



MediCard Philippines, Inc.
Accredited Physician's Terms of Agreement
January 2022

APTA # 0

DATE:

\_\_\_\_\_, MD
Specialization
HOSPITAL/CLINIC : \_\_\_\_\_
Address : \_\_\_\_\_

Dear DR. \_\_\_\_\_:

Our warm greetings to you!

Our company, one of the leading Health Maintenance Organization (HMO) in the country with a client base of more than eight hundred thousand (800,000) members and accepted by most major medical institutions throughout the country would like to extend its invitation to you to be part of our network of accredited physicians (Medical Service Team) in the above mentioned facility.

Your inclusion would definitely be a big boost to our roster of specialists, and would likewise be appreciated by the entire MPI family.

I. TERMS OF AGREEMENT

- 1. You, the "ACCREDITED PHYSICIAN", who voluntarily presents herself / himself to "MEDICARD PHILIPPINES INC." as an independent contractor, agrees to provide reasonable, necessary, professional and able health care services appropriate to your specialty to bona fide members of MEDICARD. In consideration of such services MEDICARD shall compensate you based on standard rates, applicable to all members' physician, as herein described (see Schedule of Professional Fees).
2. The ACCREDITED PHYSICIAN agrees to abide by the company's administrative policies and guidelines (please see attached) in servicing members of MEDICARD. Any complaints regarding this Agreement must be coursed to the MPI Provider Relations Manager.
3. MEDICARD shall evaluate the partnership with the ACCREDITED PHYSICIAN at least once a year. This is a way to touch base and get feedback and at the same time re-assess our mutually beneficial relationship.
4. As an ISO requirement, the ACCREDITED PHYSICIAN shall submit updated credentials of Philhealth ID and PRC license through email to provider@medicardphils.com.
5. The ACCREDITED PHYSICIAN shall inform MEDICARD for any changes in contact details, clinic schedule or additional trainings.
6. The ACCREDITED PHYSICIAN shall timely and properly accomplish the Out-patient Consultation Form including the chief complaint, history of present illness, vital signs, physical examination, Diagnosis and signature of patient and attending physician. The ACCREDITED PHYSICIAN shall strictly adhere to the 'NO SIGNATURE, NO PAYMENT POLICY' which is hereby strictly implemented.
7. The ACCREDITED PHYSICIAN agrees not to balance bill the patient and for those who have exceeded their limit, to bill patients at HMO rate only. Violation of this provision would be grounds for the termination of this contract.
(Balance billing is defined as the act by some physicians or health practitioners duly affiliated with MEDICARD to charge MEDICARD members for the difference between their desired higher professional fees and the agreed MEDICARD professional fee for services schedule.)
8. The ACCREDITED PHYSICIAN agrees not to enter to any private fee/internal arrangements with MEDICARD patient, even with the latter's consent. Violation of this provision would be grounds for the termination of this contract.
9. The ACCREDITED PHYSICIAN shall refrain from discussing the member's coverage, examples: Pre-Existing Conditions (PEC), General Exclusions, Maximum Benefit Limit (MBL) etc. Please allow MEDICARD to discuss these with the member so they will be guided on their coverage.
10. The professional fees due to the ACCREDITED PHYSICIAN which are payable by MEDICARD are subject to withholding tax rates.

Signature

Signature

11. The 12% Value Added tax (VAT) shall be shouldered by MEDICARD provided, the ACCREDITED PHYSICIAN submits VAT registration certificates.
12. PhilHealth benefits on ACCREDITED PHYSICIAN's fee shall go to the attending ACCREDITED PHYSICIAN.
13. The ACCREDITED PHYSICIAN agrees that all covered illnesses that shall be charged to MEDICARD according to a standard rate of Relative Unit Value. MPI undertakes to pay the physician within **30 working days from the receipt of the billing statement**. Under no circumstances shall the physician charge extra fees to the patient unless approved by MPI.
14. For members with incremental charge. Incremental costs, if any, of involuntary room upgrades (i.e. from one category to the next higher room category, not from a particular level to the next level within the same category), shall be shouldered by MEDICARD member based on MEDICARD agreement with the member.  
  
