PHILHEALTH BOARD RESOLUTION NO. 324-00

SUBJECT: ***Revised Rules and Regulations Implementing the National Health Insurance Act of 1995 (Republic Act No. 7875)***

TITLE I
Guiding Principles

SECTION 1. Declaration of Principles and Polices. — 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 an 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 Revised 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 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. Can 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 revised 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 such 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. Accredited Collecting Agency — refers to a bank or any other institution accredited by the Corporation to receive premium contributions from members.

b. Act — refers to Republic Act No. 7875 otherwise known as the National Health Insurance Act of 1995.

c. Accreditation — refers to 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 participation in the NHIP and assuring that health care services rendered by them are of the desired and expected quality.

d. Benefit Package — refers to services that the NHIP offers to members, subject to the classification and qualifications provided in this Rules.

e. Board — refers to the Board of Directors of the Philippine Health Insurance Corporation.

f. Capitation — refers to a payment mechanism where a fixed rate, whether per person, family, household or group, is negotiated by the Corporation with a health care provider who shall deliver or arrange the delivery of health services due to a covered person under the terms of a health care provider contract.

g. Complaint — refers to 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 the member's coverage and/or entitlement to benefits under the NHIP.

h. Coverage — refers to the entitlement of an individual, as a member or as a dependent, to the benefits of the NHIP.

i. Dependent — refers to 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 NHI Act.

j. Diagnostic Procedure — refers to any procedure to identify a disease or condition through analysis and examination.

k. Emergency — refers to 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.

l. Employee — refers to 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.

m. Employer — refers to a natural or juridical person who employs the services of an employee.

n. Enrollment — refers to the process determined by the Corporation to enlist individuals as members or dependents covered by the NHIP.

o. Fee-for-Service — refers to a reasonable and equitable health care payment system under which health care providers receive a payment that does not exceed their billed charge for each unit of service.

p. Global Budget — refers to an approach in the purchase of medical services by which health care provider negotiates the cost of providing a specific package of medical benefits based solely on a pre-determined and fixed budget as determined by the Corporation.

q. Government Employee — refers to 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.

r. Government Service Insurance System (GSIS) — refers to 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.

s. Grievance — refers to a ground for complaint as provided for in this Rules by a member, dependent or health care provider who believe they have 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.

t. 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 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 hour use or longer by patients in the treatment of disease, injures deformities or abnormal physical and mental states, maternity cases or sanitarial care; or infirmaries, nurseries, dispensaries 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 organization (CBHO), 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.

u. Health Insurance Arbiter (Arbiter) — refers to an official of the Corporation who has been appointed to hear and decide, complaints filed against accredited health care providers and enrolled members.

v. Household — refers to a unit composed of an enrolled member and the legal dependents.

w. Indigent — refers to 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 NHI Act.

x. Individually-Paying — refers to a person who pays the required contribution in full.

y. Initial Accreditation — refers to an 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.

z. Inpatient Education Package — refers to a set of informational service made available to an individual who is confined in a hospital to provide the beneficiary and family members with knowledge about the illness and its treatment, the means available to prevent the recurrence or aggravation of such illness and to promote health in general.

aa. Local Health Insurance Office (LHIO) — refers to the offices established by the Corporation in every province and chartered city, or wherever it is deemed practicable. Pending full operationalization of the LHIO, the Regional Health Insurance Office (RHIO) established by the Corporation in every region shall be referred to as the LHIO.

bb. Local Government Contribution Subsidy — refers to the counterpart contributions that the local governments shall provide for indigents and partly paying members enrolled by the local government units where they reside.

cc. Local Government Units (LGUs) — refer to provinces, cities, municipalities, and barangays where an enrolled member resides.

dd. Means Test — refers to 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.

ee. Mechanism for Feedback — refer to 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.

ff. Medicare — refers to the health insurance program initially implemented under Republic Act 6111 as amended, which is now the NHIP under Republic Act 7875.

gg. Member — refers to any person enrolled in the NHIP whose required premium contribution has been regularly paid.

hh. National Contribution Subsidy — refers to the counterpart premium contribution that the national government, through the Corporation, shall provide to indigents who are enrolled in the NHIP.

ii. National Health Insurance Program (NHIP) — refers to a compulsory health insurance program of the government as established in the National Health Insurance Act of 1995 (Republic Act No. 7875) which shall provide universal health insurance coverage and ensure affordable, acceptable, available and accessible health care services for all citizens of the Philippines.

jj. Non-Paying Member — refers to:

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 law on March 4, 1995; or

2. A pensioner of the GSIS or SSS prior to the effectivity of the law on March 4, 1995; or

3. A member who has reached the age of retirement as provided for by law and has paid at least 120 monthly premium contributions.

kk. Outcomes Assessment — refers to the process monitoring and review of outcomes resulting from the health care services rendered by accredited providers. Information that can result from an outcomes assessment includes knowledge and attitudes changes, short-term or intermediate behavior shifts, reduction of morbidity and mortality, satisfaction of patients with care and cost, among others.

ll. Out-Patient Clinic — refers to 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.

mm. Overseas Workers' Welfare Administration (OWWA) — refers to the Overseas Workers' Welfare Administration created by Presidential Decree No. 1694, as amended.

nn. Peer Review — refers to 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 the payment or non-payment of claims.

oo. Performance Monitoring — in the health field, it refers to an on-going measurement of a variety of indicators of health care quality to identify potential problems and to provide remedial measures in health care delivery.

pp. PhilHealth Employer Number (PEN) — refers to the permanent and unique number issued by the Corporation to employers.

qq. PhilHealth Identification Number (PIN) — refers to the permanent and unique number issued by the Corporation to its members and contained in the PhilHealth Identification Card.

rr. PhilHealth Identification Card — refers to the card issued by the Corporation to its members containing vital information which will be the basis of the member's identification, eligibility for availment of program services and other transactions with the Corporation.

ss. Philippine Health Insurance Corporation (PHIC or PhilHealth) — refers to the Corporation mandated by law to administer the NHIP, hereinafter referred to as the Corporation.

tt. Philippine Medical Care Commission (PMCC) — refers to the Philippine Medical Care Commission created under Republic Act No. 6111, as amended.

uu. Philippine National Drug Formulary (PNDF) — refers to the essential drugs list for the Philippines which is prepared by the National Drug Committee of 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 every year.

vv. Policy Review and Formulation — refers to 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.

ww. Portability — refers to the entitlement of a member to avail of NHIP benefits in an area outside the jurisdiction of the member's LHIO.

xx. Premium Contribution — refers to 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.

yy. Prescription Drug — refers to 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.

xx. Private Sector Employee — an employee who renders services in any of the following:

1. Corporations, partnerships, or single proprietorships, non-government organizations, cooperatives, non-profit organizations, social, civic, or charitable institutions, organized in the Philippines, whether based in the Philippines or abroad;

2. Foreign corporations, business organizations, non-governmental organizations based in the Philippines or abroad;

3. Foreign governments or international organizations with quasi-state status based in the Philippines or abroad which entered into an agreement with the Corporation to cover its Filipino employees in the NHIP;

4. Foreign business organizations based abroad with agreement with the Corporation to cover its Filipino employees in the NHIP;

5. Household employers availing services of household helpers.

aaa. Privately-Sponsored Member — refers to one whose premium contribution is being paid for by charitable organizations, duly registered associations, CBHOs, cooperatives, private non-profit health insurance organizations or an individual through a defined criteria set by the Corporation.

bbb. Program Implementor — refers to 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, 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.

ccc. Prosecutor — refers to an employee of the Corporation who is given the power and authority to conduct fact-finding investigation on complaints filed by any person against health care providers and/or members.

ddd. Quality Assurance — refers to 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 direct patient, administrative and support services.

eee. Re-accreditation — refers to 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 capability of institutional health care providers.

