Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
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www.philhealth.gov.ph

September 27, 2017

PHILHEALTH CIRCULAR

No. 2017 - 0029

TO : **ALL PHILHEALTH MEMBERS, ACCREDITED AND CONTRACTED HEALTH CARE PROVIDERS, PHILHEALTH REGIONAL OFFICES AND ALL OTHERS CONCERNED**

SUBJECT : **Z Benefits for Children with Developmental Disabilities**

I. RATIONALE

Developmental disability refers to any activity limitation and/or participation restriction secondary to a delay, regression or loss in the developmental milestone of a child. It can be neurological or non-neurological in origin. The affected milestones may be in one or more of the following developmental domains: (a) cognitive and adaptive, (b) speech and language (communication), (c) social and emotional (behavioral), and (d) motor (gross and fine). Data between 2012 to 2015 coming from the two leading pediatric rehabilitation units in the country show that the four leading consults for developmental disability are Autism Spectrum Disorders (ASD), Attention Deficit-Hyperactivity Disorder (ADHD), Cerebral Palsy and Global Developmental Delay (PGH and PCMC, 2015). A recent local modeling estimates that there are 1.6 M cases of developmental disability among children less than 19 years of age (PFP, 2016 [unpublished]).

Timing is crucial in potentially mitigating the impact of developmental disability. Developmental disability can be properly diagnosed such that specific and individual plan for therapy services can be crafted. With rehabilitation therapy, children can attain their highest level of development, optimize their capacities and increase their participation in education and the community. However, this specialized care is often inaccessible to children who belong to poor communities. The burden is magnified among households who have to manage the needs of children with developmental disabilities on top of the difficulty of meeting even their basic necessities.

The Philippine Health Insurance Corporation (PhilHealth) is mandated to ensure financial risk protection for all Filipinos, with provisions towards persons with disabilities. Thus, the PhilHealth Board, per Board Resolution No. 2125 s. 2016, approved an improved, rationalized and relevant benefit package for Children with Disabilities with the perspective of capturing the preventive to curative approach to patient care. Z benefits, in particular, are designed to prevent catastrophic spending among the marginalized that are enrolled in the program while ensuring the provision of quality healthcare services.

This Circular describes the benefit package for children with developmental disabilities, covering services from assessment to rehabilitation therapy, aimed at increasing the functional capacities of the children, and improving quality of life for both the children and the caregivers. A previously issued Circular on benefits for children with disability (PhilHealth Circular 2016-032) provides an overarching guidance in the implementation of this policy.

II. OBJECTIVES

This Circular aims to establish the guiding principles and define the policies and procedures in the delivery of quality of health service for children with developmental disabilities under the Z Benefits.

III. SCOPE

This Circular shall apply to all health care institutions (HCIs) contracted to provide the Z Benefits for children with developmental disabilities, and other relevant stakeholders involved in the implementation of the Z Benefits.

IV. DEFINITION OF TERMS

A. Assessment - process of examination, interaction, and observation of a child with a potential developmental disability, and the degree of limitations in function, activity and participation. Assessment is required to determine the provision of rehabilitation services.

B. Contracted Health Care Institution – a health facility that is PhilHealth-accredited and enters into a contract for specialized care with PhilHealth.

C. Developmental disability - refers to the manifestation of delays, regressions, or deviations in any of the following developmental domains: cognitive-adaptive, sensorimotor, communication, social, emotional, or behavioral.

D. Lost to follow-up - means the patient has not come back as advised for immediate next rehabilitation visit or within four weeks from last patient-attended clinic visit. Failure to visit the clinic for a treatment more than four weeks from advised scheduled rehabilitation visit renders the patient "lost to follow-up".

E. Member Empowerment (ME) Form – a document that ensures that the patient is informed of the Z benefits being availed of, the treatment plan and options, treatment schedule and follow-up visits, member roles and responsibilities, member education and counseling and other pertinent courses of actions, which is jointly signed by the patient or the parent or guardian, and the attending health care provider in-charge upon diagnosis.

F. Pre-authorization – an approval process from PhilHealth that gives the contracted HCI the information that the patient has passed the eligibility and minimum clinical selections criteria required for availment of the Z benefits.

G. Rehabilitation Therapy - refers to physical therapy, and/or occupational therapy, and/or speech therapy services aimed at achieving developmental and functional gains for the children with developmental disability, and improved quality of lives, based on specific standardized developmental and functional assessment tools, the WHO-ICF Checklist and WHOQOL, and the goals and needs of the clients and their families.

H. Z Benefits – benefit packages that focus on providing relevant financial risk protection against illnesses perceived as medically and economically catastrophic.

V. CONTRACTING HCIs AS PROVIDERS FOR THE Z BENEFITS FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES

With the mandate of PhilHealth to provide financial risk protection against catastrophic illness and to pay for quality health care services, the Corporation has the prerogative to negotiate and enter into contracts with HCIs and professionals. This is to define the terms of pricing and benefit package delivery that is of quality, in behalf of its members.

In this regard, PhilHealth shall initially engage with identified tertiary government HCIs for the provision of specialized multi- and interdisciplinary health care delivery for this Z benefit. Subsequent contracting of other capable government and private HCIs shall be done to expand benefit utilization and improve implementation efficiency. PhilHealth Circular 2015-014 provides guidance on the contracting process.

Coordination and collaboration with PhilHealth and among contracted HCIs for Z Benefits for children with developmental disability shall be required for quality improvement and operational purposes, such as, but not limited to, pertinent training, regular patient audits, patient referrals, patient tracking, and pooled procurement of supplies.

The HCI should have the following specialists to provide for the services under the Z Benefits for children with developmental disabilities:

a. Physiatrist (Rehabilitation Medicine Specialist)
b. Neurodevelopmental Pediatrician or Developmental and Behavioral Pediatrician
c. Physical Therapist
d. Occupational Therapist
e. Speech Therapist

In the event that the contracted HCI does not have any of the above specialists among its staff, the HCI may contract with private specialists to provide the needed services as long as they comply with the minimum qualifications set under Section VI. on the Minimum Standards of Care.

The contracted HCI shall also designate at least one Z Benefits Coordinator to perform the tasks specified in PhilHealth Circular 2015-35 Section V, providing guidance and navigation services to patients, coordination with PhilHealth, and encoding of patient information.

The prescribed HCI Standards of Providers for Children with Developmental Disabilities are provided for in Annex F.

Since PhilHealth does not allow out-of-pocket expense for the availment of the Z Benefits for children with developmental disabilities by all sponsored and indigent members of PhilHealth and their qualified dependents, a negotiated co-pay for all other member categories of PhilHealth shall be reflected in the individual contracts by the contracted HCIs.

VI. MINIMUM STANDARDS OF CARE

A. The Z Benefits for children with developmental disabilities shall reflect the following mandatory services:

Table 1. Mandatory services for Z Benefits for children with developmental disabilities

Mandatory Services
1. Assessment and plan by a medical specialist using any of the following standardized tests: Developmental Assessments • Griffiths Mental Developmental Scale • Battelle Developmental Inventory • Brigance Inventory of Early Development • Vineland Adaptive Behavior Scales Functional Tests • Functional Independence Measure (FIM & WEE-FIM) • Pediatric Quality of Life Inventory • WHO-Quality of Life Assessment

Mandatory Services (Cont.)
2. Assessment and plan by an allied health professional/s using <u>any</u> of the following standardized tests Occupational therapist • Beery-Buktenica Developmental Test of Visual-Motor Integration • Test of Visual Perceptual Skills Physical therapist • Gross Motor Function Measure • Peabody Developmental Motor Scale • Erhardt Developmental Prehension Assessment Speech therapist • Preschool Language Scale • Clinical Evaluation of Language Fundamentals • Picture Articulation Test 3. Rehabilitation therapy done 4. Discharge assessment and plan by medical specialist/s using <u>any</u> of the above standard tests for developmental assessment and functional tests 5. Discharge assessment and plan by allied health professional/s using <u>any</u> of the above standardized tests by an occupational therapist, physical therapist, and speech therapist

B. The following SERVICES ARE NOT INCLUDED:

1. Psychometric tests and other recommended developmental and functional tests that are not included in the mandatory services listed above

2. Laboratory tests and diagnostic procedures (e.g., brain scans, X-rays, blood tests)

3. Medications prescribed by the medical specialist/s

VII. GUIDELINES ON AVAILMENT OF THE Z BENEFITS FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES

A. Assessment of Patients

1. The provision of services for the Z Benefits for developmental disabilities shall cover only those cases that fulfill the following selections criteria:

   a. Chronological age must be zero to 17 years and 364 days old; and

   b. A child presents with functional problems secondary to delays, regressions, or deviations in any of the following developmental domains: cognitive-adaptive, sensorimotor, communication, social, emotional, or behavioral.

2. In order to qualify for the Z Benefits, children shall be assessed by appropriate health care providers at the contracted HCIs. If qualified, these children shall be enrolled in this program.

   a. The physiatric assessment is done by a physiatrist (Rehabilitation Medicine Specialist) certified by the Philippine Board of Rehabilitation Medicine;

   b. The developmental assessment is done by a neurodevelopmental pediatrician or a developmental and behavioral pediatrician certified by the Philippine Society for Developmental and Behavioral Pediatrics;

   c. The Occupational Therapy and Physical Therapy assessments and treatments are carried out by Professional Regulation Commission (PRC) licensed physiotherapists and occupational therapists;

   d. The speech and language assessments and treatments are carried out by graduates of the BS Speech Pathology/BS Speech Language Pathology program of an academic institution recognized and accredited by the Commission on Higher Education and a member of the Philippine Association of Speech Pathologists (PASP).

3. Contracted HCIs shall be responsible for developing an efficient process for assessing Z Benefits patients that is applicable in their local setting.

B. Application for Pre-authorization

1. Pre-authorization from PhilHealth based on the approved selections criteria shall be required to avail of the Z Benefits. All requests for pre-authorization shall be completely and properly accomplished by the contracted HCI by filling out the Pre-authorization Checklist and Request (Annex A) and submitted by a designated liaison of the contracted HCIs to the Local Health Insurance Office (LHIO) or to the office of the Head of the PhilHealth Benefits Administration Section (BAS) in the region for approval.

2. Contracted HCIs shall follow the prescribed process of seeking approval for the pre-authorization as described in PhilHealth Circular 2015-035 Section VII.

3. The approved Pre-Authorization Checklist and Request shall be valid for one year from the date of approval by PhilHealth. All contracted HCIs are responsible for tracking the validity of their approved pre-authorizations. The contracted HCI should inform PhilHealth in cases when the validity has lapsed. When needed, a new Pre-Authorization Checklist and Request can be submitted, provided that the child is still below 18 years old.

4. The member or the dependent should have at least one day remaining from the 45-day annual benefit limit prior to submission of the Pre-authorization Checklist and Request. Five days shall be deducted from the 45-day annual benefit limit upon approval of the application for pre-authorization.

5. While the Pre-authorization Checklist and Request is submitted manually, it shall be submitted together with the properly accomplished ME form (Annex B).

6. The ME Form shall be discussed by the attending health professional/s and accomplished together with the patient to be enrolled in the Z Benefits. The ME Form aims to support patients to be active participants in health care decision-making, making them educated and informed of the conditions, and all management options. Further, the ME Form aims to encourage the attending health care professionals in the contracted HCIs to dedicate adequate time to discuss with patients. The overall goal is to achieve better health outcomes and patient satisfaction.

C. Guidelines on Reimbursement

1. The rates for assessment, rehabilitation therapy and discharge assessment of children with developmental disabilities are specified in the following tables:

Table 2. Package rates for assessment of children with developmental disability

Z Code	Description of services	RATE (Php)
Z017.1	Developmental and functional assessment by a medical specialist only	3,626.00
Z017.2	Developmental and functional assessment by a medical specialist and one allied health professional or rehabilitation therapist	4,176.00
Z017.3	Developmental and functional assessment by a medical specialist and two allied health professionals or rehabilitation therapists	4,726.00
Z017.4	Developmental and functional assessment by medical specialist and three allied health professionals or rehabilitation therapists	5,276.00

Table 3. Rates for rehabilitation therapy sessions for children with developmental disability

Z Code	Description of services	RATE (PhP)
Z017.5	Rehabilitation therapy	5,000.00 per set*

*Eligible children with developmental disability can only avail of a maximum of nine sets of therapies. Each set of therapies has a maximum of 10 sessions.

Table 4. Rates for discharge assessment of children with developmental disability

Z Code	Description of services	RATE (PhP)
Z017.6	Developmental and functional discharge assessment by a medical specialist only	3,626.00
Z017.7	Developmental and functional discharge assessment by a medical specialist and one allied health professional or rehabilitation therapist	4,176.00
Z017.8	Developmental and functional discharge assessment by a medical specialist and two allied health professionals or rehabilitation therapists	4,726.00
Z017.9	Developmental and functional discharge assessment by a medical specialist and three allied health professionals or rehabilitation therapists	5,276.00

2. The above rates are inclusive of applicable government taxes. Discounts for persons with disabilities will be governed by specific terms espoused in Republic Act 10754 "An Act Expanding the Benefits and Privileges of Persons With Disabilities (Amending RA 7277)".

3. HCI shall establish their own guidelines on the administration of reimbursement funds including how professional fees will be dispensed. Monies in excess of the amount needed to deliver the services will be utilized to improve the facility used to care for children with developmental disabilities, and its equipment.

4. Rules on pooling of professional fees in government hospitals apply.

D. Claims Filing and Reimbursement

1. After receipt of the approved Pre-authorization Checklist and Request by the contracted HCI, the contracted HCI can only file a claim for reimbursement upon rendering all mandatory services specified in Section VI. Table 1, of this Circular, within the context of a multi- and interdisciplinary approach to patient care.

2. The claim application filed by the contracted HCI shall include the following documentation:

   a. Transmittal Form of claims for the Z Benefit Package to be used by the contracted HCI per batch of claims;

   b. Photocopy of the approved Pre-authorization Checklist and Request signed by the patient, parent or guardian, and the health care providers who are members of the multi- and interdisciplinary team managing the patient, as applicable, for the first tranche;

   c. PhilHealth Benefit Eligibility Form (PBEF) printout or its equivalent (e.g. PhilHealth Claim Form 1 or CF1) attached as proof of eligibility during the pre-authorization process;

   d. Photocopy of the properly accomplished ME Form for the first tranche;

      A copy of the properly accomplished ME Form shall be provided to the patient by the contracted HCI and the signed original copy should be attached in the patient's chart as a permanent record;

   e. Properly accomplished PhilHealth CF2 for all tranches;

   f. Checklist of Mandatory Services for the corresponding tranches;

g. Corresponding Checklist of Requirements for Reimbursement; and

h. Photocopy of the accomplished Z Satisfaction Questionnaire for services rendered for that particular tranche;

i. Photocopy of certificate from medical specialist and rehabilitation therapist for assessment and recommendations

Table 5. Summary of forms to be utilized in claims filing and reimbursement

First Payment (Assessment)	Rehabilitation Tranches (up to 9 claims)	Final Payment (Discharge Assessment)
a. Checklist of Requirements for Reimbursement b. Pre-authorization Checklist and Request c. ME Form d. PBEF or CF1 e. PhilHealth CF2 f. Checklist of Mandatory Services g. Z Satisfaction Questionnaire h. Certificate of assessment and recommendations	a. Checklist of Requirements for Reimbursement b. PhilHealth CF2 c. Checklist of Mandatory Services d. Z Satisfaction Questionnaire	a. Checklist of Requirements for Reimbursement b. PhilHealth CF2 c. Checklist of Mandatory Services d. Z Satisfaction Questionnaire e. Certificate of assessment and recommendations

3. Rules on late filing shall apply;

4. If the delay in the filing of claims is due to natural calamities or other fortuitous events, the contracted HCI shall be accorded an extension period of 60 calendar days as stipulated in Section 47 of the Implementing Rules and Regulations (IRR) of the National Health Insurance Act of 2013 (Republic Act 7875, as amended);

5. There shall be no direct filing of members;

6. The claims shall be evaluated according to the process stipulated in PhilHealth Circular 2015-035 Section IX.

7. The terms of payment for the Z Benefits for children with developmental disability shall be given in tranches with the corresponding amounts, filing schedule and allowed frequency of availment as follows:

Table 6. Description of services, amount per tranche and filing schedule per one cycle year and maximum availment for initial assessment

Description	Tranche	Amount (Php)	Filing Schedule	Maximum Availment*
Initial assessment by a medical specialist	1	3,626.00	Within 30 calendar days after assessment by the medical specialist	1 per cycle year for a maximum of three cycles
Initial assessment by a medical specialist and one rehabilitation therapist or allied health professional	1	3,626.00	Within 30 calendar days after assessment by the medical specialist	1 per cycle year for a maximum of three cycles
	2	550.00	Within 30 calendar days after submission of rehabilitation plan of care by the rehabilitation therapist or allied health professional	
Initial assessment by a medical specialist and two rehabilitation therapists or allied health professionals	1	3,626.00	Within 30 calendar days after assessment by the medical specialist	1 per cycle year for a maximum of three cycles
	2	1,100.00	Within 30 calendar days after submission of rehabilitation plan of care by the rehabilitation therapist or allied health professional	
Initial assessment by a medical specialist and three rehabilitation therapists or allied health professionals	1	3,626.00	Within 30 calendar days after assessment by the medical specialist	1 per cycle year for a maximum of three cycles
	2	1,650.00	Within 30 calendar days after submission of rehabilitation plan of care by the rehabilitation therapist or allied health professional	

*One cycle of care can be availed of for a second or third time during the duration of eligibility as specified in the recommendations of the Discharge Assessment.

Table 7. Description of services, amount per tranche and filing schedule per one cycle year of rehabilitation therapy

Description	Tranche	Amount (Php)	Filing Schedule	Maximum Availment*
Rehabilitation Therapy**	Nine tranches (as needed)	5,000.00 per tranche	Within 30 days after the last session for one set of therapies completed	Nine sets of therapies per one year cycle starting from the first day of initial team assessment

*One cycle of care can be availed of for nine times during the duration of eligibility as specified in the recommendations of the Discharge Assessment.

**Eligible children with developmental disability can only avail of a maximum of nine sets of therapies. Each set of therapies has a maximum of 10 sessions.

Table 8. Description of services, amount per tranche and filing schedule per one cycle year and maximum availment for discharge assessment

Description	Tranche	Amount (Php)	Filing Schedule	Maximum Availment*
Discharge assessment by a medical specialist	1	3,626.00	Within 30 calendar days after submission of discharge assessment and plan	1 per cycle year for a maximum of three cycles
Discharge assessment by one rehabilitation therapist or allied health professional and a medical specialist	1	550.00	Within 30 calendar days after submission of discharge assessment and plan	1 per cycle year for a maximum of three cycles
	2	3,626.00		
Discharge assessment by two rehabilitation therapists or allied health professionals and a medical specialist	1	1,100.00	Within 30 calendar days after submission of discharge assessment and plan	1 per cycle year for a maximum of three cycles
	2	3,626.00		
Discharge assessment by three rehabilitation therapists or allied health professionals and a medical specialist	1	1,650.00	Within 30 calendar days after submission of discharge assessment and plan	1 per cycle year for a maximum of three cycles
	2	3,626.00		

*One cycle of care can be availed of for a second or third time during the duration of eligibility as specified in the recommendations of the Discharge Assessment.

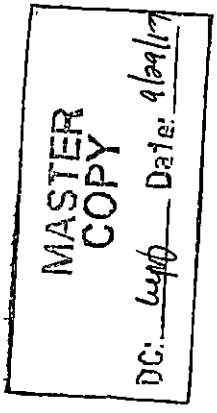
8. One cycle of package availment consists of initial assessment, the recommended nature and number of rehabilitation therapy sessions and a discharge assessment. One cycle should be completed within a year and it begins when a designated health team in the contracted HCI first sees a child. All services within a given cycle are considered expended and cannot be carried over to the next cycle.

9. A re-evaluation of the child by the attending physiatrist, developmental pediatrician and allied health professional is required before one cycle of care can be availed of for a second or third (final) time.

10. The written recommendation from the attending physiatrist or developmental pediatrician to continue rehabilitation therapy must be presented to PhilHealth when filing to avail for the package for a second or third cycle.

11. Children needing assistive technologies to improve mobility, function and communication will be advised to avail of the other Z packages for children with disabilities.

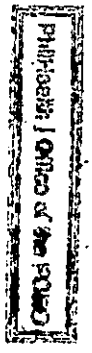
12. In the event that the patient expires or is declared "lost to follow-up" in the course of the rehabilitation therapy, the contracted HCI may still file claims for the payment of services rendered to PhilHealth. For rehabilitation therapy sessions, at least six recommended sessions should have been completed for the treatment to be eligible for claims reimbursement. The contracted HCI should submit a sworn declaration (e.g., notarized) for all "lost to follow-up" and expired patients.



13. In instances that these patients who were declared "lost to follow-up" by the contracted HCI were provided rehabilitation services in other HCIs, claims for the succeeding rehabilitation services for the applicable cycle of care for this particular Z Benefit package shall be denied.

VIII. MONITORING AND POLICY REVIEW

The implementation of the benefit package shall be monitored. Contracted HCIs shall comply with PhilHealth guidelines in establishing the HCI Portal that will facilitate efficient tracking and reporting of patient outcomes through the ZBITS.



Field monitoring of service provision by contracted HCI shall also be conducted. It shall follow the guidance, tools and consent forms provided in PhilHealth Circular 2015-035 Section XI. The performance indicators and measures to monitor compliance to the policies of this Circular shall be established in collaboration with relevant stakeholders and experts. This shall be incorporated in the Health Care Provider Performance Assessment System that is governed by another policy issuance.

Results of reports and monitoring visits shall serve as inputs to the regular policy review described in PhilHealth Circular 2015-035 Section XII.

IX. MARKETING, PROMOTION AND PATIENT EMPOWERMENT

The implementation of the benefit package shall promote the role of patients and their caregivers as active participants in health care decision-making. PhilHealth Circular 2015-035 Section XIII specifies guidance to this end.

X. REPEALING CLAUSE

Provisions of previous issuances inconsistent with this circular are hereby amended, modified or repealed accordingly. Those that are consistent shall remain valid and binding.

XI. EFFECTIVITY

This circular shall take effect after fifteen (15) days of complete publication in a newspaper of general circulation and shall therefore be deposited with the National Administrative Register, University of the Philippines Law Center.

These Special Benefit Packages shall be open to all capable HCIs following contracting guidelines issued by the Accreditation Department of PhilHealth.

X. ANNEXES (These annexes shall be uploaded in the PhilHealth website)

A. Pre-authorization Checklist and Request
B. ME Form
C. Checklist of Mandatory Services
D. Z Satisfaction Questionnaire
E. Checklists of Requirements for Reimbursement
F. HCI Standards as Providers for Children with Developmental Disabilities
G. General process flow for the provision of care for a child with neurodevelopmental disorder or developmental disability
H. Transmittal Form for the Z Benefits
I. Sample Claim Form 2
J. Certificate from medical specialist/s and rehabilitation therapist/s for assessment and recommendations

for:
DR. CELESTINA MA. JUDE P. DE LA SERNA
Interim/OIC President and CEO
Date Signed: 9-22-2017

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Case No. _____

Annex "A – Developmental Disability"

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

Fulfilled selections criteria ☐ **Yes** If yes, proceed to pre-authorization application
☐ **No** If no, specify reason/s and encode
_____

PRE-AUTHORIZATION CHECKLIST
Z BENEFITS FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES

Place a (✓) if yes

	General Qualifications	Yes
1.	The child's chronological age is 0 to 17 years and 364 days old	
2.	The child presents with functional problems secondary to delays, regressions, or deviations in any one of the following developmental domains: ☐ Cognitive-adaptive ☐ Motor ☐ Social ☐ Emotional ☐ Behavioral	
3.	The child was assessed by any or both of the following medical specialists: ☐ Physiatrist/ Rehabilitation Medicine Specialist ☐ Behavioral Developmental Pediatrician or Neurodevelopmental Pediatrician	

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PhilHealth Office of the PCSO

Place a (✓) on the appropriate box/es for the appropriate assessment/s or evaluation/s that will be given to the child:
☐ Speech Therapy Assessment ☐ Occupational Therapy Assessment ☐ Physical Therapy Assessment

Conforme by Patient/Parent/Guardian:

Printed name and signature

Attested by Attending Medical Specialist

Printed name and signature

PhilHealth Accreditation No. ☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐

Note:
Once approved, the contracted hospital shall print the approved pre-authorization form and have this signed by the patient, parent or guardian and health care providers, as applicable. This form shall be submitted to the Local Health Insurance Office (LHIO) or the PhilHealth Regional Office (PRO) when filing the first tranche.

There is no need to attach laboratory results. However, these should be included in the patient's chart and may be checked during the field monitoring of the Z Benefits. Please do not leave any item blank.

MASTER COPY
DC: Date: 9/29/17

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PRE-AUTHORIZATION REQUEST
Z BENEFITS FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z benefit package for _____ in _____
(NAME OF PATIENT) (NAME OF HOSPITAL)
under the terms and conditions as agreed for availment of the Z Benefit Package.

The patient belongs to the following category (please tick appropriate box):

☐ No Balance Billing (NBB)
☐ Co-pay

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Medical Specialist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No.	PhilHealth Accreditation No.

Conforme by:

(Printed name and signature)
Patient/Parent/Guardian

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

(Printed name and signature)
Authorized Personnel, Benefits Administration Section (BAS)

MASTER COPY DC: 4440 Date: 9/29/17

INITIAL APPLICATION			COMPLIANCE TO REQUIREMENTS		
Activity	**Initial**	**Date**	☐ APPROVED ☐ DISAPPROVED (State reason/s)		
Received by LHIO/BAS:					
Endorsed to BAS (if received by LHIO):					
☐ Approved ☐ Disapproved			**Activity**	**Initial**	**Date**
Released to HCI:			Received by BAS:		
This pre-authorization is valid for one (1) fiscal year from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to HCI:		

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Numero ng kaso: _____
Case No.

Annex "B-ME Form"

MEMBER EMPOWERMENT FORM

Magpaalám, tumulong, at magbigay kapangyarihan
Inform, Support & Empower

Mga Panuto:
Instructions:

1. Ipaliliwanag at tutulungan ng kinatawan ng ospital ang pasyente sa pagsasagot ng ME form.
   The health care provider shall explain and assist the patient in filling-up the ME form.
2. Isulat nang maayos at malinaw ang mga impormasyon na kinakailangan.
   Legibly print all information provided.
3. Para sa mga katanungang nangangailangan ng sagot na "oo" o "hindi", lagyan ng marka (√) ang angkop na kahon.
   For items requiring a "yes" or "no" response, tick appropriately with a check mark (√).
4. Gumamit ng karagdagang papel kung kinakailangan . Lagyan ito ng kaukulang marka at ilakip ito sa ME form.
   Use additional blank sheets if necessary, label properly and attach securely to this ME form.
5. Ang kinontratang ospital na magkakaloob ng dalubhasang pangangalaga sa pagpaparami ng kopya ng ME Form.
   The ME form shall be reproduced by the contracted health care institution (HCI) providing specialized care.
6. Tatlong kopya ng ME form ang kailangang ibigay ng kinontratang ospital: Ang mga kopyang nabanggit ay ilalaan para sa pasyente, ospital at PhilHealth.
   Triplicate copies of the ME form shall be made available by the contracted HCI—one for the patient; one as file copy of the contracted HCI providing the specialized care and one for PhilHealth.
7. **Para sa mga pasyenteng gagamit ng Z Mobility Orthoses Rehabilitation Prosthesis Help (ZMORPH), ukol sa pagpapalit ng artipisyal na ibabang bahagi ng hita at binti, o Z Benefits para sa mga batang may kapansanan, isulat ang N/A sa tala B2, B3 at D6. Para naman sa Peritoneal Dialysis (PD) First Z Benefits, isulat ang N/A para sa tala B2 at B3.**
   For patients availing of the Z Mobility Orthoses Rehabilitation Prosthesis Help (ZMORPH) for fitting of the external lowerlimb prosthesis, or Z Benefits for children with disabilitiez, write N/A for items B2, B3 and D6 and for PD First Z Benefits, write N/A for items B2 and B3.

