



# RAMIRO COMMUNITY HOSPITAL

0139 C. Gallares Street, Poblacion II Tagbilaran City, Bohol, Philippines

Tel. No(s): 6338-4113515

## Summary of Statement of Account

Run Datetime: 5/4/2023 9:46:09 AM

Patient Name: **[REDACTED]**  
Hospitalization Plan: **Self-Pay**  
Attending Doctor(s):  
Patient Address: **Prk 4 Cayacay, Alicia, Bohol, Philippines**

Registry No: **479218**  
Age: **25Y4M4D**  
Registry Date: **05/04/2023**  
Discharge:

### PARTICULARS

### AMOUNT

0.00

Subtotal .....

Philhealth Benefits (PF)

**Total** .....

**0.00**

Refund

### Important:

The Statement of Account is not a receipt of payment. The hospital reserves the right to bill you of additional charges incurred which were not covered by your health insurance (PHILHEALTH and/or HMO).

For possible PHILHEALTH refund, please contact 411-3515 ext 1116 or 501-9646 within (30) days upon receipt of your Benefit Payment Notice.

### Remarks:

The balance reflected in this Statement of Account represents the professional fee/s paid directly to the Physician/s and/or the unpaid Hospital Bill stated in the Promissory Note hereby attached.

Billed By:

Approved By:

**CLAVE, WILLIAM DOLOGUIN**

Member/Representative  
Signature Over Printed Name / Thumbmark

Billing Clerk

PBO-Supervisor