fff. Reinstatement of Accreditation — refers to the restoration of accreditation following a suspension of an accreditation after compliance with the requirements, conditions and connections imposed by the Corporation.

ggg. Reinstatement of Membership — refers to the restoration of coverage and entitlement to benefits following a suspension of benefits due to separation from employment or discontinuance of voluntary payments. Reinstatement follows after compliance with the requirements and conditions imposed by the Corporation.

hhh. Renewal Accreditation — refers to the accreditation given to a health care provider before the expiration of a previous accreditation in accordance with the provisions of this Rules.

iii. Residence — refers to the place where a member actually lives.

jjj. Single Period of Confinement — refers to a series of confinements/procedures for the same illness with intervals of not more than ninety (90) calendar days within the calendar year.

kkk. Social Security System (SSS) — refers to the Social Security System created under Republic Act. No. 1161, as amended by Republic Act 8282, otherwise known as the Social Security Act of 1997.

lll. Sufficient Regularity of Premium Contribution — refers to the payment of premium contribution of at least nine (9) months within the twelve-month period immediately prior to the month of availment.

mmm. Therapeutic Committee — refers to the committee created by DOH Administrative Order No. 51 s. 1998. It shall be the highest professional body in the health care institution for drug related issues and shall exert genuine influence in the use of drugs.

nnn. Treatment Procedure — refers to any method used to remove the symptoms and cause of a disease.

ooo. Utilization Review — refers to a formal evaluation of the necessity, cost appropriateness and efficiency of the use of medical services, procedures and/or facilities, on a prospective, concurrent or retrospective basis including but not limited to examination of the clinical application of medical knowledge as revealed by medical records.

TITLE III
Membership And Contribution

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 15 years of its implementation.

Coverage of the employed in the government and private sectors shall be required. The enrollment of indigent households and individually-paying groups which comprise the majority of Filipinos not covered by health insurance shall be ensured. The Corporation shall likewise develop mechanisms for the phasing in of CBHOs and other institutions with the NHIP.

SECTION 5. Activities. — To achieve the above objectives, the Corporation shall undertake the following activities:

a. Require the enrollment of the employed in the government and private sectors;

b. Actively enroll individually-paying members and other persons without health insurance;

c. Coordinate with LGUs for the implementation of the government subsidy program for indigent families or the Indigent Program in their areas;

d. Develop mechanisms for the phasing in of CBHOs and other institutions with the NHIP;

e. 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;

f. Establish an efficient premium collection mechanism;

g. Establish and maintain an updated membership and contribution database; and

h. Undertake intensive information, education, and communication (IEC) and marketing activities.

SECTION 6. Nature and Scope. — The NHIP shall cover the following members and their dependents:

a. Employed

- Government Sector Employed
- Private Sector Employed

b. Indigents

c. Individually-Paying

- Self-Employed
- Overseas Filipino Workers (OFWs)
- Employers/Employees of International Organizations and Foreign Governments based in the Philippines
- Privately sponsored
- Others including the following:

- Individuals who are separated from employment and who intend to continue membership

- 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

d. Non-Paying

RULE II
General Provisions

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/Loss of the 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 unexpired identification card.

SECTION 9. Requirements for Membership Registration. — A person intending to register with the NHIP for the first time regardless of membership category should submit, together with the appropriate PhilHealth membership registration form, any of the following documents:

a. Birth Certificate

b. Baptismal Certificate

c. GSIS/SSS Members ID

d. Passport

e. Any other valid ID/document acceptable to the Corporation

The registrant may submit a photocopy of the above-mentioned documents but the original/certified true copy should be presented for authentication of the photocopy.

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

a. Marriage Contract — for dependent spouse

b. Marriage Contract and Birth/Baptismal Certificate — for dependent legitimate children

c. Birth/Baptismal Certificate — for illegitimate children

d. Adoption papers or court resolution/decision — for dependent adopted children

e. Birth/Baptismal certificate of registrant — for dependent parents

f. Marriage Contract of the parent and stepfather/stepmother and Birth Certificate of the dependent stepchildren — for dependent stepchildren

g. Duly notarized 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.

h. Certificate from the Department of Social Welfare and Development (DSWD) or Barangay Captain attesting to the fact of the relationship of the dependents to the supposed members.

i. 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 authentication of the photocopy.

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 for revision/amendment in the data which was 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

d New/Additional/Change of Dependent/s — submit Birth Certificate of the dependent

e. Change of address — submit written notice

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

SECTION 13. General Provisions on Contribution. — Remittance of premium contribution shall be made through the LHIO or to any of the Accredited Collecting Agency.

SECTION 14. Penalties. — Late remittance of premium contribution for employed and indigent members shall make the employer or the LGU concerned liable for the payment of penalties at rates prescribed by the Board without prejudice to the penal sanctions that may be instituted as provided for in Article X of Republic Act 7875.

RULE III
Specific Provisions Concerning Employed Members

SECTION 15. Government and Private Sector Employees. — All government and private sector employees are compulsory members of the NHIP.

All officers and uniformed personnel and non-uniformed employees of the Armed Forces of the Philippines (AFP), Philippine National Police (PNP) Bureau of Jail Management and Penology (BJMP), and Bureau of Fine Protection (BFP) who entered the service after the effectivity of Republic Act 8291, otherwise known as the new GSIS Act on June 24, 1997, are likewise compulsory members of the NHIP.

All persons who are employed for the first time should be registered with the NHIP by the employer.

SECTION 16. Registration of Employers. — All government and private employers including branches, regional offices and other sub-units that deduct premium contribution of their respective employees and subsequently remit the same together with the employer counterpart to PhilHealth are required to register with the Corporation and each shall be issued a permanent PhilHealth Employer Number (PEN). Branches/regional offices and sub-units possessing the above-mentioned characteristics shall therefore register separately from their central/main offices with the Corporation.

Private sector employers including household employers 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 17. Employer Data Amendment/Revision. An employer may request for revision/amendment in the data which was 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 business name/legal personality — submit certificate of filing of business name with the Bureau of Domestic Trade 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

        — Certification from City Hall

c. Termination/dissolution

1. For single proprietorship — submit approved application for business retirement by the Municipal Treasurer's Office.

2. For partnership or corporation — submit Deed of Dissolution approved by the Securities and Exchange Commission (SEC) or Minutes of the Meeting certified by the corporate secretary.

3. Death certificate in case the owner dies.

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.

SECTION 18. Obligations of the Employer. — It is the obligation of the employer to report to the Corporation its newly-hired employees within thirty (30) calendar days from assumption to office. The report should contain whether the employee is an old or new member of the NHIP and should indicate the PIN in case the said employee is an old member.

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 give notice 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.

SECTION 19. Schedule of Premium Contributions. — The following premium contribution schedule shall be used by employed members in the government and private sectors:

Premium Contribution Schedule From January 1 to December 31, 2000

Monthly Salary Range	Salary Base	Monthly Contribution	Employee Share	Employer Share
P3,499.99 and below	P3,000.00	P75.00	P37.50	P37.50
P3,500.00 to P3,999.99	3,500.00	87.50	43.75	43.75
P4,000.00 to P4,499.99	4,000.00	100.00	50.00	50.00
P4,500.00 to P4,999.99	4,500.00	112.50	56.25	56.25
P5,000.00 and up	5,000.00	125.00	62.50	62.50

Premium Contribution Schedule From January 1 to December 31, 2001

Monthly Salary Range	Salary Base Contribution	Monthly Share	Employee Share	Employer
P3,499.99 and below	P3,000.00	P75.00	P37.50	P37.50
P3,500.00 to P3,999.99	3,500.00	87.50	43.75	43.75
P4,000.00 to P4,499.99	4,000.00	100.00	50.00	50.00
P4,500.00 to P4,999.99	4,500.00	112.50	56.25	56.25
P5,000.00 to P5,499.99	5,000.00	125.00	62.50	62.50
P5,500.00 to P5,999.99	5,500.00	137.50	68.75	68.75
P6,000.00 to P6,499.99	6,000.00	150.00	75.00	75.00
P6,500.00 to P6,999.99	6,500.00	162.00	81.25	81.25
P7,000.00 to P7,499.99	7,000.00	175.00	87.50	87.50
P7,500.00 and up	7,500.00	187.50	93.75	93.75

The Corporation however, reserves the right to adopt a new premium contribution schedule.

