Annexes

Slides for Module 4: Administrative and Financial Management of a HMIS

Module 4

Administrative and Financial Management of HMIS

Session

4.1: Administrative Tools

4.2: Financial Management Tools

Module 4 Objectives

- describe the importance in putting in place administrative and financial management systems and tools into their HMIS operations
- enumerate and describe the different administrative systems and tools
- describe the different financial management systems and tools
- determine which of the administrative and financial systems and tools are applicable to their respective situations and needs and make an assessment of their current systems and tools

Session 4.1
Administrative Tools

Importance of Establishing HMIS Management System

- Build confidence
- Ensure viability of the scheme
- Minimize dysfunctions

HMIS Resources To Be Managed

RESOURCES

- Human Resource
- Material Resources
- Financial Resources

Aspects of HMIS Management

Organization and Functioning

- organizational structures
- By-Laws and Policies, Systems and Procedures (PSPs) established
- meetings your organization undertakes
- relationship with service providers or external partners

Aspects of HMIS Management

- **Administrative Management**
  - tasks on membership registration and monitoring
  - collection of contributions
  - entry on the books
  - monitoring and payment or benefits

- **Importance**
  - contributions and benefits are main source of income and expenditure respectively of your HMIS
  - tools used make it possible to have all the information necessary to carry out monitoring and analysis of overall performance of your HMIS

Aspects of HMIS Management

Accounting and Financial Management

- **accounting management**
  - records the various HMIS transactions in the form of inflows and outflows of resources
  - files and process them
  - follows different stages of HMIS activities in a given period (a financial year from start-up, operation and closure)
- **financial management**
  - ensures long-term HMIS financial viability
  - forecasts and controls revenue and expenditure,
  - analyzes financial situation and manages financial investments

Main Management Aids and Tools

Administrative Management

- Membership Card
- Register of Members
- Certificate of Entitlement
- Invoice

Main Management Aids and Tools

Accounting Management

- Cash Journal
- Cash-in-Bank Journal
- Cash Receipt Book
- Cash Disbursement Book
- Petty Cash Form
- General Ledger
- Statement of Income and Expenditure
- Balance Sheet

Main Management Aids and Tools

Financial Management

- Action Plan
- Budget
- Cash Flow Forecast
- Statement of Income and Expenditure
- Balance Sheet
- Financial Ratios Record

Organization and Functioning

- must have a precise definition of the authorities and responsibilities of management bodies
- organizational chart must precisely determine the following:
  - place of each structure/unit
  - define each of their functions and responsibilities
  - attribute corresponding authority

The Management Structures

- General Assembly
- Board of Directors
- Executive Body
- Auditing Body
- Medical Committee
- Committee of Experts
- Monitoring and Evaluation Committee (in some cases, this is merged with the Auditing Body)
- Grievance Committee

The General Assembly (GA)

Overall Function:

- highest decision-making body in your HMIS
- determines By-Laws
- its decisions bind all its members and all the other management units.

Frequency of Meeting:

- normally convened at least once a year to approve the annual accounts and budget
- convenes upon the request of at least one fifth of the members of the HMIS - Special General Assembly.
- may also be convened at the request of the Board of Directors, the Executive Body or even the Auditing Body

General Assembly (GA)

Duties and Responsibilities

- define the mission of the HMIS and formulate its By-Laws
- approve and alter the By-Laws
- examine and approve the activity reports of the various bodies, including the Auditing Body
- examine and approve the annual accounts and budget
- establish the amount of contributions and any special contributions
- elect the members of the Board of Directors

General Assembly (GA)

Duties and Responsibilities

- elect the members of the Auditing Body
- define the new directions of the HMIS
- decide on mergers with another HMIS, or wind-up the HMIS
- decide on the admission or exclusion of members of the scheme (more common in small health micro-insurance schemes or those with annual contributions)
- decide on any other matters provided for by the By-Laws
- decide on the benefits offered by the HMIS

Board of Directors (BD)

Overall Function

- body responsible for managing the HMIS
- exercises all the responsibilities not specifically entrusted by law or the HMIS By-Laws to the GA or the Auditing Body
- members of BD are all volunteers who agree to make their skills and part of their time available to others

Delegation of Powers

- may delegate part of its powers to the Chairperson or to one or more directors
- may delegate certain powers to the Executive Board as far as the daily functioning and specific implementation of decisions is concerned

Board of Directors (BD)

Duties and Responsibilities:

- ensure respect for the By-Laws with a view to attaining the objectives of the HMIS
- propose the admission or expulsion of members and apply the disciplinary penalties provided for, if necessary
- nominate the responsible members of the Executive Body
- draw up the annual accounts and budget for the following financial year
- coordinate the work of the various committees

Board of Directors (BD)

Duties and Responsibilities:

- draw up the activity reports of the HMIS on an annual basis
- represent the HMIS in its relations with the third parties and establish relations with other associations, particularly other social movements which are also founded on solidarity
- sign agreements/conventions, specially with care providers
- establish staff pay
- recruit the director/manager (if are paid and not elected)
- fulfil all other missions entrusted by the By-Laws or the GA

Executive Body (EB)

Overall Function:

- responsible for the day-to-day administration of the HMIS which involves day-to-day tasks, organizing activities, supplies or the maintenance of premises
- also called the Executive Committee, Management Committee or Management Board

Executive Body (EB)

Duties and Responsibilities

- prepare budget BD and ensure proper implementation once approved
- present to BD the annual accounts and execute the budget
- make any proposal to BD to achieve HMIS objectives more thoroughly
- negotiate conventions/agreements after submission to BD
- manage the HMIS assets and funds
- recruit/supervise personnel (except the director/manager)
- ensure liaison between members and the management
- negotiate with providers and protect members' health interests
- exercise functions indicate in the By-Laws or endorsed by BD and GA

Auditing Body (AB)

Overall Function

- verifies the implementation of the GA's decisions
- proposes improvements
- guarantees that the HMIS management bodies function efficiently
- also tasked to do the monitoring and evaluation, hence they become the Monitoring Committee

Auditing Body (AB)

Duties and Responsibilities:

- ensure that minutes of the management bodies conform to the By-Laws as well as the PSPs and do not contravene laws and regulations in force in the country
- control the accuracy of the accounts and regularity of financial transactions
- control the execution of decisions of the GA
- draw the attention of the responsible management bodies to irregularities committed and propose measures or procedures to avoid repetition

Auditing Body (AB)

Duties and Responsibilities:

- ensure respect for the HMIS By Laws and PSPs
- receive complaints from members concerning the services offered and ask the competent body/person to correct them;
- require the competent person or body to carry out a task which has not been performed or which has been poorly performed, and ask for necessary procedures to be applied
- examine and check the conditions of eligibility of members taking part in the GA
- exercise all the functions assigned to it by the By-Laws and the PSPs

Administrative Tools

- By-Laws
- Policies, Systems and Procedures
- Minutes of Meetings
- Memorandum of Agreement

What are the By-Laws for?

- incorporates the HMIS; gives it a legal personality.
- defines the rules relating to the objectives and functioning of your HMIS which determine the rights and duties of the members and the role of the different management bodies
- establish the means, guaranteeing that the HMIS functions democratically and jointly
- Note: In the Philippines, the functioning of the HMIS is regulated according to the needs of the community and is derived from legislative laws on cooperatives and non-profit making associations, mutual savings and credit banks

What are the By-Laws for?

What information does the By-Laws contain?

Title 1	**:**	**The General Provisions**
Title II	**:**	**Administration/Functioning of the Health Micro-Insurance Scheme: composition, election and powers of the management bodies**
Title III	**:**	**Financial Provisions**
Title IV	**:**	**Obligations of the Health Micro-Insurance Scheme and its Members (may be specified in the internal rules of procedure)**
Title V	**:**	**Rules of Application, Amendments, Membership of Unions, Federation, Merger, Winding-up and Liquidation**

How are the By Laws Processed?

- generally drafted by the Executive Body or the Board of Directors
- approved by the General Assembly
- administered by the Executive Body
- only the GA may alter the provisions laid down in the By-Laws
- sent to the administrative authorities to be recorded, in accordance with the regulations in force
- Note: By Laws may be simplified to the level of understanding of members

  to improve transparency and participative democracy in your HMIS

What are the Policies, Systems and Procedures for?

- provisions concerning the practical functioning of the HMIS but not articulated in the By-Laws like:

  - documents for members contributing for the first time
  - content of membership records
  - conditions required to be considered a beneficiary or dependent
  - amount and details of membership fees and contributions
  - detailed functioning of structures
  - conditions of access to the benefits detailed

What are the Minutes of Meetings for?

