Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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PHILHEALTH CIRCULAR
No. 2025 - 0006

TO : **ALL PHILHEALTH ACCREDITED HEALTH FACILITIES, PHILHEALTH OFFICES (HEAD OFFICE AND REGIONAL OFFICES) AND OTHERS CONCERNED**

SUBJECT : **Flexibility in Claims Submission Deadline for Claims Filed from January 1, 2018 to December 31, 2024**

I. RATIONALE

PhilHealth is committed to continuous improvement in service delivery and in strengthening partnerships with its accredited Health Facilities. One critical area for improvement is the policy on 60-day deadline/filing period for benefit claims. Over the years, this deadline/filing period has led to a significant number of valid claims being returned and/or denied, not only causing financial strain on Health Facilities but also on operational inefficiencies within the PhilHealth's system.

Pursuant to Legal Opinion dated 27 December 2024 issued by the Office of the Government Corporate Counsel (OGCC), the PhilHealth charter authorizes the adjustment or extension of the period for Health Facilities to file their claims reimbursements for reasonable causes that it may determine. The policy is considered in furtherance of its mandate to administer the state's National Health Insurance Program, which seeks to provide Filipinos, especially the underprivileged, with the mechanism to gain financial access to health services.

Section 35 of the National Health Insurance Act of 2013 (Republic Act No. 10606) and Section 46 of the Revised Implementing Rules and Regulation of the National Health Insurance Act of 2013 state that:

"All claims for reimbursement or payment for services rendered shall be filed within a period of sixty (60) calendar days from the date of discharge of the patient from the health care provider. The period to file the claim may be extended for such reasonable causes as may be determined by the Corporation."

The above provision underscores PhilHealth's authority to extend the filing period for claims when justified by reasonable causes. The intent behind this flexibility is to ensure that Health Facilities are fairly compensated for the services they have already rendered, even when delays in claims submission occur due to circumstances beyond their control.

Accordingly, the PhilHealth Board of Directors has issued PhilHealth Board Resolution No. 2995 s. 2025, approving the flexibility in claims submission deadlines for a specific period which aims to reduce claim denials, ensure equitable reimbursement of valid claims, and improve relationship with health facilities.

II. OBJECTIVES

The policy aims to achieve the following objectives:

A. Introduce Flexibility in Claims Submission Deadlines. This ensures that services rendered are appropriately reimbursed by reconsidering denied claims solely due to late submission, emphasizing flexibility and fairness in support of financial sustainability and operational efficiency of health facilities, thereby ensuring continuing delivery of quality healthcare.

B. Strengthen Provider-PhilHealth Partnership. Improving the claims submission process and ensuring fair compensation for services already rendered will enhance trust and cooperation between PhilHealth and its accredited health facilities. This strengthened relationship will contribute to better healthcare delivery across the country.

C. Align with Legal Mandates. The PhilHealth Circular aligns with PhilHealth's legal obligations in accordance with pertinent provisions of R.A. No. 7875, as amended by R.A. Nos. 9241 and 10606, and R.A. No. 11223, and their respective Implementing Rules and Regulation (IRR) and other pertinent laws and rules, ensuring that claims are processed in compliance with the Corporation's mandate.

III. SCOPE

This PhilHealth Circular applies to all previously denied claims solely due to late submission with claim series number as proof of receipt of PhilHealth, commencing from the mandatory implementation of eClaims or PhilHealth Electronic Claims System (PhilHealth Circular 2017-0030) from January 1, 2018 up to December 31, 2024.

This also includes Z Benefit and Outpatient HIV/AIDS Treatment packages (currently on manual mode of filing) that have claim series numbers and denied due to late submission and filed on the same period of January 1, 2018 to December 31, 2024.

However, this shall not apply to claims that are:

A. already beyond the prescribed filing period;
B. have never been received by PhilHealth; and
C. are still in the possession of the Health Facilities (HFs)

Further, this PhilHealth Circular does not apply to claims related to Primary Care Benefits (PCB), PhilHealth Konsulta Benefit Package, or any other specific benefit packages that have separate filing guidelines and deadlines.