SECTION 20. Payment of Premium Contributions. —

a. The premium contribution of employed members shall be paid on a monthly basis and should be remitted by the employer on or before the tenth (10th) calendar day following the month for which the payment is due and applicable.

b. Each employer shall submit quarterly remittance reports to the Corporation not later than the fifteenth (15th) calendar day of the month after the applicable quarter and stating therein the name of all its employees, their corresponding employment status, positions, salaries, monthly contribution and changes therein, if any.

c The member's contribution shall be deducted and withheld automatically by the employer from the former's salary, wage or earnings. The employer's counterpart contribution shall not in any manner be recovered from the employee.

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 would 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.

RULE IV
Specific Provisions Concerning Members of the Indigent Program

SECTION 21. 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 22. Enrollment of Indigent Members. — The determination of indigent members will be undertaken through the conduct of a social research survey referred to as the means test to determine current socio-economic and health profile of the indigent sector in each LGU. The means test being used is the Community Based Information System — Minimum Basic Needs (CBIS-MBN). The Corporation, however reserves the right to identify and adopt other means test mechanisms as it may deem appropriate.

The LGU takes the lead role and supervision in the installation, maintenance and updating of the CBIS-MBN in coordination with the DSWD. The Corporation and other concerned government agencies shall provide technical, manpower and financial assistance, where necessary, in the conduct, administration and management of CBIS-MBN.

Prioritization in the grant of membership in the NHIP Indigent Program shall be based on a scoring system to be agreed upon by the Corporation and the CBIS-MBN implementing arm in the LGU. In the absence or unavailability of a scoring system, a proposed "List of Eligible NHIP Indigent Members" duly certified by the City Development and Social Welfare Officer (CSWDO)/Municipal Social Welfare Development Officer (MSWDO) as having been obtained from CBIS-MBN Family Data Survey Form (FDSF) or in compliance with CBIS-MBN rules shall be submitted to the Corporation for approval.

The Corporation may verify the propriety of formulating the proposed List of Eligible NHIP Indigent Members, under the conditions prevailing in the preceding paragraph based on the results of the CBIS-MBN.

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

SECTION 23. Annual Verification 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 24. Grounds for Revocation/Cancellation of Membership and Replacement. — 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.

The LGU may propose for the replacement of the indigent member during the membership year. The "replacement member" should also be certified by the CSWDO/MSWDO.

SECTION 25. Continuation of Coverage in Case of Death of Member. — In case of death of the member the dependents of the deceased shall continue to avail of NHIP benefits for the unexpired portion of the coverage.

SECTION 26. Premium Contribution Schedule for the Indigent Program. — Premium contribution subsidy for indigents as determined by the Corporation shall be shared by the national and the LGUs as follows:

Premium Sharing Scheme Between the National and Local Governments

Year	1st - 3rd Class LGUs	4th - 6th Class LGUs
1st year		90-10
2nd year		90-10
3rd year	50-50	80-20
4th year		70-30
5th year		60-40
6th year and onwards		50-50

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.

The municipal classification, in case of component municipalities of provinces and the barangay classification in case of component barangays of cities, shall be used in the determination of counterpart local government subsidy.

SECTION 27. 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. 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 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 28. SSS Self-Employed. — All self-employed and voluntary paying members of the SSS who are already enrolled in the Medicare Program/NHIP before July 1, 1999 are deemed automatically registered. However, they shall be required to update their membership records with the Corporation.

SECTION 29. Privately Sponsored Members. — Charitable organizations, duly-registered associations. CBHOs, cooperatives, private non-profit health insurance organizations, or an individual may pay the premium contribution of individuals identified through a defined criteria set by the Corporation.

SECTION 30. Venue for Enrollment. — Enrollment for membership as an individually-paying member shall be made through the Corporation's offices or through some other mechanism as may be prescribed by the Corporation.

SECTION 31. Enrollment as Individually-Paying, After Separation from Employment. — A member of the NHIP separated from employment may continue membership by enrolling as an individually paying member within three (3) months after separation. Otherwise, benefit entitlement is suspended.

SECTION 32. Suspension of Benefits. — Failure of an individually paying member to remit at least three (3) months or one quarter contributions and to establish sufficient regularity of premium contributions as defined in this Rules shall result in the suspension of benefits.

SECTION 33. Reinstatement of Benefits. — Benefit availment shall be subject to the three-month waiting period. The qualifying three month premium contribution shall refer to the three regular monthly premiums within six months prior to availment.

SECTION 34. Contribution Schedule. — The premium contribution of individually paying members (including all existing self-employed members of the SSS) shall be at a minimum of P75.00 per month and can be paid quarterly, semi-annually, or annually. Overseas Filipino Workers (OFWs) enrolled with the NHIP shall pay an annual contribution in an amount to be set by the Corporation. The premium rates shall remain until otherwise prescribed by the Corporation.

RULE VI
Specific Provisions Concerning Non-Paying Members

SECTION 35. GSIS and SSS Retirees/Pensioners. — All retirees and pensioners of the GSIS and SSS prior to the effectivity of RA 7875 on March 4, 1995, are automatically considered non-paying members of the NHIP.

SECTION 36. Eligibility Requirements. — Members who reach the age of retirement as provided for by law and have paid at least 120 monthly premium contributions shall register with the corporation as a non-paying member.

The age of retirement referred to is sixty (60) years old with the exception of those covered by special laws. Members who retired under the early retirement programs of agencies shall not be covered unless the retirement age and the minimum required contributions are met.

SECTION 37. Employment of a Non-Paying Member. — A non-paying member who gains regular employment shall resume paying monthly premium contributions 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. Included Benefits. — The benefits under the NHIP shall consist of the following:

a. Inpatient 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

    6. Inpatient education packages

b. Outpatient Care

1. Services of health care professionals
2. Diagnostic, laboratory and other medical services
3. Personal preventive services
4. Prescription drugs and biologicals

c. Emergency and Transfer Services; and,

d. Such other health care services that the Corporation determines to be appropriate and cost effective.

SECTION 41. Benefit Package. — The benefits for confinement of members and their dependents shall not exceed the following:

BENEFIT ITEM	**HOSPITAL CATEGORY**		
	Primary	Secondary	Tertiary
ROOM AND BOARD	120	220	345
a. Maximum of forty-five (45) days for members; and b. Maximum of forty-five (45) days for all dependents,			
Any unused benefit for any prior year shall not be carried over to the succeeding year			
One day room and board shall be deducted from the forty-five (45) day allowance for every outpatient surgical procedure availed except cataract extraction			
DRUGS AND MEDICINES *(per single period of confinement/availment)*			
Ordinary Case	1,165	1,595	2,670
Intensive Case	2,430	3,280	7,660

Catastrophic Case	---	6,575	11,885

X-RAY, LABORATORY, ETC.
(per single period of confinement/availment)

Ordinary	305	760	1,625
Intensive	590	1,680	3,405
Catastrophic	---	3,405	9,810

PROFESSIONAL FEES
(per single period of confinement/availment)
P105/day for General Practitioners and P150/day for Specialists

Ordinary

General Practitioner	540	540	540
Specialist	810	810	810

Intensive/Catastrophic

General Practitioner	810	810	810
Specialist	1,350	1,350	1,350

OPERATING ROOM FEE
(per single period of confinement/availment)

RUV 5.1 and below	385	670	1,060
RUV 5.1 to 10.0	---	1,140	1,350
RUV 10.1 and above	---	2,160	3,490
Surgeon	Maximum of P15,930		
Anesthesiologist	Maximum of P4,785		

SURGICAL FAMILY PLANNING

Vasectomy	900	900	900
Tubal Ligation	1,125	1,125	1,125

The Corporation also provides outpatient services to its members such as chemotherapy, radiation therapy, dialysis, cataract extraction and minor surgical procedures performed in an operating room complex of an accredited facility. For the purposes of this Rules, the operating room fee shall cover services availed of in the operating room, emergency room, delivery room, dialysis, and chemotherapy and radiation rooms.