- important documents for the strategic management of your HMIS
- records the decisions taken during the management meetings and in inter-action with external partners
- constitutes the history of the collective decisions of your HMIS
- minutes are recorded for meetings of the General Assembly, Board of Directors or the Executive Body

What are the Minutes of Meetings for?

What information does the Minutes of Meetings contain?

- date of meeting
- place or venue of meeting
- body convening (General Assembly, Executive Body, Board of Directors, Auditing Body)
- agenda
- excused absentees
- absentees not excused
- decisions taken
- end of meeting (time)
- signature of the chairperson and secretary of sessions

Managing Relations With External Partners

- care providers
- suppliers of services and equipment
- beneficiaries and members
- banking, legal and government institutions and supporting structures

Managing Relations With External Partners

Care Providers

- special partners in operating your HMIS
  - barangay health station (BHS)
  - a barangay health and nutrition post
  - Rural Health Unit (RHU) or a health center
  - an infirmary
  - a hospital
  - a pharmacy
  - individual providers (doctor or radiologist)
  - a health transport company

Managing Relations With External Partners

Financial Structures

- **savings banks, or savings and credit co-operatives from which your HMIS may secure its funds**

Legal or Public Authorities

- **in the event of disputes, theft, fraud or other matters, your HMIS must be supported by these legal or public authorities**

- **certain national agencies (with administrative authority) and decentralized services may provide activities or services in favour of your HMIS**

Granting Benefits

Option 1: Indirect Third Party Payment

- either your beneficiary pays the total amount of the services they have used and are reimbursed subsequently by your HMIS

Option 2: Direct Payment

- your HMIS pays the provider directly

Indirect Payment or Third Party Payment

- In this option, you ask your beneficiaries to pay the costs of the services provided before you reimburse them
- your beneficiary pays according to the methods adopted by the care provider (payment at the time, by episode of illness or by outpatient care), and according to the rates you have agreed upon with your service provider.
- your beneficiary will therefore request the care provider you contracted for a proof of payment, usually a receipt or invoice, that must include at least:
  - the identification of the care provider
  - the identification of the beneficiary
  - the nature, cost and date of the benefit

Direct Payment by the HMIS

- called the direct (third party) payment because it is not your beneficiary who pays but your HMIS - the third party in addition to the provider and the beneficiary
- often adopted for ‘major risks’ involving substantial costs which your beneficiary cannot meet (e.g. hospitalization or surgery)
- in certain cases, your beneficiary also pays a patient’s contribution to the provider or your HMIS pays the service provider directly, upon presentation of an invoice

Direct Payment by the HMIS

- you may negotiate with the provider and make a deposit available to them
  - deposit will assure the care provider of your HMIS ability to pay
  - with this gesture of confidence, the care provider may issue invoices for care over a longer period, thus in turn, adopt longer payment times
  - may negotiate with the provider to use the deposit as working capital for supplying stocks of medicines

What is the Memorandum of Agreement (MOA) for?

- otherwise known as co-operation agreement
- formalizes partnership with external partners
- describes how to operationalize the partnership
- establishes among others, benefits and means of meeting cost of treatment
- ensures that your beneficiaries receive quality care at a reasonable pre-established cost
- consolidates relations with your service provider and is a tool for

What is the Memorandum of Agreement (MOA) for?

- consolidates relations with your service provider and is a tool for arbitration in the event of disputes

- may include the following:
  - methods of paying invoices (e.g. reimbursement, direct payment or indirect payment)
  - system of granting benefits
  - payment of invoices

- may also include the procedure for meeting costs and the membership procedure for your beneficiaries

What information does the Memorandum of Agreement contain?

Preamble:	**Presentation of the Two Parties**
Article 1:	**Object: Objective of the Cooperation, Type of Services Covered (must be described as accurately as possible)**
Article 2:	**Commitments**
	a. Health Micro-Insurance Scheme
	b. Care Provider: Conditions for Meeting Beneficiaries' costs
Article 3:	**Duration of the Agreement**
Article 4:	**Arbitration: Procedure in the Event of Dispute**
Article 5:	**Revision: Possibility to Alter the Terms of the MOA**
Article 6:	**Termination: End of the MOA**
Signature of the Two Parties	
Signature of the Arbitration Authority	
Annexes:	**List of Benefits Offered Plus Costs**

Administrative Tools

- For membership
  - Membership Book
  - Register of Beneficiaries
  - Register of Contributions
- For benefits
  - Certificate of Entitlement
  - Invoice
  - Register of Benefits

What is the Membership Book for?

