MediCard Philippines, Inc.
Accredited Physician's Terms of Agreement
January 2019

APTA # 0

Name: _____
Specialization: _____
Hospital: _____
Address: _____

Dear Doctor:

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.

Signature

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.

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.

Signature

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

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

Signature

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

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., 8th floor World Center bldg., 330 Gil Puyat Avenue., Makati City or email to 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) 884-9999 loc 9930 and 9931, 811-6131. 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.

LULU C. TERENCIO, M.D.
Provider Relations Manager

Conforme:

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

MediCard
Prescribed by Doctors

Please attach a Photo

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?	❑ Yes, I passed both written & oral exam ❑ Yes, I passed the written exam ❑ No, I'm still going to take the exam	❑ Yes, I passed both written & oral exam ❑ Yes, I passed the written exam ❑ No, I am still going to take the exam
Specialty Org/Association Affiliation	_____ _____ _____	_____ _____ _____
Membership Category in above Org./Association (Please Check only one)	❑ Associate Member ❑ Diplomate ❑ Fellow ❑ Honorary Member Others: _____	❑ Associate Member ❑ Diplomate ❑ Fellow ❑ 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

Date:

Dear Dr. _____:

Good Day!

MediCard can now deposit your professional fee **directly to your bank account** and inform you as soon as the same is credited to your account.

With this E-Payment Facility, you can now enjoy the convenience and faster processing of your Claims payment. Simultaeously with the online crediting, we will be sending you an email indicating the details of your payment together with your BIR 2307. Plus, you don't have to worry about lost, tampered or stolen checks.

ENROLL NOW BY ACCOMPLISHING THE ATTACHED MEDICARD E-PAYMENT ENROLLMENT FORM. For inquiry, please feel free to call Claims Department at (02) 801-4734 & (02) 884-9999 loc. 7034. We would appreciate receiving feedback from you.

Thank you for your continued partnership with us.

Sincerely,

LULU C. TERENCIO, M.D.
Provider Relations Manager

MEDICARD E-PAYMENT ENROLLMENT FORM

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

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

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

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 or send to Medicard Philippines Inc., 8th Floor, Provider Relations Department, The World Centre Bldg., 330 Senator Gil Puyat Avenue, Makati City.*

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

- *Banco De Oro (BDO)*
- *Bank of the Philippine Islands (BPI)*
- *Chinabank*
- *EastWest Bank*
- *Land Bank of the Philippines (LBP)*
- *Metrobank*
- *Security Bank*
- *Philippine National Bank (PNB)*
- *Rizal Commercial Banking Corporation (RCBC)*
- *United Coconut Planters Bank (UCPB)*
- *Unionbank of the Philippines (UBP)*

For inquiry, you may call at (02) 801-4734 or 884-9999 loc. 7034