For voluntary room upgrade, you may bill MEDICARD member only for the difference in professional fees between the member's original room category and the upgraded room used, based on the schedule of fees.
15. All statement of accounts (out-patient consultation form / laboratory diagnostic forms) with corresponding charge slips incurred by our patient-members must be submitted within **one (1) month from the time of availment**, otherwise, MEDICARD shall not process all bills submitted after the said one (1) month. Moreover, MEDICARD agrees to reconcile any submitted unpaid accounts/charges **within the period of three (3) months from the date of discharge or availment**. Moreover, MEDICARD shall not process those follow-ups or unpaid charges if beyond three months.
16. MEDICARD can now deposit your payment to your Hospital bank account using e-payment. The following banks are accredited by our online payment service provider: Banco De Oro (BDO); Bank of the Philippine Islands (BPI); Metrobank; Rizal Commercial Banking Corporation (RCBC); United Coconut Planters Bank (UCPB); Union Bank of the Philippines; China Bank; East West Bank; Land Bank of the Philippines; Security Bank; Philippine National Bank (PNB). Email us at provider@medicardphils.com for details.
17. The ACCREDITED PHYSICIAN is considered an independent contractor, hence you are not considered as an employee of MEDICARD. MEDICARD shall not assume any statutory employer obligations such as but not limited to social security, PhilHealth and employee compensation premium.
18. The ACCREDITED PHYSICIAN holds MPI free and harmless from any and all suits or claims by, or liability to any person by reason of his fault, mistake or negligence in the performance of his function as a medical professional.
19. The ACCREDITED PHYSICIAN of MEDICARD have fully read and understood the terms of agreement and agree to abide by the guidelines and procedures that were stated.

## II. SCHEDULE OF PROFESSIONAL FEE

The ACCREDITED PHYSICIAN accepts that the MEDICARD rates shall not be lower than the rates agreed in the Memorandum of Agreement between AHMOPI and the Specialty Boards of the Medical & Surgical Societies.

### II.1 MEDICAL

#### A. PROFESSIONAL FEES FOR OUT-PATIENT SERVICES:

- Consultation Fee P 300.00 (gross)
- For routine pre-procedure medical evaluation, in and out patient. P 600.00
- For pre-procedure medical evaluation, in and out patient but with evaluation P 800.00

#### B. PROFESSIONAL OB-GYNECOLOGY ONLY:

- Consultation Fee with Pap Smear P450.00
- Consultation Fee with Internal Examination (with use of gloves & KY Jelly) P350.00

Signature

**C. PROFESSIONAL FEES FOR IN-PATIENT SERVICES**

- Ward P 450.00/day
- Semi-Private P 550.00 /day
- Private P 650.00/day
- Suite P 1,000.00/day
- ICU P 1,200.00/day
- Intra-operative monitoring P 1,200.00

**2. SURGICAL**

**A. PROFESSIONAL FEES FOR OUT-PATIENT SERVICES:**

- Consultation Fee P 300.00 (gross)

**B. PROFESSIONAL FEES BASED ON SURGICAL PROCEDURES:**

- The Relative Unit Value (RUV) is based on the PHIC RVS 2009
  - OPD/Ward P 110 x PHIC RUV
  - Semi-Private P 115 x PHIC RUV
  - Private P 120 x PHIC RUV
  - Suite P 125 x PHIC RUV

**Note:** Professional fees for surgical procedures will be paid only based on the above schedule inclusive of visits during confinement.