IV. DEFINITION OF TERMS

A. Administrative Protest - the administrative remedy of healthcare providers or members against notice of denial of PhilHealth Regional Office- Benefit Administration Section (PRO- BAS).

B. Appeal - the administrative remedy of healthcare providers or member against notice of denial of PRO-CRC.

C. Benefit Claims - the claims/requests submitted by health facilities to PhilHealth for reimbursement of healthcare services provided to PhilHealth members. These claims include inpatient, outpatient, and emergency care services, among others, as defined by PhilHealth's existing policies.

D. Denied Claims - Claims that have been determined to be invalid and unworthy of payment or reimbursement due to an absolute deficiency that cannot be remedied through return-to-sender or due to a finding of an unmet requirement.

E. Health Facilities (HF) - hospitals, clinics, and other healthcare institutions accredited by PhilHealth to provide healthcare services to PhilHealth members. These facilities are responsible for the submission of claims for reimbursement of services rendered to PhilHealth members.

F. PhilHealth Regional Office – Benefit Administration Section (PRO-BAS) – the claims administration section tasked to administer the processing and payment of claims.

G. PhilHealth Regional Office - Claims Review Committee (PRO-CRC) – A collegial body that deliberates and resolves administrative protests filed by healthcare providers and members regarding notice of denial of or reduced payments by PRO - Benefit Administration Section.

H. Protests and Appeals Review Department (PARD) – The office responsible for the review of appeals on denied administrative protests filed by healthcare providers or members.

I. Refiled Claims - claims that have been previously submitted by HFs or members but returned due to deficiency and/or compliance of documentary requirements.

V. POLICY STATEMENTS

A. As a matter of Corporate Policy, all Health Facilities are strongly encouraged to submit their claims to PhilHealth at the earliest possible time and to strictly comply with the provision of Section 35 of R.A. No. 7875, as amended by R.A. Nos. 9241 and 10606, which provides that "all claims for reimbursement or payment for services rendered shall be filed within a period of sixty (60) calendar days from the date of discharge of the patient from the health care provider."

Early submission of claims facilitates faster reimbursement, improves cash flow for facilities, reduces administrative burden, and allows PhilHealth to process claims more efficiently, ultimately benefiting both parties and enhancing the overall quality of healthcare service delivery.

B. Flexibility Coverage

1. Guided by the principle of flexibility and to allow liberal implementation of the rules and regulation in line with PhilHealth Board Resolution No. 2995 s. 2025 and OGCC Legal Opinion dated 27 December 2024, this PhilHealth Circular shall cover flexibility on claims submission deadlines, to include, without need for further justification for the late filing as approved by PhilHealth Board, for reprocessing of the following claims first filed during the period of January 1, 2018 to December 31, 2024:

   a. Denied claims due to late submission which are in the possession of the PRO BAS;

   b. Unprotested and un-appealed denied claims with claim series due to late submission which are in the possession of the HF.

      Affected claims must be re-filed by HFs to their respective PhilHealth Regional Offices (PRO) within a prescribed period of 6 months from date of effectivity of this PhilHealth Circular with the submission of a Transmittal Letter (Annex A: Flexibility in Claims Transmittal List) that includes the complete information required in the Transmittal Letter:

      b.1. Series Number;
      b.2. Member's PIN;
      b.3. Date of Admission;
      b.4. Date of Discharge; and
      b.5. Date Initially Filed.

      For Z Benefit package and OHAT previously denied solely due to late filing, the original physical claims and pertinent supporting requirements under their respective PhilHealth Circulars (Annex B: Prescribed Documentary Requirements for Reprocessing of Denied Claims Due to Late Submission) must be manually re-filed by HF to the PRO within the same prescribed period;

   c. Denied claims due to late submission under administrative protest in the PRO-CRC and/or under appeal with the PARD.

      CRC/PARD shall remand the internal transmittal lists with denied claims due to late submission together with pertinent supporting documents under their jurisdiction to the PRO-BAS;

   d. Claims previously denied with finality due to late submission according to the current Implementing Rules and Regulation (IRR) starting from the mandatory implementation of eClaims, January 1, 2018 to December 31, 2024.