The Corporation shall likewise develop other outpatient packages including basic diagnostics and consultations with general practitioners and other packages as may be included subject to the succeeding section.

SECTION 42. Phasing-in of Benefits. — The Board shall cause the inclusion of all the benefits provided in the Act after the same have been pilot tested to determine their viability, impact on costs and acceptability to providers and beneficiaries. In all cases, actuarial studies must be undertaken.

SECTION 43. Case Type Classification. —

a. Catastrophic — refers to:

Illnesses or injuries such as but not limited to cancer cases with metastasis and/or requiring chemotherapy or radiation therapy, meningitis, encephalitis, cirrhosis of the liver (childs C), myocardial infraction, cerebrovascular attack, rheumatic heart disease grade III, renal failure, other conditions requiring dialysis or transplant, other conditions with massive hemorrhage, shock of any cause;

Surgical procedure or multiple surgical procedures done in one sitting with a total Relative Unit Value of 20 and above such as but not limited to coronary angioplasty, coronary bypass, open heart surgery, or neurosurgery.

b. Intensive — refers to:

All confinements requiring services in an intensive care unit such as respiratory and monitoring support, cardiac/hemodynamic monitoring and maintenance;

Other similar serious illnesses or injuries such as but not limited to cancer, pneumonia, moderately or far advanced pulmonary tuberculosis including its complications, cardiovascular attack disease of the heart, chronic obstructive pulmonary disease, liver disease, typhoid fever, fever grade III, H-fever, kidney disease, septicemia,

diarrhea with severe dehydration, hepatitis B, dengue hemorrhagic or severe injuries;

Surgical procedure or multiple surgical procedures done in one sitting with a total Relative Unit Value of 8 but not exceeding 19.99.

c. Ordinary — refers to illnesses or injuries other than those included in the above enumeration.

Case type of diseases under each category may be upgraded or downgraded based on the information presented in the prescribed PhilHealth form and/or clinical chart.

The Corporation may change the category of illness or injuries and to adopt other payment mechanisms as maybe appropriate.

SECTION 44. Inpatient Education. — The Board shall provide for a basic inpatient education program as part of the benefits available to a program beneficiary. This package shall include training and instructions on disease prevention, health promotion, and rehabilitation as defined in this Rules.

SECTION 45. 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. Outpatient psychotherapy and counseling for mental disorders;

b. Home and rehabilitation services;

c. Normal obstetrical delivery;

d. Non-prescription drugs and devices;

e. Drug and alcohol abuse or dependency treatment;

f. Cosmetic surgery;

g. Optometric services; and,

h. Cost-ineffective procedures as defined by the Corporation.

SECTION 46. Entitlement to Benefits. — Members and/or their dependents shall be entitled to benefits if the following conditions are met:

a. Confinement in an accredited health care institution due to illness or injury requiring hospitalization; or

   Undergoes a surgical procedure on an outpatient basis in an accredited health care institution; or, Receives out patient benefits provided by the Corporation in a health care institution accredited to provide such services.

b. The member must have paid at least three (3) monthly premium contributions within the immediate six (6) months prior to the first day of availment. If covered through the indigent Program and the OWWA Medicare Program, the members are entitled to avail of benefits on the date of effectivity stated in the ID Card/Eligibility Certificate (EC).

SECTION 47. Requirements for the Availment of Benefits. — To avail of NHIP benefits, a member must present the PhilHealth Identification Card or any other proof of identification and contribution in its absence.

SECTION 48. Single Period of Confinement. — The series of confinement/procedures for the same illness with the interval between such confinements not exceeding ninety (90) calendar days within the calendar year shall be considered as a single period of confinement. Hence, the member shall only be entitled for the remainder of the benefit ceilings set by the Corporation for that period for drugs and medicines, x-rays, laboratories, and others.

SECTION 49. Benefits of Members and their Dependents while Abroad. — Members and/or their dependents shall be eligible to avail of benefits while they are outside the country. Provided, That the

conditions for entitlement under this Rules are met and the following requirements an submitted:

a. Official receipt of payment 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.

SECTION 50. Benefits of Dependents of Deceased SSS Pensioners. — Qualified dependents who have survived SSS pensioners and 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. The survivors shall cease to qualify as dependents for the following reasons:

a. Spouse
   - when gainfully employed; or
   - subsequent marriage

b. Children
   - when gainfully employed; or
   - when they reach the age of 21; or
   - when they get married

RULE VIII
Payment of Claims

SECTION 51. Payment Mechanisms. — Payment of a health care provider shall be made through any of the following mechanisms:

a. Fee for service;

b. Capitation of health care professionals and institutions or networks of the same including HMOs medical cooperatives, and other legally formed health service groups;

c. Such other mechanisms as may hereafter be determined by the Corporation.

SECTION 52. Fee for Service Guidelines on Claims Payment. —

a. The health care provider shall file the claim using the prescribed 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. Otherwise, the claim shall be barred from payment except if the delay in the filing of the claim is due to natural calamities and other fortuitous events. If the claim is sent through mail, the date of mailing as stamped by the post office of origin 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 the claim is caused by the health care provider and the Medicare benefits had already been deducted, the claim will not be paid. If the claim is 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 refiled within sixty (60) calendar days from receipt of notice. The date of reckoning shall be based on the date the returned claims were received by the health care institution or member, as stamped on the envelope or receipt by the postal/courier service, if sent through the mail, or on the claims as stamped by the Corporation, in case of directly-filed claims. The date of mailing as stamped on the envelope or receipt by the postal/courier service, if the claim is sent through mail, or on the date stamped by the Corporation, in case of directly-filed claims shall be considered as the date of re-filing.

c. When the member has complied with the requisites for availment, the health care provider shall deduct from the total charges all expenses reimbursable by the Corporation upon discharge. Payment of medical benefits shall be made directly to the health care provider.

d. Health care institutions are not allowed to charge processing fees from the member when claiming reimbursement from the Corporation.

e. No direct payment to the member is allowed except in the following cases:

    1. the member or dependent was confined abroad;

    2. drugs, medicines and other medical supplies bought by the member within the confinement period and supported with official receipts and which were used during such confinement;

    3. full payment was made by the member because of failure to submit the required documents;

    4. the member paid professional fees directly. 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 and under-utilization of services;

    2. unnecessary diagnostic and therapeutic procedures and intervention;

    3. irrational medication and prescriptions;

4. fraud;

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.

Further, the Corporation may deny or reduce the payment for claims when such claims are attended by fraudulent, false or incorrect information and when the claimant fails without justifiable cause to comply with the pertinent provisions In the law and the 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 beneficiary involved.

The outcome of a peer review conducted by a professional organization or health care institution without the authority or consent of the Corporation shall not in any way bind the latter with respect to payment of claims.

g. All prescriptions and orders for drugs and medicines in institutional health care providers shall be in generic terminology. DOH Administrative Order No. 62 s. 1989, "Rules and Regulations to Implement Prescribing Requirements Under the Generics Act of 1988" shall be used as the guide in evaluating the appropriateness of prescription and written orders in the patient chart.