- Membership Pass Book, Membership Card
  - a family card which displays all information to precisely identify family member and each of his/her dependents
  - individual card (one for each beneficiary)
- an evidence of membership of individuals to your HMIS
- principal objective is to identify members and beneficiaries and check that their contributions are paid regularly
  - shows the logical succession of contributions paid and the benefits used by each member
  - constitutes the “continuous ‘memory.”

What is the Membership Book for?

- serves as "passport" of HMIS members
  - confirms to health care provider that members are covered by the HMIS
  - checks accuracy of records on the Register of Contributions and Register of Beneficiaries any time
  - serves as a monitoring tool
- serves as a health record; have several blank pages for use by health care providers to record their services and prescriptions

What information does the Membership Book contain?

- identification of members and their dependents
- monitoring of contributions
- may also include a brief description of your PSPs on:
  - methods of meeting costs
  - benefits covered/not covered
  - illustrations or flowchart to visualise the procedure for meeting costs

How is the Membership Book used?

(1) request applicant to accomplish information form; may request for photographs of his/her beneficiaries

(2) attribute a code to each beneficiary, in the knowledge that the member is both a member and a beneficiary

(2) after each contribution is paid, person responsible for collecting contributions puts a stamp or signature on the space provided in the MB and indicates the total amount of contributions paid

How is the Membership Book used?

Uses:

- members can check if their contributions are up-to-date
- care providers to know whether the person concerned meets the HMIS conditions for meeting the cost, together with the Certificate of Entitlement
- a means of control (comparison with register of contributions and membership book)

What is the Register of Beneficiaries for?

- ascertains the following on a regular basis:
  - the number of beneficiaries (members and dependents)
  - new memberships and withdrawals during an accounting period
  - payments of membership fees and contributions,
  - renewal of contributions to track, from one accounting to the next, growth in number of members and, where relevant, of cancellations of membership

What is the Register of Beneficiaries for?

- enables HMIS to record information relating to beneficiaries
- makes it possible to monitor the number of beneficiaries of HMIS at all times, particularly your members and their dependents
- serves to record any changes within a member's family (birth, death, etc)
- intended to reflect payment of contributions and identify any arrears

What information does the Register of Beneficiaries contain?

- makes it possible for you to record the following data:
  - beneficiary code: indicating the number of the beneficiary and their status (member or simple beneficiary)
  - surname and first name
  - sex
  - address
  - date of birth
  - status: member or dependant
  - date of joining: first contribution
  - date of leaving
  - comments: reasons for leaving, other relevant information

How is the Register of Beneficiaries used?

- must record any beneficiary into the Register of Beneficiaries for whom a contribution is paid to your HMIS
- must assign them with a beneficiary code
- use any time to find information on your beneficiaries; find the details of all your members (e.g. those who attended the GA

How is the Register of Beneficiaries used?

- can also be used for:
  - monitoring the number of members/beneficiaries by means of the coding system
  - assessing reasons for leaving your HMIS: for example, members who have not paid their contributions for the last six months
  - identifying the number of men/women members of your HMIS, their age group, their location (e.g. if they are near the care provider)

Schemes in the Collection of Fees

(1) **Peer Strategy: The Mangloy, MPC -Tagum, Davao Norte**

- **organize structure: for every 5 members, assign one member to collect premiums daily**
- **daily collections submitted to the HMIS office base weekly**
- **requires collector in-charge to remain in the area until all the premiums are collected from the group**
- **demands that the payment of premium of one is the responsibility of all the 5 members;**
  - **(a) peer pressure is employed if there is one who is unable to pay regularly**
  - **(b) peers also became a source of assistance and guidance for the rest , thus building up solidarity among the group and sense of responsibility for one another**

Schemes in the Collection of Fees

(2) <u>Automatic Deduction:</u> The SAKAHA

- group's decision to include social protection for health among their groups required the automatic deduction of Php 30.00 from their savings in case an immediate member of the family dies or falls sick

- SAKAHA as a credit organization collects loan payment daily through their organized cell groups and chapter structures

- Included in the loan payment by each member is a contribution for their savings in the amount of Php 50.00. It is from these savings collected daily where the Php 30.00 for health services are automatically withdrawn

Schemes in the Collection of Fees

(3) SEA K Project

- SSS premium is collected as part of the regular collection of loan payment;
- credit organization only charges Php .50 each of the monthly collection for administrative fee, part of which is for transmitting these collections to the SSS

Schemes in the Collection of Fees

(4) In ORT-OHPS in La Union

- set up 13 satellites which provide education and health services to members
- satellites ensure that contributions of their members are collected
- ORT-OHPS staff in these satellites receive the contributions of the members by issuing provisional receipts to the paying members
- at end of week, collections are remitted to home office where the official receipts are issued

What is the Register of Contributions for?

