING CLERK / ACCOUNTANT MEMBER/ PATIENT/ AUTHORIZED REPRESENTATIVE** | | | | | | | | | | | | | | | |
| **( SIGNATURE OVER PRINTED NAME ) ( SIGNATURE OVER PRINTED NAME )** | | | | | | | | | | | | | | | |
| **DATE SIGNED :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP TO MEMBER OF AUTHORIZED REPRESENTATIVE:** | | | | | | | | | | | | | | | |
| **CONTACT NO.: 09178043593 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | |
| **DATE SIGNED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CONTACT NO.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | |
| **REMARKS : ( ) NO BALANCE BILLING FOR ( ) INDIGENT ( )SENIOR ( ) NHTS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | |
| **NOTE: 1. FILL OUT FORM LEGIBLY 2. THE MEMBER/ PATIENT/ AUTHORIZED REPRESENTATIVE SHOULD NOT SIGN A BLANK SOA.** | | | | | | | | | | | | | | | |
| **3.PRINTED COPY OF SOA OR ITS EQUIVALENT SHOULD BE FEE OF CHARGED** | | | | | | | | | | | | | | | |
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