PANGALAN NG OSPITAL *HEALTH CARE INSTITUTION (HCI)*
ADRES NG OSPITAL *ADDRESS OF HCI*

A. Impormasyon ng Miyembro/ Pasyente
A. Member/Patient Information

PASYENTE (Apelyido, Pangalan, Panggitnang Apelyido, Karagdagan sa Pangalan)
PATIENT (Last name, First name, Middle name, Suffix)

NUMERO NG PHILHEALTH ID NG PASYENTE ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐☐
PHILHEALTH ID NUMBER OF PATIENT

MIYEMBRO (kung ang pasyente ay kalipikadong makikinabang) (Apelyido, Pangalan, Panggitnang Apelyido, Karagdagan sa Pangalan)
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)

NUMERO NG PHILHEALTH ID NG MIYEMBRO ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐☐
PHILHEALTH ID NUMBER OF MEMBER

PERMANENTENG TIRAHAN
PERMANENT ADDRESS

Petsa ng Kapanganakan (Buwan/Araw/Taon) *Birthday (mm/dd/yyyy)*	Edad *Age*	Kasarian *Sex*
Numero ng Telepono *Telephone Number*	Numero ng Cellphone *Mobile Number*	Email Address *Email Address*

Kategorya bilang Miyembro:
Membership Category:

☐ Empleado sa
Employed Sector
- ☐ Gobyerno *Government*
- ☐ Pribado *Private*
  - ☐ May-ari ng Kompanya / *Enterprise Owner*
  - ☐ Kasambahay / *Household Help*
  - ☐ Tagamaneho ng Pamilya/ *Family driver*

☐ *Self Employed*
- ☐ Filipinong Manggagawa sa ibang bansa
  Migrant Worker/OFW
- ☐ Informal Sector / May sariling pinagkakakitaan (Halimbawa: Negosyante, Nagmamaneho ng traysikel at taxi, mga propesyonal, artista, at iba pa)
  Informal Sector / Self-Earning Individuals (Ex. Business owner/ tricycle/ taxi drivers/ street vendors, entrepreneurs, professionals, artists, etc.)
- ☐ Filipino na may dalawang pagkamamamayan/ *Naturalized Filipino Citizen*
  Filipino with Dual Citizenship/Naturalized Filipino Citizen
- ☐ *Organized Group* ☐ *IGroup Gold*

☐ Marálitâ
Indigent (4Ps/ CCT, MCCT)

☐ Inisponsuran
Sponsored
- ☐ Bayan | *LGU*
- ☐ Nakatatandang mamamayan | *Senior Citizen* (RA 10645)
- ☐ Iba pa | *Others*

☐ Habambuhay na kaanib/ Lifetime Member

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B. Impormasyong Klinikal *B. Clinical Information*	
1. Paglalarawan ng kondisyon ng pasyente *Description of condition*	
2. Napagkasunduang angkop na plano ng gamutan sa ospital *Applicable Treatment Plan agreed upon with healthcare provider*	
3. Napagkasunduang angkop na alternatibong plano ng gamutan sa ospital *Applicable alternative Treatment Plan agreed upon with health care provider*	
C. Talatakdaan ng Gamutan at Kasunod na Konsultasyon *C. Treatment Schedule and Follow-up Visit/s*	
1. Petsa ng unang pagkakaospital o konsultasyon [a] (buwan/araw/taon) *Date of initial admission to HCI or consult[a] (mm/dd/yyyy)* [a] Para sa ZMORPH/ mga batang may kapansanan, ito ay tumutukoy sa pagkonsulta para sa rehabilitasyon ng external lower limb pre-prosthesis/ device. Para naman sa PD First, ito ay ang petsa ng konsultasyon o pagdalaw sa PD provider bago magsimula ang unang PD exchange. *[a] For ZMORPH/children with disabilities (CWDs), this refers to the consult prior to the provision of the device and/or rehabilitation. For PD First, this refers to the date of medical consultation or visit to the PD Provider prior to the start of the first PD exchange.*	
2. Pansamantalang Petsa ng susunod na pagpapa-ospital o konsultasyon [b] (buwan/araw/taon) *Tentative Date/s of succeeding admission to HCI or consult[b] (mm/dd/yyyy)* [b] Para sa ZMORPH/ mga batang may kapansanan, ito ay petsa ng paglalapat at pagsasayos ng device. Para naman sa PD First, ito ay ang kasunod na pagbisita sa PD Provider. *[b] For ZMORPH/CWDS, this refers to the measurement, fitting and adjustments of the device. For the PD First, this refers to the next visit to the PD Provider.*	
3. Pansamantalang Petsa ng kasunod na pagbisita [c] (buwan/araw/taon) *Tentative Date/s of follow-up visit/s (mm/dd/yyyy)* [c] Para sa ZMORPH/ mga batang may kapansanan, ito ay tumutukoy sa rehabilitasyon ng external lower limb post-prosthesis. *[c] For ZMORPH/CWD, this refers to the external lower limb post-prosthesis rehabilitation consult.*	

D. Edukasyon ng Miyembro *D. Member Education* Lagyan ng tsek (√) ang angkop na sagot o NA kung hindi nauukol *Put a check mark (√) opposite appropriate answer or NA if not applicable.*	OO YES	HINDI NO
1. Ipinaliwanag ng kinatawan ng ospital ang uri ng aking karamdaman. *My health care provider explained the nature of my condition/ disability.*		
2. Ipinaliwanag ng kinatawan ng ospital ang mga pagpipiliang paraan ng gamutan/interbensyon [d] *My health care provider explained the treatment options/ intervention[d].* [d] Para sa ZMORPH, ito ay ukol sa pangangailangan ng pagbibigay at rehabilitasyon para sa pre at post-device. *[d] For ZMORPH, this refers to the need for pre- and post-device provision and rehabilitation.*		
3. Ipinaliwanag ng kinatawan ng ospital ang mga posibleng mga epekto/ masamang epekto ng gamutan/ interbensyon. *The possible side effects/ adverse effects of treatment/ intervention were explained to me.*		
4. Ipinaliwanag ng kinatawan ng ospital ang kailangang serbisyo para sa gamutan ng aking karamdaman/ interbensyon. *My health care provider explained the mandatory services and other services required for the treatment of my condition/ intervention.*		
5. Lubos akong nasiyahan sa paliwanag na ibinigay ng ospital. *I am satisfied with the explanation given to me by my health care provider*		
6. Naibigay sa akin nang buo ang impormasyon na ako ay mahusay na aalagaan ng mga dalubhasang doktor sa aking piniling kinontratang ospital ng PhilHealth at kung gustuhin ko mang lumipat ng ospital ay hindi ito maka-aapekto sa aking pagpapagamot. *I have been fully informed that I will be cared for by all the pertinent medical and allied specialties, as needed, present in the PhilHealth contracted HCI of my choice and that preferring another contracted HCI for the said specialized care will not affect my treatment in any way.*		
7. Ipinaliwanag ng kinatawan ng ospital ang kahalagahan ng pagsunod sa panukalang gamutan/interbensyon. Kasama rito ang pagkompleto ng gamutan/interbensyon sa unang ospital kung saan nasimulan ang aking gamutan/interbensyon. *My health care provider explained the importance of adhering to my treatment plan/ intervention. This includes completing the course of treatment/ intervention in the contracted HCI where my treatment/ intervention was initiated.* Paalala: Ang hindi pagsunod ng pasyente sa napagkasunduang gamutan/interbensyon sa ospital ay maaaring magresulta sa hindi pagbabayad ng mga kasunod na claims at hindi dapat itong ipasa bilang case rates. *Note: Non-adherence of the patient to the agreed treatment plan/ intervention in the HCI may result to denial of filed claims for the succeeding tranches and which should not be filed as case rates.*		

Lagyan ng tsek (√) ang angkop na sagot o N.A kung hindi nauukol *Put a check mark(√) opposite appropriate answer or N.A if not applicable.*	OO YES	HINDI NO
8. Binigyan ako ng ospital ng talaan ng mga susunod kong pagbisita. *My health care provider gave me the schedule/s of my follow-up visit/s.*		
9. Ipinaalam sa akin ng ospital ang impormasyon tungkol sa maaari kong hingan ng tulong pinansiyal o ibang pang suporta, kung kinakailangan. a. Sangay ng pamahalaan (Hal.: PCSO, PMS, LGU, etc.) b. Civil society o non-government organization c. Patient Support Group d. Corporate Foundation e. Iba pa (Hal. Media, Religious Group, Politician, etc.) *My health care provider gave me information where to go for financial and other means of support, when needed.* *a. Government agency (ex. PCSO, PMS, LGU, etc.)* *b. Civil society or non-government organization* *c. Patient Support Group* *d. Corporate Foundation* *e. Others (ex. Media, Religious Group, Politician, etc.)*		
10. Nabigyan ako ng kopya ng listahan ng mga kinontratang ospital para sa karampatang paggagamot ng aking kondisyon o karamdaman. *I have been furnished by my health care provider with a list of other contracted HCIs for the specialized care of my condition.*		
11. Nabigyan ako ng sapat na kaalaman hinggil sa benepisyo at tuntunin ng PhilHealth sa pagpapa-miyembro at paggamit ng benepisyong naaayon sa Z benefits: I have been fully informed by my health care provider of the PhilHealth membership policies and benefit availment on the Z Benefits: a. Kaalipikado ako sa mga itinakdang batayan para sa aking kondisyon/kapansanan. *I fulfill all selections criteria for my condition/disability.*		
b. Ipinaliwanag sa akin ang polisiya hinggil sa "No Balance Billing" (NBB). *The "no balance billing" (NBB) policy was explained to me.* Paalala: Ang polisiya ng NBB ay maaaring makamit ng mga sumusunod na miyembro at kanilang kalipikadong makikinabang kapag na-admit sa ward ng ospital: inisponsuran, maralita, kasambahay, senior citizens at miyembro ng iGroup na may kaukulang Group Policy Contract (GPC) *Note: NBB policy is applicable to the following members when admitted in ward accommodation: sponsored, indigent, household help, senior citizens and iGroup members with valid Group Policy Contract (GPC) and their qualified dependents.*		
Para sa inisponsuran, maralita, kasambahay, senior citizens at miyembro ng iGroup na may kaukulang Group Policy Contract (GPC) at kanilang kwalipikadong makikinabang, sagutan ang c, d at e. ***For sponsored, indigent, household help, senior citizens and iGroup members with valid GPC and their qualified dependents, answer c, d and e.*** c. Nauunawaan ko na sakaling hindi ako gumamit ng NBB ay maaari akong magkaroon ng kaukulang gastos na aking babayaran. *I understand that I may choose not to avail of the NBB and may be charged out of pocket expenses*		

d. Sakaling ako ay pumili ng pribadong doktor o kaya ay nagpalipat sa mas magandang kuwarto ayon sa aking kagustuhan, nauunawaan ko na hindi na ako maaaring humiling sa pagamutan para makagamit ng pribilehiyong ibinibigay sa mga pasyente na NBB (kapag NBB, wala nang babayaran pa pagkalabas ng pagamutan)
In case I choose a private doctor or I choose to upgrade my room accommodation, I understand that I can no longer demand the hospital to grant me the privilege given to NBB patients (that is, no out of pocket payment upon discharge from the hospital)

e. Ninanais ko na lumabas sa polisiyang NBB ang PhilHealth at dahil dito, babayaran ko ang anumang halaga na hindi sakop ng benepisyo sa PhilHealth
I opt out of the NBB policy of PhilHealth and I am willing to pay on top of my PhilHealth benefits

f. Pumapayag akong magbayad ng hanggang sa halagang PHP _____* para sa:
I agree to pay as much as PHP _____ for the following:*