- makes it possible to monitor the situation of contributions of members on a daily basis
- principal function is to show whether the beneficiary is entitled to the HMIS benefits
- may establish a waiting period during which your member regularly pays their contributions without being entitled to use the HMIS services (e.g covering deliveries)

What information does the Register of Contributions contain ?

- contains the following information to make monitoring of the payment of your members' contributions possible
  - member's code: member's beneficiary code-responsible for paying the household's contributions to the HMIS
  - surname and first names
  - number of beneficiaries: member and dependents
  - total amount of monthly contributions
  - possible arrears from previous year
  - amount of contributions paid
    * by month January, February, March, April, etc.)
    * by year: 2002, 2003, 2004

How is the Register of Contributions used?

- member pays a contribution to HMIS according to the agreed-upon frequency (monthly, quarterly, yearly) in your By-Laws
- after recording the contribution in the MB, record the amount of the contribution again in the Register of Contributions
- when beneficiary appears, verify whether his/her contributions are up-to-date before issuing the Certificate of Entitlement
- Register of Contributions allows you to examine the number of beneficiaries who are entitled to HMIS' benefits

Recording of Benefits

- for day-to-day management, record HMIS benefits based on three reference key documents
  - Certificate of Entitlement
  - Register of Benefits
  - Invoice

What is the Certificate of Entitlement for?

- assures service provider that the contributions of the beneficiary concerned are up-to-date and confirms that their costs will be met according to the terms defined in the MOA
- use depends on size of HMIS, level of care (cost and frequency) to be provided and level of management
- may no longer be useful if there is a significant social control among the beneficiaries of your HMIS

What information does the Certificate of Entitlement contain?

- composed of three parts
  - ♦ Beneficiary Profile Section
  - ♦ Guarantee Section
  - ♦ Certificate of Care Section

What information does the Certificate of Entitlement contain?

- Beneficiary Profile Section: contains particulars on the beneficiary
  - member's name
  - member's code
  - beneficiary name
  - beneficiary code
  - address
  - sex
  - date of application

What information does the Certificate of Entitlement contain?

- Guarantee Section
  - referred to by the service provider before administering the service
  - indicates your HMIS is guaranteeing the payment of cost of services to be provided to your beneficiaries

What information does the Certificate of Entitlement contain?

- Guarantee Section information
  - number of certificate of entitlement
  - beneficiary code number
  - beneficiary name
  - name of provider
  - application to meet the cost
  - signature of a person in charge of HMIS
  - with a reference to the date

What information does the Certificate of Entitlement contain?

- Certificate of Care Section
  - detached by service provider upon providing care or treatment and send it back to HMIS

- contains following information
  - number of certificate of entitlement
  - beneficiary name
  - beneficiary code number
  - type of benefits
  - certificate of care form
  - amount paid by the beneficiary and HMIS
  - date and signature of provider

How is the Certificate of Entitlement used?

- when a member falls ill, issue a CE to that particular member
- keep the Beneficiary Profile which serves as key reference before issuance
- sick member uses the Guarantee and Service Provider Certificate sections of the CE and presents these to service provider
  - Guarantee Section acts as confirmation (a guarantee) by HMIS that the beneficiary's costs will be met by HMIS according to MOA
  - Certificate of Care Section certifies that care has been provided; detached and filed by the provider and returned with invoice to HMIS
- for emergencies (e.g. transport during the night), recommend the possibility of presenting CE within 24 hours of the first aid as part of MOA
- quality and correct use of CE influences quality of cooperation between HMIS and care providers

How is the Certificate of Entitlement used?

(1) When beneficiary falls ill, he/she goes to HMIS with MB

(2) HMIS checks MB and Register of Contributions to confirm that beneficiary's contributions are up-to-date.

(3) HMIS hands over a CE to member and retains Beneficiary Profile Section

(4) beneficiary goes to care provider and presents MB and CE

(5) provider verifies whether it is the same person indicated in the CE and may carry out a second check on MB for his/her contributions.

