OSPITAL NG PARAÑAQUE	Document Code: **OSPAR-AFS-BILL-PHIC 002**
	Issue Date:
ADMINISTRATIVE AND FINANCE APPROVAL MATRIX	Section / Department **BILLING -PHILHEALTH SECTION**
Policy Title: **POLICY ON PROCESSING OF PHIC MATTERS AND BENEFITS**	Page No. 1 of 2

Prepared By:	Reviewed By:	Approved by :
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OBJECTIVE:

To properly disseminate information and guidelines for the prompt processing of all matters concerning the Philippine Health Insurance Corporation (PHIC).

COVERAGE:

This policy shall cover all Sections of this hospital who are members or beneficiaries of such insurance.

RESPONSIBILITIES:

I. It shall be the responsibility of this Section to inform all members and their beneficiaries of the requirements for filing and subsequent processing of documents to maximize claims for both the patient and the hospital.

II. It shall be the responsibility of the Cash Section to accept deposits for payment if with incomplete attachments and to issue a temporary receipt to the patient; to issue an Official Receipt for checks received as payment by the PHIC.

III. It shall be the responsibility of the medical staff to complete the admitting and final diagnosis and procedures, if any, according to the International Classification of Diseases -10 (ICD-10) before processing of claims.

IV. It shall be the responsibility of the Medical Record Section staff to input into each chart the equivalent ICD-10 code before receipt of this section.

POLICIES:

I. This policy shall enforce compliance with the requirements set by the Philippine Health Insurance Corporation. (PHIC) for accurate computation and faster processing of all benefits covered by this claim.

II. This policy shall create a limit to claims as set by the standards established by the same insurance corporation.

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PROCEDURES:

I. The PHIC member/beneficiary shall fill out the official Claim Form 1 (CF-1) duly signed by the member and the employer. This form shall be submitted to the Billing Section for processing on or before patient discharge.

II. This section shall issue the list of requirements to be attached to Claim Forms 1 & 2(CF1 & CF2). The section shall compute for the PHIC benefits that may be due to the patient against the charges accumulated by his stay in the hospital.

III. The section shall inform the member and/or beneficiary of the ceiling or limit set by PHIC based on the type of illness (Fee for Service/Case rate). They shall also be advised to inform their Medical Specialist/s, if a private case, of their claim to get the maximum discount from the Professional fees.

IV. Once requirements are submitted and computation is completed Order of payment shall be issued if no excess, bill shall be through PHIC; if otherwise excess shall be written on the Order of Payment.

V. The Cashier Section shall issue clearance if no payment required. An official receipt is issued if with payment. The same section shall be authorized to receive cash deposits as payment of the total hospital bill for safe keeping in cases wherein requirements are incomplete prior to discharge.

VI. The Billing Section shall require all claimants to complete all the requirements within two (2) weeks from time of discharge so as not to compromise the process of filing.

VII. A hospital “deposit” with complete PHIC requirements will be computed and refunded to patients by the Billing section. Overdue PHIC “deposit” (4 weeks old) will be forwarded to the cashier for issuance of Official Receipt.

VIII. Official Receipt (OR) shall be issued to Phil health for reimbursement of HCI charges and Professional Fees designated for Pooling. PHIC patients shall be reimbursed by the Billing/PHIC Section, when applicable.