☐ Pagpili ko ng pribadong doktor, o
I choose a private doctor, or

☐ Paglipat ko sa mas magandang kuwarto, o
I choose to upgrade my room accommodation, or

☐ anumang karagdagang serbisyo, tukuyin _____
additional services, specify _____

* Ito ay tinantiyang halaga lamang na gagabay sa pasyente kung magkano ang kanyang babayaran at hindi dapat gawing batayan para sa pagtutuos ng kuwenta ng nagugol na gastusin sa pagkakaospital na babayaran ng PhilHealth.
This is an estimated amount that guides the patient on how much the out of pocket may be and should not be a basis for auditing claims reimbursement.

Ang mga sumusunod na katanungan ay para sa mga miyembro ng formal at informal economy at kanilang mga kalipikadong makikinabang
The following are applicable to formal and informal economy and their qualified dependents

g. Naiintindihan ko na maaari akong magkaroon ng babayaran para sa halagang hindi sakop ng benepisyo sa PhilHealth.
I understand that there may be an additional payment on top of my PhilHealth benefits.

h. Pumapayag akong magbayad ng hanggang sa halagang PHP _____* para sa aking gamutan na hindi sakop ng benepisyo ng PhilHealth.
I agree to pay as much as PHP _____ as additional payment on top of my PhilHealth benefits.*

* Ito ay tinantiyang halaga lamang na gagabay sa pasyente kung magkano ang kanyang babayaran at hindi dapat gawing batayan para sa pagtutuos ng kuwenta ng nagugol na gastusin sa pagkakaospital na babayaran ng PhilHealth.
This is an estimated amount that guides the patient on how much the out of pocket may be and should not be a basis for auditing claims reimbursement.

12. Limang (5) araw lamang ang babawasan mula sa 45 araw na palugit sa benepisyo sa isang taon para sa buong gamutan sa ilalim ng Z benefits.
Only five (5) days shall be deducted from the 45 confinement days benefit limit per year for the duration of my treatment/intervention under the Z Benefits.

E. Tungkulin at Responsabilidad ng Miyembro *E. Member Roles and Responsibilities*		
Lagyan ng (√) ang angkop na sagot o NA kung hindi nauukol *Put a (√) opposite appropriate answer or NA if not applicable.*	OO *YES*	HINDI *NO*
1. Nauunawaan ko ang aking tungkulin upang masunod ang nararapat at nakatakda kong gamutan. *I understand that I am responsible for adhering to my treatment schedule.*		
2. Nauunawaan ko na ang pagsunod sa itinakdang gamutan ay mahalaga tungo sa aking paggaling at pangunahing kailangan upang magamit ko nang buo ang Z benefits. *I understand that adherence to my treatment schedule is important in terms of clinical outcomes and a pre-requisite to the full entitlement of the Z benefits.*		
3. Nauunawaan ko na tungkulin kong sumunod sa mga polisiya at patakaran ng PhilHealth at ospital upang magamit ang buong Z benefit package. Kung sakali na hindi ako makasunod sa mga polisiya at patakaran ng PhilHealth at ospital, tinatalikuran ko ang aking pribilehiyong makagamit ng Z benefits. *I understand that it is my responsibility to follow and comply with all the policies and procedures of PhilHealth and the health care provider in order to avail of the full Z benefit package. In the event that I fail to comply with policies and procedures of PhilHealth and the health care provider, I waive the privilege of availing the Z benefits.*		

F. Pangalan, Lagda, Thumb Print at Petsa *F. Printed Name, Signature, Thumb Print and Date*		
Pangalan at Lagda ng pasyente:* *Printed name and signature of patient** *Para sa mga menor de edad, ang magulang o tagapag-alaga ang pipirma o maglalagay ng thumb print sa ngalan ng pasyente. ** For minors, the parent or guardian affixes their signature or thumb print here on behalf of the patient.*	Thumb Print (kung hindi makakasulat ang pasyente) *(if patient is unable to write)*	Petsa (buwan/ araw/ taon)
Pangalan at lagda ng nangangalagang Doktor: *Printed name and signature of Attending Doctor*		Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*
Mga Saksi: *Witnesses:*		
Pangalan at lagda ng kinatawan ng ospital: *Printed name and signature of HCI staff member*		Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*
Pangalan at lagda ng asawa/ magulang / pinakamalapit na kamag-anak/awtorisadong kinatawan *Printed name and signature of spouse/ parent/ next of kin / authorized guardian or representative* ☐ walang kasama/ *no companion*		Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*

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G. Detalye ng Tagapag-ugnay ng PhilHealth para sa Z benefits *G. PhilHealth Z Coordinator Contact Details*		
Pangalan ng Tagapag-ugnay ng PhilHealth para sa Z benefits na nakatalaga sa ospital *Name of PhilHealth Z Coordinator assigned at the HCI*		
Numero ng Telepono *Telephone number*	Numero ng CellPhone *Mobile number*	Email Address

H. Numerong maaaring tawagan sa PhilHealth *H. PhilHealth Contact Details*
Opisinang Panrehiyon ng PhilHealth _____ *PhilHealth Regional Office No.* Numero ng telepono _____ *Hotline Nos.*

I. Pahintulot sa pagsusuri sa talaan ng pasyente *I. Consent to access patient record*	J. Pahintulot na mailagay ang *medical data* sa Z benefit information and tracking system (ZBITS) *J. Consent to enter medical data in the Z benefit information & tracking system (ZBITS)*
Ako ay pumapayag na suriin ng PhilHealth ang aking talaang medikal upang mapatunayan ang katotohanan ng Z-claim *I consent to the examination by PhilHealth of my medical records for the sole purpose of verifying the veracity of the Z-claim*	Ako ay pumapayag na mailagay ang aking impormasyong medikal sa ZBITS na kailangan sa Z benefits. Pinahihintulutan ko din ang PhilHealth na maipaalam ang aking personal na impormasyong pangkalusugan sa mga kinontratang ospital. *I consent to have my medical data entered electronically in the ZBITS as a requirement for the Z Benefits. I authorize PhilHealth to disclose my personal health information to its contracted partners*

Ako ay nagpapatunay na walang pananagutan ang PhilHealth o sinumang opisyal, empleyado o kinatawan mula sa pahintulot na nakasaad sa itaas sapagkat kusang-loob ko itong ibinigay upang makagamit ng Z benefits ng PhilHealth.
I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with the Z claim for reimbursement before PhilHealth.

Buong pangalan at lagda ng pasyente* *Printed name and signature of patient**	Thumb print (Kung hindi na makasusulat) *(if patient is unable to write)*	Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*
* Para sa mga menor de edad, ang magulang o tagapag-alaga ang pipirma o maglalagay ng thumb print sa ngalan ng pasyente. * *For minors, the parent or guardian affixes their signature or thumb print here on behalf of the patient.*		
Buong pangalan at lagda ng kumakatawan sa pasyente *Printed name and signature of patient's representative* ☐ walang kasama/ *no companion*		Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*

Relasyon ng kumakatawan sa pasyente (Lagyan ng tsek ang angkop na kahon)
Relationship of representative to patient (tick appropriate box)

☐ asawa *spouse*	☐ magulang *parent*	☐ anak *child*	☐ kapatid *next of kin*	☐tagapag-alaga *guardian*	☐ walang kasama *no companion*

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PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 Trunkline (02) 441-7444
www.philhealth.gov.ph

Case No. _____

Annex "C1 – Developmental Disability"

CHECKLIST OF MANDATORY SERVICES
Z BENEFITS FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES

DEVELOPMENTAL AND FUNCTIONAL ASSESSMENT

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐ - ☐
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐ - ☐

Place a (✓) on the appropriate boxes

MANDATORY SERVICES	
MEDICAL ASSESSMENT	
Type of Assessment ☐ Initial ☐ Discharge	Assessment done by: ☐ Physiatrist/ Rehabilitation Medicine Specialist ☐ Neurodevelopmental Pediatrician or Developmental and Behavioral Pediatrician
Assessed using any of the following standardized tests:	
Developmental Assessments ☐ Griffiths Mental Developmental Scale ☐ Battelle Developmental Inventory ☐ Brigance Inventory of Early Development ☐ Vineland Adaptive Behavior Scale	Functional Assessments ☐ Functional Independence Measure (FIM & WEE-FIM) ☐ Pediatric Quality of Life Inventory ☐ WHO-Quality of Life Assessment

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Medical 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)

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Case No. _____

Annex "C2 – Developmental Disability"

CHECKLIST OF MANDATORY SERVICES
Z BENEFITS FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES
DEVELOPMENTAL AND FUNCTIONAL ASSESSMENT

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

Place a (✓) on the appropriate boxes

MANDATORY SERVICES

REHABILITATION THERAPY/ALLIED HEALTH PROFESSIONAL ASSESSMENT

Type of Assessment	Assessment done by:
☐ Initial ☐ Discharge	☐ Occupational Therapist ☐ Physical Therapist ☐ Speech Therapist / Speech Language Pathologist

Assessed using any of the following standardized tests:

Occupational Therapist	Physical Therapist	Speech Therapist
☐ Beery-Buktenica Developmental Test of Visual-Motor Integration ☐ Test of Visual Perceptual Skills	☐ Gross Motor Function Measure ☐ Peabody Developmental Motor Scale ☐ Erhardt Developmental Prehension Assessment	☐ Preschool Language Scale ☐ Clinical Evaluation of Language Fundamentals ☐ Picture Articulation Test

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Certified correct by:	Certified correct by:
(Printed name and signature) Attending Rehabilitation Therapy 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)

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Case No. _____

Annex "C – Developmental Disability"

CHECKLIST OF MANDATORY SERVICES
Z BENEFITS FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES
REHABILITATION THERAPY

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

MANDATORY SERVICES										
REHABILITATION THERAPY										
Therapy received	**Dates of Therapy Sessions***									
☐ Occupational Therapy										
☐ Physical Therapy										
☐ Speech Therapy										

* maximum of 10 sessions per tranche from appropriate rehabilitation therapist/s based on assessment

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Certified correct by:	Certified correct by:
(Printed name and signature) Attending Rehabilitation Therapy 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)

PhilHealth

Benefits

Annex "D"

Share your opinion with us!

We would like to know how you feel about the services that pertain to the Z Benefit Package in order that we can improve and meet your needs. This survey will only take a few minutes. Please read the items carefully. If you need to clarify items or ask questions, you may approach your friendly health care provider or you may contact PhilHealth call center at 441-7442. Your responses will be kept confidential and anonymous.

For items 1 to 3, please tick on the appropriate box.

1. Z benefit package availed is for:
   - ☐ Acute lymphoblastic leukemia
   - ☐ Breast cancer
   - ☐ Prostate cancer
   - ☐ Kidney transplantation
   - ☐ Cervical cancer
   - ☐ Coronary artery bypass surgery
   - ☐ Surgery for Tetralogy of Fallot
   - ☐ Surgery for ventricular septal defect
   - ☐ ZMORPH/Expanded ZMORPH
   - ☐ Orthopedic implants
   - ☐ PD First Z benefits
   - ☐ Colorectal cancer
   - ☐ Prevention of preterm delivery
   - ☐ Preterm and small baby
   - ☐ Children with developmental disability
   - ☐ Children with mobility impairment
   - ☐ Children with visual impairment
   - ☐ Children with hearing impairment

2. Respondent's age is:
   - ☐ 19 years old & below
   - ☐ between 20 to 35
   - ☐ between 36 to 45
   - ☐ between 46 to 55
   - ☐ between 56 to 65
   - ☐ above 65 years old

3. Sex of respondent
   - ☐ male
   - ☐ female

For items 4 to 8, please select the one best response by ticking the appropriate box.

4. How would you rate the services received from the health care institution (HCI) in terms of availability of medicines or supplies needed for the treatment of your condition?
   - ☐ adequate
   - ☐ inadequate
   - ☐ don't know

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5. How would you rate the patient's or family's involvement in the care in terms of patient empowerment? (You may refer to your Member Empowerment Form)
   - ☐ excellent
   - ☐ satisfactory
   - ☐ unsatisfactory
   - ☐ don't know

6. In general, how would you rate the health care professionals that provided the services for the Z benefit package in terms of doctor-patient relationship?
   - ☐ excellent
   - ☐ satisfactory
   - ☐ unsatisfactory
   - ☐ don't know

7. In your opinion, by how much has your HCI expenses been lessened by availing of the Z benefit package?
   - ☐ less than half
   - ☐ by half
   - ☐ more than half
   - ☐ don't know

8. Overall patient satisfaction (PS mark) is:
   - ☐ excellent
   - ☐ satisfactory
   - ☐ unsatisfactory
   - ☐ don't know

9. If you have other comments, please share them below:

   _____
   _____
   _____

Thank you. Your feedback is important to us!

_____
Signature of Patient/ Parent/ Guardian

Date accomplished: _____

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Case No. _____

Annex "E1 – Developmental Disability"

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 1)
Z Benefits for Children with Developmental Disabilities
Developmental and Functional Assessment

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Tranche 1) (Annex E1-Developmental Disability)	
2. Photocopy of approved Pre–Authorization Checklist & Request (Annex A- Developmental Disability)	
3. Photocopy of accomplished ME FORM (Annex B)	
4. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
5. Checklist of Mandatory Service for Developmental Disabilities (Annex C1 – Developmental Disability)	
6. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
7. Photocopy of Certificate of Assessment and Recommendations from Medical Specialist (Annex J)	
DATE COMPLETED :	
DATE FILED :	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Medical 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)

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Case No. _____

Annex "E2 – Developmental Disability"

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2)
Z Benefits for Children with Developmental Disabilities
Developmental and Functional Assessment

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Tranche 2) (Annex E2-Developmental Disability)	
2. Completed PhilHealth Claim Form 2	
3. Checklist of Mandatory Service for Developmental Disabilities (Tranche 2) (Annex C 2.1 – Developmental Disability)	
4. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
5. Photocopy of Certificate of Assessment and Recommendations from Rehabilitation Therapist/s	
DATE COMPLETED :	
DATE FILED :	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Medical 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)

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Case No. _____

Annex "E – Developmental Disability"

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT
Z Benefits for Children with Developmental Disabilities
Rehabilitation Therapy

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E-Developmental Disability)	
2. Completed PhilHealth Claim Form 2	
3. Checklist of Mandatory Service for Developmental Disabilities (Annex C – Developmental Disability)	
4. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
DATE COMPLETED :	
DATE FILED :	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Rehabilitation Therapy 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)

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Self- assessment/ Survey Tool for Z Benefit Package Providers for Children with Developmental Disabilities

Name of HCI: _____

Date of Survey: _____ Time started: _____ Time ended: _____

Directions for the HCI:

1. Put a check (√) in the box if the service is available or an X if the same is not available in the HCI.
2. For outsourced services, put an X in the "no" box and state in the remarks that the service is outsourced and write the name of the outsourced service provider.

	REQUIREMENTS	HCI		PHIC		REMARKS
		Yes	No	Yes	No	
1	**Health Care Institution (HCI) License and Accreditation**					
1.1	The HCI has an updated DOH License					
1.2	The HCI has an updated PhilHealth Accreditation					
2	**Minimum Service Capability**					
2.1	Mandatory Services as stated in PhilHealth Circular _____ OR with formal referral process to a licensed referral facility (Memorandum of Agreement):					
2.2	Certification to conduct at least one of the following standardized tools:					
	Medical developmental assessment: (at least one certification) - Griffiths Mental Development Scale - Batelle Developmental Inventory V2 - Vineland Adaptive Behavior Scales					
	Allied health assessment: - For occupational therapists (at least one certification) • Beery-Buktenica Developmental Test of Visual-Motor Integration • Test of Visual Perceptual Skills • Brigance Inventory of Early Development					

	REQUIREMENTS	HCI		PHIC		REMARKS
		Yes	No	Yes	No	
	• Erhardt Developmental Prehension Assessment • Sensory Profile or Sensory Processing Measure • Peabody Developmental Motor Scale - For physiotherapists • Gross Motor Function Measure (tool only) - For speech therapists (at least one certification) • Preschool Language Scale • Clinical Evaluation of Language Fundamentals • Picture Articulation Test					
	Functional and outcome assessment services using the following standardized tests (tool only for both are required) - Functional Independence Measure (FIM or WEE-FIM) - Pediatric Quality of Life Inventory or WHO-Quality of Life Assessment					
3	**Technical Standards**					
3.1	General Infrastructure					
	Consultation/clinical assessment /individual therapy room					
	Accessibility features - Compliant to BP 344 "An Act To Enhance The Mobility Of Disabled Persons By Requiring Certain Buildings, Institutions, Establishments And Public Utilities To Install Facilities And Other Devices" - Ramps - Restroom for PWD					
3.2	Equipment/Supplies					
	Stethoscope					
	Sphygmomanometer					
	Digital thermometer					
	Weighing scale					
	Goniometer					
	Tape measure					
	Full length mirror and face only mirror					
	Picture cards					
	Floor mats					
	Toys (specs to follow)					

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	REQUIREMENTS	HCI		PHIC		REMARKS
		Yes	No	Yes	No	
	Educational materials (for writing, drawing e.g. crayons, coloring books)					
	Paraffin bath					
	Low-intensity ultrasound unit					
	Refrigerator					
	Trampoline					
	Tilt board					
	Equipment for the fabrication of adaptive device of daily function					
	• Thermoplastics (at least 10 sheets on stock)					
	• Electric water bath					
	• Heat gun					
	• Velcro strap					
	• Foam					
	• Scissors, pliers, cutter, hammer, screw driver					
3.3	Utilities					
	Sink (different from the CR sink)					
	First aid kit					
	Waste segregation system					
4	**Human Resource**					
	The HCI shall have a functional Multidisciplinary team:					
4.1	A Physiatrist (Rehabilitation Medicine Specialist) certified by the Philippine Board of Rehabilitation Medicine					
	i. Valid PRC License					
	ii. Valid PhilHealth Accreditation					
4.2	A Behavioral-Developmental Pediatrician or a Neurodevelopmental Pediatrician certified by the Philippine Society for Developmental and Behavioral Pediatrics					
	i. Valid PRC License					
	ii. Valid PhilHealth Accreditation					
4.3	Occupational Therapist					
	i. Valid PRC License					
4.4	Physical Therapist					
	i. Valid PRC License					
4.5	Speech Language Pathologist or Speech Therapist who graduated from a CHED accredited school (Diploma), and is a member of the Philippine Association of Speech Pathologists (PASP). (Certificate of membership)					
4.6	Medical Social Worker					

