



VINCARE PHARMA
2nd Flr Ngo Bldg, Ochoa Ave.,
Brgy. Limaha, Butuan City

EMERGENCY LOAN FORM

Date Filed: 3/5/25	Employee #:
Name: CHICLET DALAUTA	
Position: ACCOUNTING OFFICER	Department: ADMIN
Requested Amount (Php): 10,000	Amount in Words: Ten THOUSAND pesos only.
Purpose of Cash Advance: Greetings! I would like to request an emergency loan amounting ten thousand pesos for my son's hospital bill. Thank you so much for your humble consideration. <i>Note: Hospital Bill Attached.</i>	
Payment Schedule: Monthly (✓) Semi-Monthly ()	
Outstanding Balance: 140,500.00	Deduction: Php 500
Employee's Signature over Printed Name	LORIEJANE L. CABUNTOCAN APPROVED BY:



Holy Child Colleges of Butuan Hospital

102 Southdrive, Guingona Subdivision, Butuan City
Tel R: ER (085) 341-5601 Billing Section (085) 342-5186

"PhilHealth Accredited"

STATEMENT OF ACCOUNT

PATIENT: **DALAUTA, CLARK RAVENS** AGE: **22 Y.O.** NO. REFERENCE: **15-18406**
ADDRESS: **721-A 4TH ST. GUINGONA SUBD. BUTUAN CITY** ROOM NO: **205**
FINAL DIAGNOSIS: **ACUTE CYSTITIS** RATE PER DAY: **800.00**
OTHER DIAGNOSIS: **DENGUE FEVER W/ WARNING SIGNS** DATE & TIME ADMITTED: **March 1 2025 07:55AM**
DYSPNOEA DATE & TIME DISCHARGED: **March 5 2025 09 AM**
FIRST CASE RATE: **5430.9**
SECOND CASE RATE:

SUMMARY OF FEES:

AMOUNT OF DISCOUNTS

PHILHEALTH BENEFITS

PARTICULARS	QTY	ACTUAL CHARGES	VAT EXEMPT	SENIOR CITIZEN/ PWD	FIRST CASE RATE AMOUNT	SECOND CASE RATE AMOUNT	OUT OF POCKET OF PATIENT
HCI FEES							
EMERGENCY FEE	1	1,498.00					0.00
ROOM AND BOARD							
PRIVATE ROOM							0.00
WARD	4	3,200.00					0.00
LABORATORY & DIAGNOSTIC	1	9,373.00					0.00
DRUGS & MEDICINES	1	10,337.00					0.00
OXYGEN CONSUMPTION	1	0.00					0.00
OPERATING ROOM FEE	1	0.00					0.00
SUPPLIES	1	4,015.00					0.00
OTHERS:							
ADMISSION FEE	1	1,000.00					0.00
NURSING SERVICE	4	3,556.00					0.00
UTILITY SERVICES	4	3,328.00					0.00
MISCELLANEOUS	4	3,520.00					0.00
SUBTOTAL:	Php:	39,827.00	0.00	0.00	10,237.50	0.00	29,589.50
LESS: DSWD							10,000.00
LESS: ISDAP							4,000.00
TOTAL HOSPITAL BILL		39,827.00					15,489.50
PROFESSIONAL FEE							
DR. ANDAYA, ROSALIE		9,337.50	0.00	0.00	4,387.50	0.00	4,950.00
							0.00
							0.00
							0.00
							0.00
SUBTOTAL:	Php:	9,337.50	0.00	0.00	4,387.50	0.00	4,950.00
TOTAL:	Php:	49,164.50	0.00	0.00	14,625.00	0.00	20,539.50

Confirmed by

[Signature]

Member/ Patient/ Authorized Representative

Signature over Printed Name

Relationship to member or patient of authorized representative

Date signed *4/6/25* Contact Number *0917111111*

SHEILA M. MATILAC-LINSAG

(Signature over printed name)

Date signed *4/6/25*

Landline 342-5186

LIMUEL A. DAIG

Account's Head

DR. RODOLFO P. ESTEVES

Founder / President

1. All out the form legibly

The member/ Patient/ Authorized Representative should not sign a blank NOA

Printed copy of NOA or its equivalent should be free of charge

This is a final billing as of

Additional charges shall be paid if the patient fails to go home and continue to avail the services of the hospital

up off time of the issuance of final billing is 12:00 o'clock noon time from Monday to Friday