STATEMENT OF ACCOUNT

CASE NO. **IPD-4646**

PATIENT NO. **127876**

PATIENT NAME: **MOTA, EDRIAN AVISO**

ATTENDING PHYSCIAN **MA. TERESITA ZAMORA CABREIRA**

ADDRESS: **PHASE II C2 BLK 114 LOT 13 KARANGALAN PASIG CITY**

ROOM/BED # **709 - B**

ROOM RATE **2,000.00**

ADMITTED **7/4/2025 9:33 PM**

DISCHARGED **7/10/2025 10:59 AM**

PHIC **Not Applicable**

CASE TYPE **House/Walk-In**

PATIENT TYPE **Inpatient**

HMO **ASALUS CORPORATI**

First Case Rate : **A97.1**

Second Case Rate : _____

Final Diagnosis/es and ICD 10 Code/s:

1. A97.1   DENGUE FEVER WITH WARNING SIGNS- RESOLVED

Surgical Procedure/s and RVS Code/s, if Applicable :

SUMMARY OF FEES FOR HOSPITAL CHARGES

Particulars	Actual Charges	Senior Citizen/ PWD	Philhealth Benefits First Case Rate Amount	Philhealth Benefits Second Case Rate Amount	Amount of Discounts Place x ☐HMO	Amount of Discounts Place x ☐PCSO ☐DSWD	Other Discounts	Out of Pocket of Patient
HCI fees								
Room and Board 6.00 Day(s) @ 2000.00	12,000.00		12,000.00	0.00				
5TH NURSE STATION	12,188.00		0.00	0.00				12,188.00
ADMITTING	3,000.00		0.00	0.00				3,000.00
CSR	2,737.84		815.47	0.00				1,922.37
EMERGENCY ROOM	11,488.87		296.30	0.00				11,192.57
LABORATORY	21,614.32		0.00	0.00				21,614.32
PHARMACY	17,591.93		538.23	0.00				17,053.70
XRAY	1,116.06		0.00	0.00				1,116.06
Subtotal	**81,737.02**	**0.00**	PHIC1 covers Case Rate 1	**0.00**	**0.00**	**0.00**	**0.00**	**68,087.02**
SUMMARY OF FEES FOR PROFESSIONAL FEES								
Professional fee/s								
CABREIRA, MA. TERESITA ZAMORA	5,850.00		5,850.00					
TAYZON, MARIA FE RAYMUNDO								
GILLANA, MA. MAYUMI B.								
Subtotal	**5,850.00**	**0.00**	**5,850.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Total	**87,587.02**	**0.00**	**19,500.00**	**0.00**	**0.00**	**0.00**	**0.00**	**68,087.02**

Payment/s	OR Number	OR Date		Amount
			TOTAL PAYMENT:	
				0.00
			BALANCE DUE	**68,087.02**

Prepared by:

SUAREZ, CARLOS JERWIN PEREZ

BILLING CLERK / HMO CLERK
(Signature over printed name)

Date signed.: 7/10/2025 11:32 AM

Tel. No: 88787362

Conforme:

_____

Member/Patient/Authorized representative
(Signature over printed name)
Relationship to member of authorized representative:

Date signed.:   Contact no.: