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October 5, 2017

PHILHEALTH CIRCULAR
No. 2017-0031

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

SUBJECT : **Z Benefits for Children with Mobility Impairment**

I. RATIONALE

Congenital and acquired conditions during childhood, particularly the most common ones, musculoskeletal and neuromuscular disorders (UERM and PGH local data) can impair a child's mobility at different levels. Mobility impairment makes walking, moving around, changing, or maintaining body positions difficult. In a body that is just growing and learning to adapt to its environment, failure to address mobility impairment during critical phase of development leads to lifelong consequences. Cerebral palsy and clubfoot are the two most common disorders identified locally to need management for mobility impairment among pediatric patients (UERM and PGH data).

Mobility impairment can be addressed through appropriate mobility devices and habilitative / rehabilitative therapy. These can potentially halt the progression of conditions that limit mobility and then enable children to navigate access and be more independent. A recent local modeling study estimates that there are 137,474 children (i.e. less than 19 years old) who would need mobility devices (PFP, 2016 [unpublished]). The cost of intervention, however, consisting of assessment, fitting and fabrication of devices, and rehabilitation can be prohibitive.

The Philippine Health Insurance Corporation (PhilHealth) is mandated to ensure financial risk protection, 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 marginalized members and dependents through facilitating access to quality healthcare services. Adults have, thus far, been covered by PhilHealth benefits through its ZMORPH prosthesis and orthosis benefit packages (PhilHealth Circulars 0019-2013 and 2016-0033), and selected orthopedic implants for hip arthroplasty, hip fixation, pertrochanteric fracture and femoral shaft fracture (PhilHealth Circular 2016-0020). Children, defined hereafter for the purpose of this Circular, as ages less than 17 years

and 364 days, have yet to be afforded with financial risk protection from mobility impairment.

This Circular describes the benefit package for children with mobility impairment, covering services from assessment, provision of appropriate devices and rehabilitation, such that children can be enabled to navigate their homes and communities. 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 health service for children with mobility impairment 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 mobility impairment, and other relevant stakeholders involved the implementation of the Z Benefits.

IV. DEFINITION OF TERMS

A. Assessment - process of examination, interaction, and observation of a child with potential or actual conditions, and the degree of limitations in function, activity and participation. Assessment is required for the provision of assistive device and rehabilitation services.

B. Assistive device - any device that is designed, made and adapted to help a child to perform tasks. This refers to an appropriately measured, fabricated, and fitted prosthesis, orthosis, seating device or wheelchair that aims to improve the child's activity, functioning and participation.

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

D. Gross Motor Function Classification System - a standardized classification, used to categorize and describe a child with mobility impairment's ability to function in his/her home, school, or community at different age levels. The system is used to classify which appropriate assistive device can be provided.

E. Lost to follow-up - means the patient has not come back as advised for the final fitting of the device, for the training on the safe and functional use of the device, or for the immediate next rehabilitation visit. Visiting the clinic for more than two weeks from advised scheduled visit, renders the patient "lost to follow-up".

F. Mobility impairment - refers to difficulty in walking, moving around, navigation, and changing or maintaining body positions. The difficulty causes a limitation in function and participation in the life of a child.

G. 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.

H. Rehabilitation for mobility impairment - refers to physical therapy and/or occupational therapy, aimed at safe and functional use of assistive devices for children with mobility impairment towards improvement or restoration of function, and prevention of secondary disabilities, such as contractures, deformities, and pressure sores.

I. 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 BENEFIT FOR CHILDREN WITH MOBILITY IMPAIRMENT

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 capable tertiary HCIs for the provision of specialized multi- and interdisciplinary health care delivery for this Z benefit. Subsequent contracting of other capable 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 mobility impairment 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 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.

VI. MINIMUM STANDARDS OF CARE

The Z Benefits for children with mobility impairment shall reflect the following mandatory services:

1. Assessment, prescription of prostheses and orthoses, check-out and discharge by a certified Philippine Board of Rehabilitation Medicine specialist.

2. Assessment, prescription, follow-up and repair of seating devices and wheelchair with corresponding user training on safety & functional use by a trained wheelchair and seating device professional, and wheelchair technician. The list of certified training bodies shall be identified by the reference HCI.

3. Measurement, casting, fabrication, fitting and alignment of prosthesis and orthosis by a graduate of a 4 to 5-year Bachelor of Science in Prosthetics and Orthotics course.

4. Rehabilitation program prescription shall be provided by a certified Philippine Board of Rehabilitation Medicine Specialist with implementation of the therapy by a Professional Regulations Commission (PRC)- licensed Physical or Occupational Therapist

Table 1. Mandatory and other services for the Z Benefits for children with mobility impairment requiring assistive devices for upper and lower extremity prosthesis

Mandatory Services	Other services
a. Assessment & prosthetic prescription b. Measurement, casting, fabrication & fitting of prosthesis until age of 17 years and 364 days c. Rehabilitation service	Follow-up 2x/year

Table 2. Mandatory and other services for the Z Benefits for children with mobility impairment requiring a lower limb orthosis (Talipes Equinovarus or Clubfoot)

Mandatory Services	Other services
a. Assessment & orthotic prescription b. Measurement, casting, fabrication & fitting of orthosis until age of four years old c. Rehabilitation service	Follow-up 2x/year

Table 3. Mandatory and other services for the Z Benefits for children with mobility impairment requiring a lower limb orthosis

Mandatory Services	Other services
a. Assessment & orthotic prescription b. Measurement, casting, fabrication & fitting of orthosis until age of 17 years and 364 days c. Rehabilitation service	Follow-up 2x/year

Table 4. Mandatory and other services for the Z Benefits for children with mobility impairment requiring a spinal orthosis

Mandatory Services	Other services
Musculoskeletal conditions: a. Measurement of Cobb's angle and Risser sign b. Assessment & orthotic prescription c. Measurement, casting, fabrication & fitting of orthosis until < Risser 4 (skeletal maturity) d. Rehabilitation service	a. X-ray at least three months prior to assessment & after each replacement b. Follow-up /adjustment of pads with first follow-up two weeks from first orthosis
Neuromuscular conditions, after or not needing seating/positioning devices/ wheelchair: a. Measurement of Cobb's angle b. Assessment & orthotic prescription c. Measurement, casting, fabrication & fitting of orthosis until 17 years and 364 days d. Rehabilitation service	a. X-ray at least three months prior to assessment & after each replacement b. Follow-up /adjustment of pads with first follow-up two weeks from first orthosis

Table 5. Mandatory services for the Z Benefits for children with mobility impairment requiring a seating device

Mandatory Services
a. Assessment & seating device prescription b. Measurement, & fitting of seating device from six months to less than seven years old c. Training on the safe and functional use of the seating device

Table 6. Mandatory services for the Z Benefits for children with mobility impairment requiring a wheelchair

Mandatory Services
a. Assessment & wheelchair prescription b. Measurement & fitting of wheelchair from seven to less than 18 years old c. Training on the safe and functional use of the wheelchair d. Rehabilitation service

Table 7. Mandatory services for the Z Benefits for children with mobility impairment requiring replacements or yearly services of seating device or wheelchair

Mandatory Services
a. Seating device replacement, maximum of one replacement i. Assessment & seating device prescription ii. Measurement, & fitting of seating device from six months to less than seven years old b. Basic wheelchair replacement, every three years i. Assessment & wheelchair prescription ii. Measurement & fitting of wheelchair from seven to less than 18 years old c. Yearly services for seating device, maximum of six yearly services d. Yearly services for intermediate wheelchair, maximum of ten yearly services

VII. GUIDELINES ON AVAILMENT OF THE Z BENEFIT FOR CHILDREN WITH MOBILITY IMPAIRMENT

A. Assessment of Patients

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

a. General Criteria

i. Age must be 0 to 17 years and 364 days old;

ii. Absence of conditions that will compromise safety and functionality with the use of prosthesis, orthosis, wheelchair or seating device

iii. On physical examination: no fresh or non-healing wound on body part of interest

iv. At least three months-post-surgery, if acquired amputation

b. With mobility impairment, presenting with any of the following:

i. Disorders resulting to mobility impairment:

a) Musculoskeletal conditions characterized with any of the following: limb loss (amputation), limb deficiency, limb deformity and spine deformity (Cobb's angle ≥ 20 degrees and Risser <4) classified into:

i) Gross motor function classification system (GMFCS) 1 and 2 for prosthesis and orthoses,

ii) GMFCS 3, 4, and 5 for seating device, wheelchair, prosthesis and orthosis (note: For seating device, a child must be six months to six years & 364 days),

iii) Talipes equinovarus (clubfoot)

b) Neuromuscular conditions characterized with any of the following: weakness or paralysis, imbalance, incoordination, sensory deficits classified into:

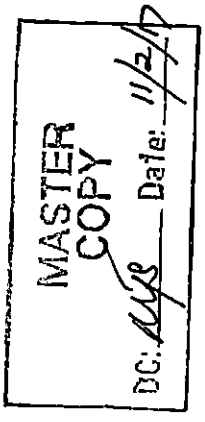
i) GMFCS 1 and 2 for prosthesis and orthosis, OR

ii) GMFCS–3, 4, and 5 for seating device, wheelchair and orthosis

ii. Presence of cardiopulmonary, behavioral or cognitive conditions that impairs a child's mobility;

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

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 hundred eighty calendar (180) days from the date of approval by PhilHealth provided that the child has not turned 18 years of age. All contracted HCIs shall be responsible in tracking the validity of the 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. An approved Pre-authorization Checklist and Request guarantees payment of the initial tranche of the Z benefit provided that mandatory services for the specified treatment phase are given to the patient and all other PhilHealth requirements are complied with.

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

7. The ME Form shall be discussed by the attending health professional/s and accomplished together with the parent or guardian/patient to be enrolled in the Z Benefits. The ME Form aims to support parent or guardians/patients to be active participants in health care decision making by being 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 optimum functional outcomes and patient satisfaction.