**C. PROFESSIONAL FEES FOR IN-PATIENT SERVICES**

**(for surgical patients admitted but are not operated)**

- Ward P 450.00/day
- Semi-Private P 550.00/day
- Private P 650.00/day
- Suite P 1,000.00/day
- ICU P 1,200.00/day

**D. The following are the Assistant Surgeon's Fee:**

- 1.1. Operations with an RVS of at least 250 units
  - 1.1a Diplomate/Fellow – 25% of Surgeon's Fee
  - 1.1b Non-specialist physician – 10% of Surgeon's Fee

**E. PROFESSIONAL FEE OF ANESTHESIOLOGIST**

- 50% of the current /prevailing PHIC Relative Unit Value multiplied by the peso conversion factor.
- Minimum professional fee per case of Php 2,000.00.
- For Monitored Anesthesia Care (MAC)
  - 1. For MAC with sedation, 30% of PCS RUV
  - 2. For MAC without sedation, intra-operative monitoring fee of Php 1,200.00.

**F. For those ACCREDITED PHYSICIANS who signed the AHMOPI INITIATIVES with their respective societies, the new rates will apply.**

**III. REQUIRED DOCUMENTS**

- a) Resume
- b) Copy of valid and updated PRC ID/License
- c) Copy of valid and updated Philhealth ID
- d) Copy of Residency Certificate
- e) Copy of Diplomate and/or Fellowship Certificate
- f) Certificate of Registration – BIR Form 2303
- g) Notarized Income Payee's Sworn Declaration of Gross Receipt/Sales
- h) Subspecialty Certificates and other Training Certificates

**NOTE:** For expired or near expiry PRC License and Philhealth ID, it is the physician's responsibility to renew her/his PRC license on given time.

Should you decide to accept this invitation, and find the terms and condition acceptable, please accomplish and submit the above documents, including this signed agreement within thirty (30) days upon receipt of this agreement to Provider Relations Dept., 8<sup>th</sup> floor World Center Bldg., 330 Gil Puyat Avenue., Makati City or email to [provider@medicardphils.com](mailto:provider@medicardphils.com).

**IV. EFFECTIVITY AND TERMINATION**

Any breach of the terms and conditions of this contract shall entitle either party to rescind this agreement by written notice without waiver to any claim for damages.

MEDICARD may pre-terminate the contract agreement or put on hold the accreditation prior to investigation if in case of fraudulent charges, negligence, etc. A written notice is given to the ACCREDITED PHYSICIAN.

This Agreement shall take effect as of \_\_\_\_\_ and shall be renewed automatically on a yearly basis unless terminated by either party by serving a thirty (30) day written notice to the other party.

For any clarification, please feel free to call us at telephone numbers (02) 8811-0367, (02) 8811-4995, (02) 8811-6131, (02) 8802-2019, (02) 8802-2085, (02) 8802-2086, (02) 8288-6915, (02) 8354-0476, (02) 8354-0531, (02) 8354-1015, (02) 8354-1059, (02) 8354-1096 and (02) 8884-7313. Our **Provider Relations Associate** will be glad to hear from you to answer your queries.

We are hoping for a mutually beneficial relationship with you.

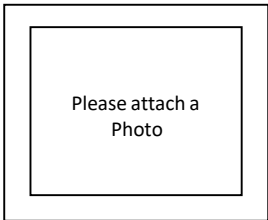
Thank you.

BY:  
**MediCard Philippines, Inc.**

**Conforme:**

**FRITZIE M. CASTRO**  
**Provider Relations Manager**

\_\_\_\_\_  
(Signature over printed name)  
Date signed: \_\_\_\_\_  
PRC No.: \_\_\_\_\_



**ACCREDITED PHYSICIAN'S INFORMATION SHEET**

**\*Please print all required information legibly and clearly using black/blue ballpen.**

Last Name										Given Name										MI

Year of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
 Residence Address: \_\_\_\_\_  
 Medical School: \_\_\_\_\_ Year Graduated: \_\_\_\_\_  
 TIN No. \_\_\_\_\_ Mobile No. \_\_\_\_\_  
 PRC License No: \_\_\_\_\_ Effectivity: \_\_\_\_\_ Validity: \_\_\_\_\_  
 PhilHealth Accredited? No ( ) / Yes ( )  
 Accreditation No: \_\_\_\_\_ Effectivity: \_\_\_\_\_ Validity: \_\_\_\_\_

CLINIC/HOSPITAL	CLINIC/HOSPITAL ROOM & SCHEDULE	TELEPHONE/ MOBILE NO.