	REQUIREMENTS	HCI		PHIC		REMARKS
		Yes	No	Yes	No	
	Valid PRC License					
4.7	Z-Benefit Coordinator					
5	**General algorithm of care**					
	Presence of policy adopting the general algorithm of care					
6	**Z Benefit Program Implementation**					
6.1	Full awareness of the PhilHealth Z benefit program including No Balance Billing (NBB) and maximum co- payments					
6.2	Action plan/ commitment of the HCI to abide with the NBB policy					
6.3	Conduct advocacy programs/seminars at least annually					
6.4	Submit report on patient outcomes, and other statistical report					
6.5	Costing for maximum co-pay					
6.6	Process for the provision of services					

PhilHealth Survey Team

Surveyor's Name	Designation	Signature

HCI Management Team

Names of Management Team	Designation	Signature

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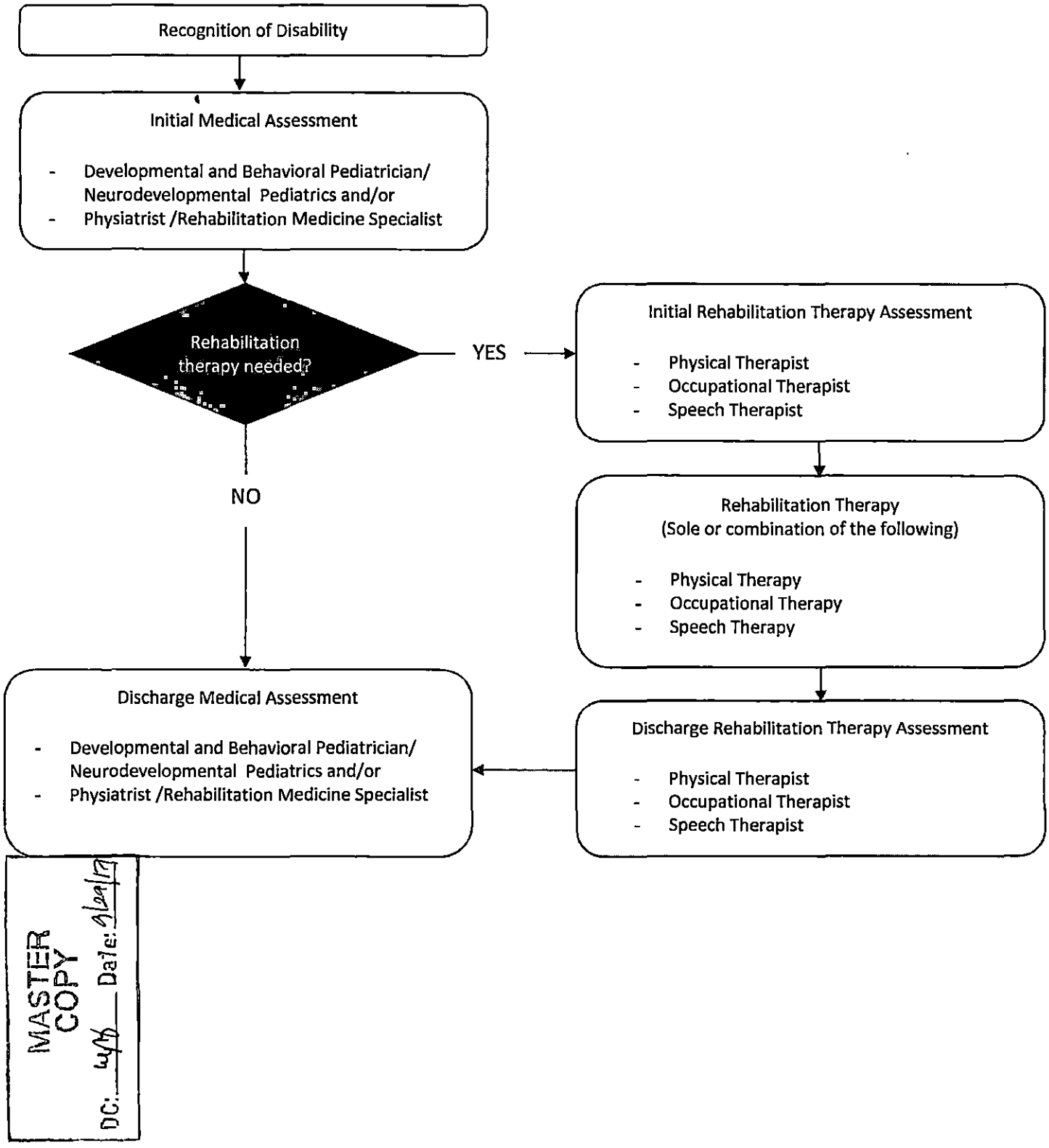
Annex "G – Developmental Disability"

General Process Flow for the Provision of Care for a Child with Neurodevelopmental disorder or Developmental disability



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Annex "H"

TRANSMITTAL FORM OF CLAIMS FOR THE Z BENEFITS

NAME OF CONTRACTED HEALTH CARE INSTITUTION (HCI)	ADDRESS OF HCI

Instructions for filling out this Transmittal Form. Use additional sheets if necessary.

1. Use CAPITAL letters or UPPER CASE letters in filling out the form.
2. For the period of confinement, follow the format (mm/dd/yyyy).
3. For the Z Benefit Package Code, include the code for the order of tranche payment. Example: breast cancer, second tranche should be written as "Z0022".
4. For the Case Number, copy the case number that is provided in the approved pre-authorization checklist and request.
5. The Remarks column may include some relevant notes which pertain to the filed claim that need to be relayed to PhilHealth.

Case Number	Name of Patient (Last, First, Middle Initial, Extension)	Period of Confinement		Z Benefit Package Code	Remarks
		Date admitted	Date discharged		
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Certified correct by authorized representative of the HCI		For PhilHealth Use Only	Initials	Date
Printed Name and Signature	Designation	Received by Local Health Insurance Office (LHIO)		
	Date signed (mm/dd/yyyy)	Received by the Benefits Administration Section (BAS)		

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SAMPLE CLAIM FORM 2 FOR DEVELOPMENTAL DISABILITY (TRANCHE 1)

PhilHealth
Your Partner in Health

This form may be reproduced and is NOT FOR SALE

CF2
(Claim Form 2)
revised November 2013

Series # _____

IMPORTANT REMINDERS:
PLEASE WRITE IN CAPITAL LETTERS AND CHECK THE APPROPRIATE BOXES.
This form together with other supporting documents should be filed within sixty (60) calendar days from date of discharge.
All information, fields and tick boxes required in this form are necessary. Claim forms with incomplete information shall not be processed.
FALSE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CRIMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.

PART I - HEALTH CARE INSTITUTION (HCI) INFORMATION

1. PhilHealth Accreditation Number (PAN) of Health Care Institution: H 9 3 0 0 5 9 4 3
2. Name of Health Care Institution: UNIVERSITY OF THE EAST RAMON MAGSAYSAY MEMORIAL MEDICAL CENTER
3. Address: 64 AURORA BLVD (Building Number and Street Name) QUEZON CITY (City/Municipality) (Province)

PART II - PATIENT CONFINEMENT INFORMATION

1. Name of Patient: DELA CRUZ (Last Name) JUAN (First Name) JR. (Name Extension (JR/SR/III)) MASIPAG (Middle Name) (example: DELA CRUZ JUAN JR SIPAG)
2. Was patient referred by another Health Care Institution (HCI)?
☑ NO ☐ YES
Name of Referring Health Care Institution | Building Number and Street Name | City/Municipality | Province | Zip Code
3. Confinement Period: a. Date Admitted: 1 0 - 0 1 - 2 0 1 7 (month - day - year) b. Time Admitted: ___ : ___ ☐ AM ☐ PM (hour : min)
OUTPATIENT
c. Date Discharged: 1 0 - 0 1 - 2 0 1 7 (month - day - year) d. Time Discharged: ___ : ___ ☐ AM ☐ PM (hour : min)
4. Patient Disposition: (select only 1)
☑ a. Improved
☐ b. Recovered
☐ c. Home/Discharged Against Medical Advise
☐ d. Absconded
☐ e. Expired, Date: ___ - ___ - ____ (month - day - year) Time: ___ : ___ ☐ AM ☐ PM (hour : min)
☐ f. Transferred/Referred
Name of Referral Health Care Institution
Building Number and Street Name | City/Municipality | Province | Zip Code
Reason/s for referral/transfer:
5. Type of Accommodation: ☐ Private ☐ Non-Private (Charity/Service)
6. Admission Diagnosis/es:
Indicate the diagnosis of the child
7. Discharge Diagnosis/es (Use additional CF2 if necessary):

	Diagnosis	ICD-10 Code/s	Related Procedure/s (if there's any)	RVS Code	Date of Procedure	Laterality (check applicable boxes)
a.			i.			☐ Left ☐ Right ☐ Both
			ii.			☐ Left ☐ Right ☐ Both
			iii.			☐ Left ☐ Right ☐ Both
b.			i.			☐ Left ☐ Right ☐ Both
			ii.			☐ Left ☐ Right ☐ Both
			iii.			☐ Left ☐ Right ☐ Both
c.			i.			☐ Left ☐ Right ☐ Both
			ii.			☐ Left ☐ Right ☐ Both
			iii.			☐ Left ☐ Right ☐ Both
d.			i.			☐ Left ☐ Right ☐ Both
			ii.			☐ Left ☐ Right ☐ Both
			iii.			☐ Left ☐ Right ☐ Both