Affected claims must be manually re-filed by HFs to their respective PhilHealth Regional Offices within 6 months from the date of effectivity of this PhilHealth Circular with the submission of a Transmittal Letter (Annex A) that includes the complete information required in the Transmittal Letter:

d.1. Series Number;
d.2. Member's PIN;
d.3. Date of Admission;
d.4. Date of Discharge; and
d.5. Date Initially Filed.

For Z Benefit package and OHAT previously denied solely due to late filing, the original physical claims and pertinent supporting requirements under their respective PhilHealth Circulars (Annex B) must be manually re-filed by HF to the PRO within the same prescribed period;

e. Claims previously denied with finality due to late submission from the start of mandatory implementation of eClaims (January 1, 2018) up to December 31, 2024 that have been elevated to the regular courts, provided that the appellants withdraw their petition and sign a Notarized Affidavit of Withdrawal of Pending Court Case for Denied Claims Due to Late Submission of Health Facility (Annex C). Claims decided by regular courts that have attained finality are not included.

Subject denied claims must be re-filed by the HFs to their respective PhilHealth Regional Offices within a period of 6 months from the date of effectivity of this PhilHealth Circular with complete and valid documentary requirements.

Affected claims must be manually re-filed by HFs to their respective PhilHealth Regional Offices within 6 months from the date of effectivity of this PhilHealth Circular with the submission of a Transmittal Letter (Annex A) that includes the complete information required in the Transmittal Letter:

e.1. Series Number;
e.2. Member's PIN;
e.3. Date of Admission;
e.4. Date of Discharge; and
e.5. Date Initially Filed.

2. Above claims previously denied due to late submission shall undergo usual claims processing reimbursement before payment, provided they were filed/re-filed during the implementation of PhilHealth Electronic Claims (PhilHealth Circular No. 2017-0030 "Implementation of the Electronic Claims Systems Using Hybrid Approach) which was mandatorily implemented from January 1, 2018 and only until December 31, 2024.

Upon re-processing, these covered claims may be denied or returned to HF for compliance due to grounds or reasons other than late filing. PhilHealth shall issue an advisory pertaining to the timeline of compliance once observed HF is still lacking documentary requirements. If still un-complied with after

the prescribed timeline, the claim shall be denied. Thereafter, filing of administrative protest or appeal shall take place.

3. Pending claims currently under administrative protest or appeal for the same coverage period of January 1, 2018 up to December 31, 2024, which were previously denied solely due to late submission, shall be re-processed subject to existing policies. The processing will proceed only if the claim documents are complete and valid, ensuring that HF receive due reimbursement for their services rendered.

C. Denied claims with deficiencies other than late filing/refiling are not covered by this policy. These shall undergo the usual process of filing/processing of administrative protest or appeal.

D. Un-protested and un-appealed denied claims due to late submission which are still in the possession of HFs must be submitted to PhilHealth within six (6) months starting from the effectivity of this PhilHealth Circular. After the 6 months from the effectivity of this PhilHealth Circular, PhilHealth shall deny with finality all un-protested and un-appealed claims covered by this policy.

E. If an HF is found to have engaged in fraudulent activities related to delayed claims submission, PhilHealth reserves the right to impose sanctions. These sanctions may include the suspension of claims processing privileges, fines, and, in severe cases, suspension of accreditation. All actions taken will be in accordance with the relevant provisions of RA No. 7875 and its amendments, as well as other applicable laws and regulations.

F. Any overpayments shall be subjected to the provisions of Payment Recovery Policy as may be applicable.

G. This PhilHealth Circular shall be regularly reviewed and enhanced, as necessary.

VI. PENALTY CLAUSE

Any violation of this PhilHealth Circular shall be dealt with and penalized in accordance with pertinent provisions of R.A. No. 7875, as amended by R.A. Nos. 9241 and 10606 (National Health Insurance Act of 2013) and R.A. No. 11223 (Universal Health Care Act), and their respective Implementing Rules and Regulations, including PhilHealth Rules on Administrative Cases (PROAC).

VII. SEPARABILITY CLAUSE

If any part of this PhilHealth Circular is declared unauthorized or invalid, unconstitutional, or unenforceable, the validity of the remaining provisions shall continue to be in effect.