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.

h. Primary hospitals are required to submit a copy of the prescribed PhilHealth Form and/or clinical records of patients in connection with their claims. Otherwise, such claims shall not be processed.

i. Secondary and tertiary hospitals may be required, on a case-to-case basis, to submit clinical records in order to facilitate the processing of claims.

j. All employee hospitalization claims under the Employees' Compensation Program, shall be automatically considered as claims under the NHIP. Provided, That the claim has been filed within the reglementary period of sixty (60) calendar days.

k. When the claims filed by a health care institution indicate that its bed occupancy rate exceeds its accredited bed capacity, such claims shall be accompanied by a justification in writing. Otherwise, the same shall not be processed.

l. Any operation performed beyond the accredited capability of the accredited health care institution shall be considered a violation and a claim for such will 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.

m. All claims for services filed by a health care institution after its category, as downgraded pursuant to this Rules shall be paid based on rates for such downgraded category, as determined by the Corporation.

n. Professional fees for services rendered by salaried health care providers may be retained by the health care institution in which 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.

o. Public health care institutions shall be allowed to 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.

p. All claims, except those under investigation, shall be acted upon within sixty (60) calendar days.

q. Hospital confinements of less than twenty-four (24) hours shall not be compensated under the NHIP except in the following instances:

    1. when the patient died;

    2. when the patient is transferred to another health care institution or,

    3. In emergency cases.

r. Claims of health care institutions that are not accredited but with current license from the DOH shall be compensated; Provided, That the following conditions are met:

    1. The claim is based on an emergency as determined by the Corporation;

    2. The physical impossibility to transfer the patient to an accredited health care institution as determined by the Corporation.

    If the above conditions are met, hospital charges, drugs, medicines and medical supplies purchased by the member shall be reimbursed. Provided, That official receipts are submitted together with the claim. Likewise, the professional

fees of accredited health care professionals shall be reimbursed by the Corporation. When filed, such claims should include the complete clinical chart 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.

SECTION 53. 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 NHIP. Based on the indices, the Board may from time to time set the allowable percentage mark-up in the prices of drugs and medicine charged by health care providers on members. Reimbursement shall only be made for drugs and medicines within the allowable mark-up price.

SECTION 54. Particularized Charges for Drugs and Medicines. — To support claims for drugs and medicines, the health care provider must specify the generic name and the brand name of each drug and medicine administered to the member with the corresponding price charges therefor. Otherwise, the claim shall not be processes.

SECTION 55. Capitation. — All capitation arrangement shall be covered by a MOA by and between the Corporation and the concerned accredited health care provider. Both parties shall be bound by the terms and conditions stated therein.

TITLE V
Accreditation and Quality Assurance

RULE IX
Quality Assurance of the NHIP

SECTION 56. Objective. — The Corporation shall implement a National Quality Assurance Program (NQAP) 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 selection.

SECTION 57. Activities. — To achieve the above objective, the Corporation shall undertake the following:

a. Verily, 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 service rendered by health care providers both from the standpoint of effects on health and member satisfaction;

d. Initiate and impose changes and corrective action based on the results of performance monitoring and outcomes assessment to ensure quality health service by using mechanisms for feedback and change; and

e. Formulate and review program policies on health insurance based on data culled from the conduct of the above, to ensure quality health services.

RULE X
Accreditation

SECTION 58. 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 Organizations (CBHOs)

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 remuneration for rendering health services, whether or not such services are rendered independent of their institutions.

SECTION 59. 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.

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 DOH and the Corporation.

c. Health care professionals must submit a certificate of Good Standing from their respective specialty societies and from the recognized national association of physicians for general practitioners.

d. Health care providers must accept the formal program of quality assurance and utilization review of the NHIP and the payment mechanisms promulgated thereby. They must have their own formal ongoing quality assurance program.

e. They must adopt all referral protocols, practice guidelines and health resource sharing arrangements of the NHIP.

f. They must recognize and respect the rights of patients.

g. They must comply with all information system requirements and regular transfer of information 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.

h. They must accept any and all corrective actions to be prescribed by the Corporation to ensure quality of services.

i. They must allow the Corporation to inspect their medical and financial records and to visit, enter and inspect their respective premises and facilities, consistent with Section 16 (m) of RA 7875.

j. They must give NHIP 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.

k. The health care professionals must be members of the NHIP.

l. Health care providers must comply at all times will all the requirements and provisions of RA 7875, this Rules and other administrative issuances of the Corporation.

SECTION 60. Three (3)-Year Operation Requirement. — The date of reckoning of the three (3)-year operation requirement shall be the effectivity date of the initial business permit issued by the office of the local chief executive in the case of private hospitals, or such date as certified by the local chief executive or the Department of National Defense (DND), in case of government and military hospitals respectively.

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 73 c of this Rules and shall comply with the DOH guidelines on licensing Hospital extensions or branches in another location shall be required to apply for a separate accreditation. 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 61. 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 assure rational drug use.

e. All tertiary hospitals must establish a Therapeutics and Infection Control Committee and other committees that will assure rational drug use.

f. It must have an ongoing quality assurance program in conformity with the provisions of this Rules.

SECTION 62. Accreditation Requirements for Out-Patient Clinics. — The corporation shall prescribe the requirements and conditions for the accreditation of out-patient clinics.

SECTION 63. 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 service 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.

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.

e. It must have an ongoing quality assurance program in conformity with the provisions of this Rules.

SECTION 64. Specific Accreditation Requirements and Conditions for CBHOs. — In addition to the general requirements and conditions prescribed in this Rules, CBHOs shall comply with the following specific requirements and conditions for accreditation as a direct provider of health care services to beneficiaries:

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 Cooperative Development Authority.

c. Its laboratory, x-ray and diagnostic facilities, if any, must comply with all the rules, regulations and licensing requirements of the DOH.

d. It must have an ongoing quality assurance program in conformity with the provisions of this Rules.

SECTION 65. Accreditation Requirements for HMOs, PPOs, and CBHOs. As Financial Intermediaries. — The Corporation shall prescribe the requirements and conditions for the accreditation of HMOs, PPOs, and CBHOs as financial intermediaries.

SECTION 66. 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 a member in good standing of any national association of licensed physicians in the Philippines duly recognized by the Corporation in accordance with its established standards and criteria.

c. They must abide by the Code of Ethics as prescribed under Section 24, Paragraph 12 of the Medical Act of 1959, as amended.

d. They must agree to follow all practice guidelines or protocols peer review and payment mechanisms of the NHIP.

e. They must agree not to change over and above the professional fees provided by the NHIP for members admitted to a ward type of accommodation.

SECTION 67. 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 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.

c. They must not charge members over and above the professional fees provided by the NHIP for members admitted to a ward type of accommodation.

d. They must follow all practice guidelines or protocols, peer review and payment mechanisms of the NHIP.

SECTION 68. Types of Accreditation. — Accreditation shall be of the following types:

a. Initial

b. Renewal

c. Re-accreditation

d. Reinstatement

SECTION 69. General Provisions for 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 sole 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. Until the accreditation function is decentralized to the LHIOs, all actions on applications for accreditation, as recommended by the Accreditation Committee, shall be approved 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 filled through the Accreditation Committee within thirty (30) calendar days from receipt of such a decision. Only one(1) motion reconsideration will 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 to 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 sold, such will be treated as an application for initial accreditation.

i. Accreditation shall operate prospectively. Claims for services rendered before the effectivity of accreditation shall be denied.

j. For renewal of accreditation, applications shall be filed within the 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 or suspend the accreditation due to adverse findings and reports.

l. Accreditation of health care providers with deficiencies shall not be renewed until a detailed inspection has been conducted and the health care provider is found to have corrected all its deficiencies.