**\*OTHER CLINIC/HOSPITAL THAT YOU WOULD WANT TO BE ACCREDITED. KINDLY FILL-OUT THE TABLE BELOW.**

CLINIC/HOSPITAL	CLINIC/HOSPITAL ROOM & SCHEDULE	TELEPHONE/ MOBILE NO.	SIGNATURE

	SPECIALTY (RESIDENCY TRAINING)	SUB-SPECIALTY (FELLOW TRAINING)
Specialization	_____	_____
Training Institution	_____	_____
Satisfactorily PASSED the Certifying Specialty Exam?	<input type="checkbox"/> Yes, I passed both written & oral exam <input type="checkbox"/> Yes, I passed the written exam <input type="checkbox"/> No, I'm still going to take the exam	<input type="checkbox"/> Yes, I passed both written & oral exam <input type="checkbox"/> Yes, I passed the written exam <input type="checkbox"/> No, I am still going to take the exam
Specialty Org/Association Affiliation	_____	_____
Membership Category in above Org./Association (Please Check only one)	<input type="checkbox"/> Associate Member <input type="checkbox"/> Diplomate <input type="checkbox"/> Fellow <input type="checkbox"/> Honorary Member Others: _____	<input type="checkbox"/> Associate Member <input type="checkbox"/> Diplomate <input type="checkbox"/> Fellow <input type="checkbox"/> Honorary Member Others: _____
Year received the Specialty Certificate	_____	_____

No. of Years of Practice in your Specialization? \_\_\_\_\_ Ave. No. of patients seen in a day? \_\_\_\_\_

I declare that this Accredited Physician's Information Sheet (APIS) has been made in good faith, verified by me, and the best of my knowledge and belief, is true and correct. As the need arises, I hereby authorize the designated representatives of my affiliated clinics or hospitals to validate the disclosed information of my Accredited Physician's Information Sheet (APIS).

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of the Physician



## CONSENT FORM

In compliance with Republic Act 10173 also known as the Data Privacy Act of 2012, we need your Consent to allow us to collect and process your information with the following purposes: accreditation; use in patient's data record per availment; processing of bills and evaluation/survey.

We will only disclose and share your information with our service providers who may also help us in assessing your application.

Withholding or withdrawal of such Consent may prevent us from including you in our list of accredited providers.

You are afforded with certain rights and protection in accordance with the said Act and you may visit [www.medicardphils.com/privacy](http://www.medicardphils.com/privacy) or email [privacy@medicardphils.com](mailto:privacy@medicardphils.com) for more information.

By signing below, we will consider that you agree to give your Consent to us.

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Signature over printed name



**MEDICARD E-PAYMENT ENROLLMENT FORM**

Please legibly fill-out and complete the necessary details below:

<b>1</b>	<b>Bank Name/Branch</b>	:																		
<b>2</b>	<b>Full Account Name</b>	:																		
<b>3</b>	<b>Bank Account Number</b>	:																		
<b>4</b>	<b>TIN Number</b>	:																		
<b>5</b>	<b>Mobile Phone Number</b>	:	<b>0</b>	<b>9</b>																
<b>6</b>	<b>Email Address</b>	:																		

Please submit this form together with a **copy of the ATM Card/Passbook/Check book (showing account holder’s name, and account number)** to our MediCard Representative, via email at [provider@medicardphils.com](mailto:provider@medicardphils.com) or send to MediCard Philippines Inc., 8<sup>th</sup> Floor, Provider Relations Department, The World Centre Bldg., 330 Senator Gil Puyat Avenue, MakatiCity.

