Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center: (02) 8441-7442 | Trunkline: (02) 8441-7444
www.philhealth.gov.ph

Case No. ________________

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	**(Answer only if the patient is a dependent; otherwise, write, "same as above")** 1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

DISCHARGE CHECKLIST FOR EXPANDED Z MORPH
Tranche 2

Place a check mark (✓) on the type of prostheses or orthosis to be given to the patient:

Z Benefits		Right	Left	Both
I. Lower limb prosthesis	1. Above knee/ knee disarticulation			
	2. Hip disarticulation			
	3. Van Ness Rotationplasty			
II. Upper limb prosthesis	4. Below elbow			
	5. Above elbow			
III. Lower limb orthosis	6. Ankle foot			
	7. Knee ankle foot			
	8. Hip knee ankle foot			
IV. Spinal orthosis	☐ Thoracolumbosacral	☐ Lumbosacral	☐ Cervicothoracic	

Rehabilitation Sessions	Dates Performed					
Physical therapy OR						
Occupational therapy						

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Rehabilitation Medicine Specialist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐	PhilHealth Accreditation No. ☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient/Parent/Guardian
Date signed (mm/dd/yyyy)