SECTION 70. General Provisions for Accreditation of Health Care Professionals. —

a. The Corporation shall determine the period of accreditation and reserve 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, capabilities, and specialty certification.

e. Until the accreditation function is decentralized to the LHIOs, all actions on applications for accreditation, as recommended by the Accreditation Committee, shall be approved by the President and CEO.

f. A revocation of accreditation is permanent.

g. Accreditation shall operate prospectively. Claims for services rendered before the effectivity of accreditation shall be denied except in emergency cases.

h. For renewal of accreditation, application shall be filed within the 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 71. Specific Provisions for Initial Accreditation. —

a. Accreditation shall be given to qualified health care providers who are applying for the first time, or those treated as if applying for the first time under certain circumstances for institutional health care providers as provided for in this Rules.

b. The accreditation shall take effect upon approval of the application.

SECTION 72. Specific Provisions for 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 until such suspension has been lifted and all requirements, conditions and corrective actions set by the Corporation have been complied with.

SECTION 73. Specific Provisions for Re-Accreditation. —

a. A health care provider whose previous accreditation had 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 charged, 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 has transferred location, must apply for re-accreditation within ninety (90) calendar days of the 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.

d. Where the accreditation lapsed due to the voluntary act of the 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

- Upgrades or downgrades its facilities in the case of institutional health care providers.

SECTION 74. Specific Provision for 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 75. 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 76. 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 a reasonable period of time from receipt of the application.

d. An Accreditation Card shall be issued to the health care professional upon approval of the application.

SECTION 77. 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. Fraud;

d. Change in the ownership 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;

f. Such other grounds as the Corporation may determine.

SECTION 78. 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 dimensions 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 79. 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 providers groups that meet the criteria for recognition set forth in this Rules.

SECTION 80. 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;

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 81. Cooperation Between the Corporation and the Recognized and 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 82. Objective. — The Corporation shall develop and implement a performance monitoring system of 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 practice;

e. Gross, unjustified deviations from currently accepted practice guidelines or treatment protocols;

f. Use of fake, adultered or misbranded pharmaceuticals or unregistered drugs; and

g. Use of drugs other than those recognized in the PNDF and those for which exemptions were granted by the Board.

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 83. Monitoring System. — 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 Reports and other reportorial requirements, as determined by the Corporation.

RULE XIII
Outcomes Assessment

SECTION 84. System of Outcomes Assessment. — The Corporation shall implement a system of assessing outcomes of service rendered by health care providers to include the following:

a. Review of mortality and morbidity rates, post-surgical infection rates and other health outcomes 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 the Board.

RULE XIV
Mechanism For Feedback

SECTION 85. 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 the list of health care providers of good standing as well as those suspended by the Corporation.

In pursuit of informed choice as enunciated in the Act, feedback reports may include information on the average support value of the benefit package based on actual charges billed by the accredited health care provider.

RULE XV
Technology Assessment

SECTION 86. Assessment of Medical Technology. — The Corporation shall assess the advantage and appropriateness of medical technologies, equipment, devices, and modalities of

treatment consistent with actual needs and current standards of medical practice and ethics and with national health objectives.

As the need arises, the Corporation shall likewise assess the advantage and appropriateness of acquiring and using new, scarce and expensive medical technologies, equipment, devices and modalities of treatment consistent with actual needs and current standards of medical practice and ethics and with national health objectives, including modem dental technology employing highly technical equipment. 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 87. 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 assure quality health care.

SECTION 88. 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 NQAP.

SECTION 89. Remedial Measures. — As the need arises and based on data obtained from performance monitoring, remedial measures and changes on treatment protocols or the clinical practice guidelines shall be imposed by the Corporation on particular health care providers found to be deficient in the delivery of cost-efficient and quality services with satisfactory outcomes and results.

RULE XVII
Quality Assurance of Health Care Providers

SECTION 90. Requisite for Accreditation. — The existence of a formal ongoing quality assurance program shall be a requisite for accreditation of health care providers.

SECTION 91. 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 beneficiaries of the NHIP;

b. Work towards the promotion of uniform health care standards throughout the country;

c. Ensure appropriateness of medical procedures and administration of drugs and medical consistent with generally accepted standards of medical practice and ethics.

SECTION 92. 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 provider;

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 records to support performance monitoring and outcomes measurement activities;

f. A system of feedback to the health care professionals and mechanism for change in practice patterns if 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 QAP Committee; and

j. The documentation of processes evaluated and improved and new processes installed.

SECTION 93. Monitoring and Verification. — The Corporation shall periodically monitor and verify compliance to this requisite during inspection of the health care provider and may require submission of periodic reports as a means of monitoring compliance.

SECTION 94. Penalties for Violation. — Gross violation of this requisite shall constitute a ground for suspension and/or revocation of accreditation.

TITLE VI
Rules of Procedure of the Corporation

RULE XVIII
Title and Construction

SECTION 95. Title of the Rules. — This Rules shall be known as the Rules of Procedure of the Corporation.

SECTION 96. Applicability. — This Rules shall apply to all cases brought before the Corporation.

SECTION 97. Construction. — This Rules shall be liberally construed to carry out the objectives of the RA 7875 and to assist the parties in obtaining an expeditious and inexpensive resolution of any case arising under the said Act.

SECTION 98. Suppletory Application of the Rules of Court and Jurisprudence. — In the absence of any applicable provisions in this Rules, the pertinent provision 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 99. Powers of the Corporation the Board and the President and CEO. — The powers vested in the Corporation by the Act, particularly Section 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 100. Board as Quasi-Judicial Body. — The Board as quasi-judicial body, may sit en banc or in division in all cases brought before it for review.

As provided for in the Act, the Board is composed of eleven (11) 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;

A representative of the self-employed sector; and

A representative of the health care providers.

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

SECTION 101. Quorum and Votes Required. — When sitting en banc or in divisions, the concurrence of the majority thereof shall be required to render a decision in all cases.

RULE XX
The Prosecutors and the Arbiters of the Corporation

SECTION 102. 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. 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. 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 103. Assignment of Prosecutors and Arbiters. — The Prosecutor and the Arbiter must be assigned to more than one LHIO, as the interest of the service may require.

RULE XXI
Grounds and Venue

SECTION 104. 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; or,

b. Commission of any of the offenses enumerated in the Title on Offenses and Penalties of this Rules.

SECTION 105. 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; or

b. Commission of any of the offenses enumerated in the Title on Offenses and Penalties of this Rules.

SECTION 106. Venue. — Any complaint against a health care provider may be filed with the Head Office or in the LHIO where the respondent health care provider is located or where the aggrieved member resides.

RULE XXII
Filing of a Complaint

SECTION 107. Who May File. — Any person may file a written complaint against a health care provider and/or a member. The Corporation, motu propio, may file a complaint brought to its attention by any of its departments, offices or units.

SECTION 108. 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 109. Duty of the Prosecutor. — After a 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 refilling 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 respondents 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 110. Caption and Title. — The complaint shall be filed in accordance with the following caption:

REPUBLIC OF THE PHILIPPINES
PHILIPPINE HEALTH INSURANCE CORPORATION
(PLACE)

Complaint/s
-versus-

PHIC Case No. _____

Respondent/s
x----------x

SECTION 111. Contents of Complaint. — A complaint shall contain among others, the following:

a The name/s and address/es of the complainants;

b The name/s and address/es of the respondents 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 should be indicated, together with a narration on 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 112. 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 indorse the complaint to the Arbiter for appropriate action.

SECTION 113. Service of Summons. — Upon the filing of the complaint the Arbiter shall then issue the summons to the respondents 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 and copies of supporting documents shall be attached to the original 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 114. 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 115. 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 116. Default. — Should the respondent/s fail to answer the complaint within the period above provided, the Arbiter may motu propio, or on motion of the complainant/s, may render judgment as may be warranted by the facts alleged in the complaint and limited to what is prayed for therein.