**The following banks are accredited by our online payment service provider:**

<p><i>Banco De Oro (BDO)</i>  <i>Bank of the Philippine Islands (BPI)</i>  <i>Chinabank</i>  <i>EastWest Bank</i>  <i>Land Bank of the Philippines (LBP)</i>  <i>Metrobank</i></p>	<p><i>Security Bank</i>  <i>Philippine National Bank (PNB)</i>  <i>Rizal Commercial Banking Corporation (RCBC)</i>  <i>United Coconut Planters Bank (UCPB)</i>  <i>Unionbank of the Philippines (UBP)</i></p>
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I hereby declare that the above information is true and correct and that I agree to the collection of my data for purposes of reviewing, evaluating, processing, and facilitating bank transactions relating to my enrollment with the MediCard Online E-Payment Facility. I further consent to receive notification or correspondence from MediCard via SMS or email and hereby acknowledge that I am afforded with certain rights and protection in accordance with Republic Act 10173 also known as the Data Privacy Act of 2012.

I understand that incomplete details may delay my enrollment to MediCard Online E-Payment Facility. By affixing my signature hereunder, I hereby consent to MediCard’s use of my personal information contained herein for purposes of achieving the objectives of the E-Payment Facility but consistent with the Data Privacy Act of 2012.

\_\_\_\_\_   
 Enrollee’s signature over printed name

For inquiry, you may call at (028) 801-4734 or 884-9999 loc. 7034



## Medicaid Accredited Physician (Medical Service Team Guidelines and Procedures)

The accredited physicians/doctors recognize the Primary Care Physician/Coordinator as the head and gatekeeper of the Medical Service Team.

### OUT-PATIENT SERVICE

1. The HMO Office and Coordinator's clinic are the only authorized to refer patients and issue referral forms to all medical service team members. Each MediCard member referred must bring with him the properly filled-up MediCard outpatient consultation form.

The accredited physician will complete the form by giving a **WORKING IMPRESSION/DIAGNOSIS**, Management plan including diagnostic exams and/or procedures to be done. The MediCard outpatient consultation form comes carbonized in two copies: the white copy which will be sent back to MediCard Head Office, and the pink copy, which will be retained by the doctor for his patient file/records. Once properly filled up, attach the white copy to the **Summary of outpatient consultation bills** and submit it to MediCard on weekly or monthly basis.

All statement of accounts (out-patient consultation/laboratory diagnostic forms) with corresponding charge slips incurred by our patient-members must be submitted within (1) one month from the time of avilment, otherwise, MediCard shall not process all bills submitted after the said (1) one month.

2. Should there be a need for referral to another doctor and/or request for laboratory/diagnostic exams or procedures, the attending physician must refer patient back to the HMO Office or Coordinator's clinic to secure a MediCard outpatient laboratory/diagnostic examination request form. Laboratory/diagnostic exams or procedures that are **more than one thousand pesos (P1,000.00)** must secure an approval number from our call management group or our Call center. This will be done by the HMO Office or Coordinator's clinic before issuing the request form. Moreover, **all outpatient surgical procedures** including those performed in doctor's clinic must have an approval from MediCard.

### IN-PATIENT SERVICE

1. Should the member need to be confined, this must be upon the recommendation of the MediCard Coordinator or MediCard accredited physician. Approval of the said confinement is based on the benefit of the member.
2. Secure Authorization number and/or Letter of Authorization (LOA) from the company through the HMO Office or assigned Coordinator for the following procedures:
  - a. Elective surgical and obstetrical-gynecological procedures.
  - b. Medical surgical intervention requiring instrumentation and/or endoscopic procedures.
  - c. All health services or treatment requiring hospitalization.
3. Should accredited physicians recommend referral of the member/patient to another accredited physician-specialist if he/she perceives the member's case is beyond the scope of his professional competence. **Referrals to non-accredited physician are discouraged.** However, should the case arise clearance from the coordinator is necessary prior to referral.
4. Prior to discharge of the member from the hospital, the accredited physician must sign the attending Physician's Professional fee statement for in-patient form with itemized list of services and number of visits rendered. (Form is provided by liaison officer in Metro Manila and HMO Office or Coordinator's clinic in provincial areas).