(6) Provider administers care and files Guarantee Section of CE

(7) Provider sends Certificate of Care Section with Invoice to HMIS

(8) HMIS manager compares Beneficiary Profile Section with Certificate of Care Section and verifies whether the cost of benefits invoiced are met by HMIS

(9) HMIS manager then pays the invoice

What is an Invoice for?

- aid used by the care provider contracted by HMIS for obtaining reimbursement of the cost of care delivered to your beneficiaries
- allows provider to add up all care delivered to members and respective amounts over a given period
- once accomplished, it is sent to HMIS, which shows exactly how much to reimburse
- For HMIS:
  - an accounting record that justifies the outflow of HMIS money on a given date from cash on hand or from the HMIS bank account
  - fosters appropriate monitoring of activities as it summarizes the number and type of transactions and expenditure incurred with a given provider over a given period

What does an Invoice contain?

- **For the health center:**

  (1) **amount per bout of illness**: center receives an amount that covers outpatient care, medicines and laboratory analyzes per case of illness; advantage is that patients' ongoing treatment is not interrupted due to lack of funds

  (2) **amount per consultation**: includes the cost of medicines and laboratory analyzes; first consultation is often costlier than subsequent ones

  (3) **a lump sum per person** registered in the center: after registration, center undertakes care for the beneficiary for a given period (generally one year) for a lump sum, irrespective of the care required

What does an Invoice contain?

- **For the hospital:**

  (1) **a lump sum per day's hospitalization**: sum includes both accommodation and medical, surgical and nursing care, technical treatments and medicines

  (2) **a lump sum covering all the time in hospital**: a single amount calculated on the basis of an estimation of the average duration of hospitalization

  (3) **a payment per benefit or per treatment**: all accommodation medical treatment, and medicines are invoiced separately

  (4) **a payment per grouped benefit**: all medical treatment, accommodation and medicines are grouped in the invoice for outpatient care, hospitalization, deliveries, transports

What does an Invoice contain?

- **Information on the Provider**:
  - details of the care provider
  - number of the invoice
  - period concerned/covered
  - date when the invoice is issued
  - who the invoice is to be sent to
- **Information on the Care Invoiced (per benefit)**:
  - date of treatment
  - identification of beneficiary: beneficiary code
  - number of certificate of entitlement
  - nature and cost of benefits: hospitalization, medicines analyzes, external care, with breakdown as to beneficiary

Other information

- total amount of invoice in figures and words
- signature of provider: competent person of the health structure (senior doctor, duty nurse, competent administrative staff member)

How is the Invoice used?

- specify provider's obligation the costs to be met by provider
- drawn up on a monthly basis
  - certain providers opt to establish Invoice according to number of times care is provided (e.g. one Invoice every 100 treatments); or
  - amounts to be reimbursed (one invoice as soon as the total amount to be reimbursed reach a certain level, e.g. Php 50,000)
- drawn up in two copies
  - one sent to HMIS
  - other is retained by the provider

How is the Invoice used?

- based on existence of Certificate of Entitlement - Certificate of Care Section which provides more accurate details of costs by type of treatment provided
- makes it possible to sum up the number of times costs are met and the monthly expenditure covered - direct payment system - by HMIS with a care provider

What is the Register of Benefits for?

- makes possible to keep track of all benefits received by the beneficiaries of HMIS
- also called the ‘register of health expenditure or ‘benefit records
- makes it possible to know the following:
  - most frequent benefits
  - monthly/annual amount of benefits: periods of epidemics or other the average cost of benefits
  - utilization rate of health services
  - most frequently visited health facility
  - age, sex, occupation, geographic location of highest-risk beneficiaries

What information does the Register of Benefits contain?

- date
- number of certificate of entitlement
- beneficiary code
- invoice number
- origin of invoice: name of care provider
- amount payable: MHIS/beneficiary/total
- Observations

What information does the Register of Benefits contain?

Note:

(1) details of the register of benefits may be organized so that each new page of the register represents another type of service

(2) HMIS and service provider may also code benefits

(3) may also organize benefit information according to care provider or according to beneficiary sub-groups (e.g. barangay, sub-office, y age group or others)

What information does the Register of Benefits contain?

(1) after receiving Invoice from care provider, HMIS records the expenditure in the Register of Benefits

(2) verify the number of Certificate of Entitlement (Beneficiary Profile Section and the Certificate of Care Section) and nature of benefits before paying the invoices