SECTION 117. 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 position 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 118. 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 therefore 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 119. 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 120. 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 121. 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 122. 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 propio 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 complaint 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 123. Postponement of Hearings. — 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 124. 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 125. Contents of Decisions. — The decision of the Arbiter shall be clear and concise and shall include a brief statements of the:

a. Facts of the case;

b. Issue/s involved;

c. Applicable laws or rules;

d. Conclusions and the reasons therefrom; 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 129 of this Rules.

RULE XXIV
Review by the Board

SECTION 126. 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; or

d. Serious errors in the finding of facts which if not corrected, would cause grave or irreparable damage or injury to the appellant.

SECTION 127. 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 128. 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 129. 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 fast day to perfect the appeal shall be the next working day.

SECTION 130. Who May File Appeal. — Any party to the complaint including the Corporation, may appeal from a judgment of the Arbiter.

SECTION 131. No Extension of Appeal Period. — No motion or request for extension of the period within which to file an appeal shall be allowed.

SECTION 132. 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 133. 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 134. 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 135. 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 136. 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 fling thereof; and

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

SECTION 137. 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 138. 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 139. 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 140. 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 141. 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 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 142. 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 143. Mitigating and Aggravating Circumstances. — The following circumstances shall affect the gravity of the violation and the liability of the erring health care provider or beneficiary:

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 commission of an offense, as provided for in this Rules.

   - Connivance and/or conspiracy to facilitate the commission of the violation.

   - Being an officer or employee of the Corporation when such is used to facilitate or cover-up the commission of the offense.

SECTION 144. 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 are neither mitigating nor aggravating circumstance, the imposable penalty 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 145. Common Provisions. — All penalties for offenses committed by health care providers and beneficiaries shall carry with them denial of payment of claim/s in question and/or refund to the Corporation, if already paid.

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.

A notice of suspension for the information of beneficiaries 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 hospitals.

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 participants of the NHIP.

RULE XXVIII
Offenses of Institutional Health Care Providers

SECTION 146. Classification of Penalties for Offenses — Offenses committed by institutional health care institutions shall be penalized as follows:

a. Serious offenses shall carry a penalty of revocation of accreditation. in addition, a recommendation shall be submitted to the DOH for cancellation of the respondent's license or accreditation, or clearance to operate whenever appropriate.

b. Less serious offenses shall carry a penalty of fine not less than Thirty Thousand Pesos (P30,000) but not more than Fifty Thousand Pesos (P50,000) and suspension of accreditation for a period not less than one (1) year but not more than two (2) years.

c. Light offenses shall carry a penalty of fine not less than Ten Thousand Pesos (P10,000) but not more than Thirty Thousand Pesos (P30,000) and suspension of accreditation for not less than six (6) months but not more than one (1) year.

SECTION 147. Padding of Claims. — Any health care provider who, for the purpose of claiming payment from the NHIP files a claim for an amount more than the benefits actually used by adding drugs, medicines, procedures, services and supplies not actually done or given, shall be punished by revocation of accreditation. In addition, a recommendation shall be submitted to the DOH for cancellation of its license, or accreditation or clearance to operate, as appropriate.

SECTION 148. 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 when such is not the case, or

b. Making it appear that the patient suffered from a compensable illness or underwent a compensable procedure; or

c. Using such other machinations that would result in claims for non-admitted patients.

The foregoing offenses shall be penalized by revocation of accreditation. In addition, a recommendation shall be submitted to the DOH, for cancellation of its license, or accreditation, or clearance to operate, as appropriate.

SECTION 149. 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 revocation of accreditation. In addition, a recommendation shall be submitted to the DOH for cancellation of its license, or accreditation, or clearance to operate, as appropriate.

SECTION 150. Postdating 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 but makes it appear so by changing, erasing, adding to the period of confinement or in any manner altering dates so as to conform to the sixty (60) calendar day prescriptive period, shall suffer a fine of not less than Thirty Thousand Pesos (P30,000) but not more than Fifty Thousand Pesos

(P50,000) and suspension of accreditation for a period not less than one (1) year but not more than two (2) years.

SECTION 151. Misrepresentation by Furnishing False or Incorrect Information. — Any health care provider shall be liable for fraudulent practice when, for 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 Thirty Thousand Pesos (P30,000) but not more than Fifty Thousand Pesos (P50,000) and suspension of accreditation for a period not less than one (1) year but not more than two (2) years.

Where such misrepresentation leads to damage to the Corporation, the penalty shall be revocation of accreditation. In addition, a recommendation shall be submitted to the DOH for cancellation of its license, or accreditation, or clearance to operate, as appropriate.

SECTION 152. 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 who has been confined once but was made to appear as having been confined for two or more times and/or for two or more different illnesses shall be punished by revocation of accreditation. In addition, a recommendation shall be submitted to the DOH for cancellation of its license, or accreditation, or clearance to operate as appropriate.

SECTION 153. 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 explanation in the form and manner prescribed by the Corporation shall suffer a fine of not less than Thirty Thousand Pesos (P30,000) but not more than Fifty Thousand Pesos (P50,000) and suspension of accreditation for a period not less than one (1) year but not exceeding two (2) years.

SECTION 154. 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 Thirty Thousand Pesos (P30,000) but not more than Fifty Thousand Pesos (P50,000) and suspension of accreditation for a period not less than one (1) year but not more than two (2) years, except, when the operation is done in an emergency to save life or referral to a higher category hospital is physically impossible.

SECTION 155. 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 Thirty Thousand Pesos (P30,000)but not more than Fifty Thousand Pesos (P50,000) and suspension of accreditation for a period not less than one (1) year but not more than two (2) years.

SECTION 156. Other Fraudulent Acts. — Any health care provider shall also be liable for the following fraudulent acts:

a. Failure or refusal to give benefits due to a qualified member;

b. Charging qualified patients for medicines or services which are legally chargeable to and covered by the NHIP;

c. Failure or refusal to refund to the member the payment received from the NHIP when the bill is fully paid in advance by the member;

d. Failure or refusal to accomplish and submit the required forms in connection with letter c;

e. Deliberate failure or refusal to comply with the requisites of RA 7875 and this Rules.

Said health care provider shall be penalized by revocation of accreditation. In addition, a recommendation shall be submitted to the DOH for cancellation of its license, or accreditation or clearance to operate, is appropriate. In letter (a), mere refusal or failure to give benefits completes an offense in letter (b), payment of the patient completes the offense. In letter (c), lapse of thirty (30) calendar days

completes the offense. In letter (d), mere refusal or failure to accomplish and submit the forms completes the offense.

SECTION 157. Breach of the Warranties of Accreditation. — Any institutional health care provider who shall make 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 three (3) months suspension from participation in the NHIP to revocation of accreditation.

SECTION 158. Gross Negligence. — Any health care provider who, by gross negligence, shall commit any of the foregoing acts, shall suffer the penalty of revocation of accreditation and recommendation to DOH for cancellation of its license or clearance to operate or accreditation, as appropriate.

Gross negligence is the utter lack of care and diligence expected of a reasonable person as to show that the respondent is indifferent or oblivious to the danger of the injury to the person or property of others.

RULE XXIX
Offenses of Health Care Professionals

SECTION 159. Misrepresentation by False or Incorrect Information. — Any health care professional shall be liable for fraudulent practice when, for purpose of participation in the NHIP or claiming payment from the Corporation, furnishes false or incorrect information concerning any matter required by RA 7875 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 not be revoked.

SECTION 160. Breach of the Warranties of Accreditation. — Any health care professional found to have made 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 161. Other Violations. — Any other willful or negligent act or omission of the health care professional in violation of RA 7875 and this Rules which tends to undermine or defeat the objectives of the NHIP shall be dealt with in accordance with Section 44 of the Act.