VIII. REPEALING CLAUSE

All previous issuances inconsistent with the provisions of this PhilHealth Circular are hereby repealed or amended accordingly.

IX. DATE OF EFFECTIVITY

This PhilHealth Circular shall take effect fifteen (15) days after its publication in the Official Gazette or in any newspaper of general circulation. Three (3) certified copies shall be filed with the Office of the National Administrative Register (ONAR) of the University of the Philippines Law Center.

EDWIN M. MERCADO, MD, MHA, MMSc
Acting President and Chief Executive Officer

Date signed: 03/05/2025

MASTER COPY
DC: Date: 3/5/25

Flexibility in Claims Submission Deadline for Claims Filed from January 1, 2018 to December 31, 2024

Annex A: Flexibility Claims Transmittal List

HEALTHCARE FACILITY NAME:
ACCREDITATION NO.:
Address

FLEXIBILITY CLAIMS TRANSMITTAL LIST

Item No.	Claims Series Number	Member's PIN	Date of Admission (mm/dd/yyyy)	Date of Discharge (mm/dd/yyyy)	Date Initially Filed (mm/dd/yyyy)
1					
2					
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(continue separate page if necessary)

Certified Complete and Accurate by:

_____
HCF Authorized Representative

MASTER COPY
DC: Date: 3/5/25

Prescribed Documentary Requirements for Reprocessing of Denied Claims Due to Late Submission

The following are the prescribed documentary requirements for denied claims with claim series number due to late submission still in the possession of Health Facility (un-appealed or un-protested).

A. eClaims Submitted, the HF shall ensure the submission of the following:

1. Claim Signature Form
2. Statement of Account
3. Claim Form 4
4. Claim Form 3, as may be applicable to benefit packages being claimed
5. Supporting Documents (operative records, diagnostic/laboratory imaging) as may be applicable to the benefit package
6. Other supporting documents lacking as may be required for payment

B. Z Benefit Packages and OHAT (manual filing-refiling)

1. Claim Form 1
2. Claim Form 2
3. Z Benefit Package Annexes per Z Benefit Package code per respective PhilHealth Circular.
4. For OHAT, CF1, CF2, SOA, Confirmatory Test Result, Health Regiment booklet, Waiver and consent to release of confidential information.

For denied claims due to late submission that are elevated and pending in regular courts. In addition to the above, the following is a requirement:

1. Notarized Affidavit of Withdrawal of Pending Court Case for Denied Claims Due to Late Submission of Health Facility

Annex C: Affidavit of Withdrawal of Pending Court Case for Denied Claims Due to Late Submission of Health Facility

Affidavit of Withdrawal of Pending Court Case for Denied Claims Due to Late Submission of Health Facility

I, _____ (Full Name), of legal age, _____ (Owner/Hospital/Medical Director)
of _____ (Name of Health Facility)
and with address at _____
_____ acknowledge that I have been duly given the appropriate notices under the law and further manifest and declare that:

1. I submit the previously denied claims of _____ (Name of Health Facility) due to late submission, amounting to _____ (Amount in Words), _____ (Amount in Figures) together with the complete and valid documentary requirements attached as Annex A, in accordance with the PhilHealth Electronic Claims (PhilHealth Circular No. 2017-0030).

2. That the above affected claims that whose petition is pending before the regular courts in the Philippines shall be withdrawn.

3. In the event the Health Facility is found to be engaged in fraudulent activities related to the affected delayed claims, PhilHealth reserves the right to impose sanction as may be authorized by laws and regulations.

4. Finally, I have read this affidavit and fully understood every word of it and its meaning and have affixed my signature hereunder voluntarily and freely with the full and complete knowledge of the meaning and intent of this document and of my rights under existing laws.

I hereunto set my hand this _____, 2025, at _____ City.

_____
(Signature above Printed Name of HF Owner/ Designated Representative)

Witnesseth:

_____
(Signature above Printed Name of Witness)

SUBSCRIBED AND SWORN to before me this ___ day of _____ 2025 at _____ City, affiant appeared exhibiting as proof of identity _____.

Doc. No. _____;
Page No. _____;
Book No. _____;
Series of 2025.

MASTER COPY DC: Date: 3/5/25