



*Republic of the Philippines*  
**PHILIPPINE HEALTH INSURANCE CORPORATION**

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[www.philhealth.gov.ph](http://www.philhealth.gov.ph)



Case No. \_\_\_\_\_

**Annex “C2.1 – Visual Disabilities”**

**CHECKLIST OF MANDATORY SERVICES  
Z BENEFITS FOR VISUAL DISABILITIES, CATEGORY 1**

**APPROPRIATE ASSISTIVE DEVICE**

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>
MEMBER (answer only if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>

Place a (✓) on the appropriate boxes or NA if not applicable

MANDATORY SERVICES	OTHER SERVICES, AS NEEDED
Any one of the following: <input type="checkbox"/> Optical aid 1: Low power distance, category 1 visual impairment eyeglasses + low power optical device; or <input type="checkbox"/> Optical aid 2: High power distance, category 1 visual impairment progressive eyeglasses + high optical device	<input type="checkbox"/> Optical aid 3: colored filter, category 1 visual impairment <input type="checkbox"/> Ocular prosthesis

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Ophthalmologist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>	PhilHealth Accreditation No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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