RULE XXX
Offenses of Members

SECTION 162. Fraudulent Acts. — Any member who, for purposes of claiming NHIP benefits or entitlement thereto, shall commit any of the offenses provided for in Sections 147 to 156, 159 and 161 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 163. Gross Negligence. — Any member who, by gross negligence, shall commit any of the acts referred to in the immediately preceding section shall suffer a fine of not less than Five Hundred Pesos (P500) but not more than Five Thousand Pesos (P5,000) and suspension from the availment of NHIP benefits for not less than three (3) months but not more than six (6) months.

RULE XXXI
Offenses of Officers and Employees of the Corporation

SECTION 164. 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 165. 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 166. 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 167. Failure to Deduct and/or Remit Contributions. — Any employer or officer who fails or refuses to deduct contributions from the employee's compensation or to remit the complete employer's and employees' contribution to the Corporation shall suffer imprisonment of not less than six (6) months but not more than one (1) year and a fine of not less than Five Hundred Pesos (P500) but not more than One thousand Pesos (P1,000) multiplied by the total number of employees employed by the firm.

SECTION 168. Misappropriation of Contributions. — Any employer or officer authorized to collect contributions who fails to remit monthly contributions already collected or deducted from the employee's compensation shall be presumed to have misappropriated such contributions and shall suffer the penalties provided for in Article 315, par 1 (b) of the Revised Penal Code on Swindling.

SECTION 169. Unlawful Deductions. — Any employer or officer who shall deduct directly or indirectly from the compensation of the covered employees or otherwise recover from them the 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 170. 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 171. 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 maybe instituted by the Corporation under existing laws.

SECTION 172. 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 173. Execution of Penalty. — When an institutional health care provider ceases operations or an independent health care

professional stops the practice before serving the suspension, execution shall be deferred, to be implemented when the same owner or medical director opens or operate 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 me 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 operations 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 174. Applicability of this Rules. — Complaints already filed with and under deliberation by appropriate bodies of the Corporation when this Rules take effect shall be penalized in accordance with previous rules.

TITLE VIII
Administrative Remedies

RULE XXXIV
Common Provisions

SECTION 175. Jurisdiction. — The Corporation, through the LHIO, 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 176. 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 177. Grounds for Grievances. — The following acts shall constitute valid grounds for grievance:

a. Any violation of the rights of patients;

b. A willful neglect of duty that results in the loss or non-enjoyment 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 period agreed upon; and

e. Any other act or neglect that tends to undermine or defeat the purposes of the Act and this Rules.

SECTION 178. Who May File. — Any aggrieved health care provider or enrolled member may file a verified complaint for grievance.

SECTION 179. Venue. — A grievance covered by this Rules may be filed with the Head Office or in the LHIO where the grievant health care provider is located or where the enrolled member resides.

SECTION 180. Contents of Grievance. — All complaints for grievance shall contain, among others, the following:

a. Name/s and address/es of the grievant/s;

b. Name/s and address/es of respondent program implementor/s;

c. A clear and concise statement of the grievant'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 181. Investigation. — Upon the filing of a complaint for grievance, the Corporation shall assign an investigating officer to 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 grievant redress.

SECTION 182. Duty of the Investigating Officer. — If the investigating officer finds cause for the grievant to prosecute the case with the GARC, a resolution shall be prepared by the Investigating officer certifying under oath that the grievant and the witnesses have been personally examined by the investigating officer, that there is reasonable ground to believe that a valid cause for grievance exists and that the respondent implementor has probably committed the same, that the respondent implementor has been informed of the complaint and has been given an opportunity to submit controverting evidence. Otherwise, the investigating officer shall recommend the dismissal of the complaint. In the former case the investigating officer 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 through the Board.

RULE XXXVI
The Grievance and Appeals Review Committee

SECTION 183. Grievance and Appeals Review Committee. — The Board shall create the Grievance and Appeals Review Committee (GARC), 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 grievant provider or member. The GARC shall be convened upon certification or endorsement by the investigating officer or upon filing of the petition, as the case maybe, and shall continue to meet as a body until a decision thereon is rendered.

SECTION 184. 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 185. Preliminary Determination. — Upon the endorsement of the grievance, the GARC from a 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 GARC within five (5) calendar days from the service of summons. Summons may be served in accordance with the provisions of this Rules.

SECTION 186. 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 propio, or upon motion of the grievant, 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 187. Position Papers. — After an answer is filed pursuant 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 188. Clarificatory Hearing. — In cases where the GARC deems it necessary to hold a hearing to classify specific factual matters before rendering judgment, it shall set the case for hearing the purpose. At such hearing, witnesses whose affidavits were previously submitted maybe 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 189. 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 190. 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 if no appeal is filed with the Board within the same period, in accordance with the procedure set forth in this Rules.

SECTION 191. Administrative Sanctions. — Upon a finding of guilt, the GARC may censure, reprimand or suspend the respondent

implementor from office, depending on the gravity of the offense. Provided, the suspension shall not exceed thirty (30) days.

SECTION 192. Degree of Proof. — In all its proceedings, the Committee 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 193. 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 194. Jurisdiction. — The Board, en banc, shall have exclusive appellate jurisdiction to review decisions of the GARC in grievance filed under the Act and this Rules.

SECTION 195. 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 196. 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 197. 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 198. Jurisdiction. — Until such time that the LHIO shall have been fully operationalized, the President and CEO, through the

Claims Review Unit (CRU), shall act on all administrative protests filed by health care providers and members against decisions of the Claims Processing Unit pertaining to processing and payment of claims.

SECTION 199. Claims Subject to Protest. — Claims that were either denied or reduced by the Claims Processing Unit may be the subject of a protest before the CRU.

SECTION 200. Form. — The protest must be in writing, duly signed by the protestant and addressed to the President and CEO. It must be accompanied by supporting documents and filed not later than sixty (60) calendar days from receipt of written notice of the decision of the Claims Processing Unit.

SECTION 201. Procedure Before the CRU . — Upon receipt of the protest, the CRU may either return the same, where the period of filing a protest has lapsed, or give it due course. The CRU 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 thereon.

SECTION 202. Action on Claims. — After thorough deliberation, the CRU shall recommend to the President and CEO any of the following actions on the protest as appropriate:

a. The denial of the protest if the claims are invalid or unmeritorious in the light of existing laws, pertinent circulars and orders or 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 President and CEO may adopt, modify or reject the recommendation of the CRU in whole or in part. Forthwith, the President and CEO 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 President and CEO shall be final and executory, unless appealed to the Board on petition for review in accordance with the procedures above stated.

TITLE IX
Transitory Provisions

SECTION 203. 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 beneficiaries can use their Eligibility Certificate (EC) in the availment of benefits.

SECTION 204. GSIS/SSS/OWWA Numbers. — Members of the GSIS SSS, and OWWA who have not yet updated their records with the NHIP may temporarily use their GSIS, SSS or OWWA numbers until such time a permanent PhilHealth Identification Number has been issued.

SECTION 205. 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).

SECTION 206. Income Classification of LGUs. — Until such time that the Department of Finance (DOF) prescribes the income classification of barangays in cities, the income classification of the city shall be used in the determination of local government subsidy.

TITLE X
Miscellaneous Provisions

SECTION 207. Repealing Clause. — All PhilHealth circulars, orders and memoranda inconsistent with the provisions of this Rules are hereby considered repealed or amended.

SECTION 208. 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 circumstances shall not be affected by such declaration.

SECTION 209. Promulgation and Effectivity. — The Board shall promulgate this Rules in at least two national newspapers of general circulation. It shall take effect on July 1, 2000.

Done in Manila, Philippines, this 26th of April 2000.