8. Special Considerations:
a. *For the following repetitive procedures, check box that applies and enumerate the procedure/session dates [mm-dd-yyyy]. For chemotherapy, see guidelines.*
☐ Hemodialysis ☐ Peritoneal Dialysis ☐ Radiotherapy (LINAC) ☐ Radiotherapy (COBALT)
☐ Blood Transfusion ☐ Brachytherapy ☐ Chemotherapy ☐ Simple Debridement
b. *For Z-Benefit Package* Z-Benefit Package Code: Z 017.3 Tranche 1
c. *For MCP Package (enumerate four dates [mm-dd-yyyy] of pre-natal check-ups)*
1 _____ 2 _____ 3 _____ 4 _____
d. *For TB DOTS Package* ☐ Intensive Phase ☐ Maintenance Phase
e. *For Animal Bite Package (write the dates [mm-dd-yyyy] when the following doses of vaccine were given)* NOTE: Anti Rabies Vaccine (ARV), Rabies Immunoglobulin (RIG)
Day 0 ARV _____ Day 3 ARV _____ Day 7 ARV _____ RIG _____ Others (Specify) _____
f. *For Newborn Care Package* ☐ Essential Newborn Care ☐ Newborn Hearing Screening Test ☐ Newborn Screening Test
For Newborn Screening, *please attach NBS Filter Sticker here*
For Essential Newborn Care, (check applicable boxes)
☐ Immediate drying of newborn ☐ Timely cord clamping ☐ Weighing of the newborn ☐ BCG vaccination ☐ Hepatitis B vaccination
☐ Early skin-to-skin contact ☐ Eye prophylaxis ☐ Vitamin K administration ☐ Non-separation of mother/baby for early breastfeeding initiation
g. *For Outpatient HIV/AIDS Treatment Package* Laboratory Number: _____
9. PhilHealth Benefits
ICD 10 or RVS Code: a. First Case Rate _____ b. Second Case Rate _____

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Date of initial consult/ assessment

Date of completion of assessment

Write OUTPATIENT in lieu of time admitted & discharged

Tick YES if the patient was referred by another HCI

This is not required as this is done in an out-patient setting

Indicate the diagnosis and ICD-10 code

Indicate the appropriate "Z benefit package code" and order of tranche

This is not required

10. Professional Fees / Charges (Use additional CF2 if necessary):

Accreditation Number / Name of Accredited Health Care Professional / Date Signed	Details
Accreditation No.: 1 2 3 4 - 5 6 7 8 9 0 1 - 2 JUANA DELA CRUZ, MD Signature Over Printed Name Date Signed: month day year	☐ No co-pay on top of PhilHealth Benefit ☑ With co-pay on top of PhilHealth Benefit P _____
Accreditation No.: Signature Over Printed Name Date Signed: month day year	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____
Accreditation No.: Signature Over Printed Name Date Signed: month day year	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____

Tick this box if patient paid no additional Professional fee

Tick this box if patient paid an additional Professional fee

PART III - CERTIFICATION OF CONSUMPTION OF BENEFITS AND CONSENT TO ACCESS PATIENT RECORD/S

NOTE: Member/Patient should sign only after the applicable charges have been filled-out

A. *CERTIFICATION OF CONSUMPTION OF BENEFITS*

☑ PhilHealth benefit is enough to cover HCI and PF charges.
No purchases of drugs/medicines, supplies, diagnostics, and co-pay for professional fees by the member/patient.

Tick this box if patient has NO out of pocket payment

	Total Actual Charges*
Total Health Care Institution Fees	4,726.00
Total Professional Fees	
Grand Total	4,726.00

☑ The benefit of the member/patient was completely consumed prior to co-pay OR the benefit of the member/patient is not completely consumed BUT with purchases/expenses for drugs/medicines, supplies, diagnostics and others.

Tick this box if patient has an out of pocket payment

a.) The total co-pay for the following are:

	Total Actual Charges*	Amount after Application of Discount (i.e., personal discount, Senior Citizen/PWD	PhilHealth Benefit	Amount after PhilHealth Deduction
Total Health Care Institution Fees	4,726.00		4,726.00	Amount P _____ Paid by *(Check all that applies)*: ☐ Member/Patient ☐ HMO ☐ Others (i.e., PCSO, Promissory note, etc.)
Total Professional Fees *(for accredited and non-accredited professionals)*				Amount P _____ Paid by *(Check all that applies)*: ☐ Member/Patient ☐ HMO ☐ Others (i.e., PCSO, Promissory note, etc.)

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b.) Purchases/Expenses NOT included in the Health Care Institution Charges

Total cost of purchase/s for drugs/medicines and/or medical supplies bought by the patient/member within/outside the HCI during confinement	☐ None ☐ Total Amount P _____
Total cost of diagnostic/laboratory examinations paid for by the patient/member done within/outside the HCI during confinement	☐ None ☐ Total Amount P _____

**NOTE: Total Actual Charges should be based on Statement of Account (SoA)*

B. *CONSENT TO ACCESS PATIENT RECORD/S*

I hereby consent to the examination by PhilHealth of the patient's medical records for the purpose of verifying the veracity of this claim.
I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim for reimbursement before PhilHealth.

JUAN MASIPAG DELA CRUZ, JR.
Signature Over Printed Name of Member/Patient/Authorized Representative

Affix signature of patient

Date Signed: month day year

Relationship of the representative to the member/patient: ☐ Spouse ☐ Child ☐ Parent ☐ Sibling ☐ Others, Specify _____

Reason for signing on behalf of the member/patient: ☐ Patient is Incapacitated ☐ Other Reasons: _____

If patient/representative is unable to write, put right thumbmark. Patient/representative should be assisted by an HCI representative. Check the appropriate box: ☐ Patient ☐ Representative

PART IV - CERTIFICATION OF HEALTH CARE INSTITUTION

I certify that services rendered were recorded in the patient's chart and health care institution records and that the herein information given are true and correct.

MIGUEL DELOS SANTOS
Signature Over Printed Name of Authorized HCI Representative

RECORDS OFFICER
Official Capacity / Designation

Date Signed: 10 . 19 . 2016 (month day year)

Affix signature of HCI representative

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Case No. _____

Annex "J – Developmental Disability"

Z BENEFITS FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES

PATIENT (Last name, First name, Middle name, Suffix)	AGE
ADDRESS	
CONTACT NUMBER	

CERTIFICATE OF ASSESSMENT AND RECOMMENDATIONS

I. Nature of Client Visit:

☐ Initial consult/assessment
☐ Follow-up consult/assessment
Date of previous assessment: (mm/dd/yyyy) ___/____/_____
Outcome of previous assessment (Please include standard test score if applicable):
_____
_____

II. Summary for Present Consult/Assessment

Date completed: (mm/dd/yyyy) ___/____/_____
Nature of consult/assessment and standard test done, if applicable:

☐ Medical, Developmental Pediatrics
- ❑ Griffiths Mental Developmental Scale
- ❑ Battelle Developmental Inventory
- ❑ Brigance Inventory of Early Development
- ❑ Vineland Adaptive Behavior Scales

☐ Medical, Rehabilitation Medicine
- ❑ Functional Independence Measure (FIM & WEE-FIM)
- ❑ Pediatric Quality of Life Inventory
- ❑ WHO-Quality of Life Assessment

☐ Physical therapy
- ❑ Gross Motor Function Measure
- ❑ Peabody Developmental Motor Scale
- ❑ Erhardt Developmental Prehension Assessment

☐ Occupational therapy
- ❑ Beery-Buktenica Developmental Test of Visual-Motor Integration
- ❑ Test of Visual Perceptual Skills

☐ Speech therapy
- ❑ Preschool Language Scale
- ❑ Clinical Evaluation of Language Fundamentals
- ❑ Picture Articulation Test

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Assessment Results:

If applicable: Previous test score: _____ Current test score: _____

Assessment Summary:

1. Developmental disability
   - ☐ Cognitive
   - ☐ Motor
   - ☐ Communication
   - ☐ Social/Emotional
   - ☐ Adaptive
2. Functional disability
   - ☐ Home care and management of children with disability (CWD)
   - ☐ Activities of daily living
   - ☐ Learning, applying knowledge &/or undertaking tasks
   - ☐ Domestic life, relationships and interactions
   - ☐ Mobility and safety
   - ☐ Education/employment/community/social and or civic life
   - ☐ Contextual (environmental and personal) barriers
3. Others: Please specify _____

III. Recommendation:

- ☐ Refer to medical specialist, please specify: _____
- ☐ Refer to other services
  - ☐ SPED & other school systems
  - ☐ Placement
  - ☐ Psychological
  - ☐ Community-based rehabilitation service
  - ☐ Social service
  - ☐ Others, please specify _____
- ☐ For assessment/reassessment by a rehabilitation therapist
  - ☐ Physical therapist, specify number of sessions: _____
  - ☐ Speech therapist, specify number of sessions: _____
  - ☐ Occupational therapist, specify number of sessions: _____
- ☐ For temporary discharge with follow-up visit on: _____
- ☐ For final discharge
- ☐ Other Z Benefits for CWDs
  - ☐ Mobility ☐ Visual ☐ Hearing
- ☐ Others, please specify _____

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Conforme by Patient/Parent/Guardian:

_____
Printed name and signature

Certified by:
☐ Attending Medical Specialist
☐ Rehabilitation Therapy Specialist

_____
Printed name and signature

PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐ - ☐