C. Guidelines on Reimbursement

1. The package codes and corresponding rates per laterality of the Z benefits for children with mobility impairment are specified in the following tables:

Table 8. Package codes and rates for the Z Benefits for children with mobility impairment requiring assistive devices for upper and lower extremity prosthesis, lower extremity orthosis and spinal bracing or orthosis

Description	Package Code			Package Rate (Php) per laterality*
	Right	Left	Both	
I. Upper Extremity Prosthesis**				
Shoulder disarticulation	Z1801A	Z1801B	Z1801C	132,300.00
Above elbow (AE)	Z1802A	Z1802B	Z1802C	67,300.00
Below elbow (BE)	Z1803A	Z1803B	Z1803C	47,300.00
Finger glove (for 1 finger)	Z1804A	Z1804B	Z1804C	17,300.00
Hand glove (for more than 1 finger)	Z1805A	Z1805B	Z1805C	22,300.00
II. Lower Extremity Prosthesis**				
Hip disarticulation (HD)	Z1806A	Z1806B	Z1806C	163,540.00
Above knee or with knee disarticulation (AKKD)	Z1807A	Z1807B	Z1807C	61,940.00
Below knee or ankle disarticulation	Z1808A	Z1808B	Z1808C	31,540.00
Partial foot	Z1809A	Z1809B	Z1809C	26,540.00
III. Lower Extremity Orthosis***				
Talipes Equinovarus or clubfoot	Z1810			17,860.00
Ankle foot orthosis (AFO)	Z1811A	Z1811B	Z1811C	13,110.00
Knee ankle foot orthosis (KAFO)	Z1812A	Z1812B	Z1812C	29,210.00
Hip knee ankle foot orthosis (HKAFO)	Z1813A	Z1813B	Z1813C	50,810.00
IV. Spinal Bracing or Orthosis				
Spinal bracing / orthosis	Z1814			32,180.00

* The package rate per laterality shows the rates of the benefits per side, left or right. If both sides are provided with the assistive device at the same time, the package rate is multiplied by two. Exemptions to this are the benefits for Talipes Equinovarus or clubfoot, and spinal bracing or orthosis, where laterality is not applicable.

**For cases involving more than one amputation, the patient is not allowed to claim two prosthesis simultaneously with the same laterality in either the upper (i.e. BE, AE) or in the lower (i.e. AKKD, HD) limb.

*** For cases involving more than one limb, the patient is not allowed to claim two orthoses simultaneously with the same laterality.

Table 9. Package codes and rates for the Benefits for children with mobility impairment requiring seating device, basic and intermediate wheelchair

Description	Package code	Package rate (Php)
Seating device, for ages six months to less than seven years old	Z1815	15,470.00
Basic wheelchair, for ages seven to less than 18 years old	Z1816	12,730.00
Intermediate wheelchair, for ages seven to less than 18 years old	Z1817	29,450.00

Table 10. Package codes and rates for yearly services and replacement of seating device, replacement of basic wheelchair and yearly services of intermediate wheelchair

Description	Package code	Package rate (Php)
Yearly services for seating device, for ages six months to less than seven years old (to be given minimum of one year after provision of the seating device until less than seven years old)	Z1818	1,590.00
Yearly services for intermediate wheelchair, for ages seven to less than 18 years old (to be given minimum of one year after provision of the intermediate wheelchair until less than 18 years old)	Z1819	6,104.00
Seating device replacement for ages four to less than seven years old	Z1820	13,690.00
Basic wheelchair replacement, for ages seven to less than 18 years old	Z1821	7,170.00

2. HCIs 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 develop the mobility section of the facility.

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

4. There shall be no out-of-pocket expenses for the availment of the Z Benefit for mobility impairment for all member categories of PhilHealth, except for upgrade of services. The details of the co-payment arrangement will be arranged with the contracted HCI and shall be stipulated in the individual contracts of health care institutions.

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. Tables 1 to 7 of this Circular, within the context of a multi- and interdisciplinary approach to patient care.

2. The contracted HCI should provide and claim reimbursement only for new and unused components or devices under the Z benefits.

3. Patients should keep their used or replaced devices and are discouraged to sell or donate them.

4. 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 only, during provision of assistive device;

   c. Photocopy of the properly accomplished ME Form for the first tranche only, during provision of assistive device;

      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 to the patient's chart as a permanent record;

   d. PhilHealth Benefit Eligibility Form printout or its equivalent (e.g. PhilHealth Claim Form 1 or CF1) attached as proof of eligibility during the pre-authorization process and for all tranches during repair, replacement and yearly service of assistive device;

   e. Properly accomplished PhilHealth CF2 for all tranches;

   f. Checklist of Mandatory Services for the corresponding tranches;

   g. Corresponding Checklist of Requirements for Reimbursement;

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

i. Certification of Training Completed; or Certificate of Outcome after rehabilitation session.

Table 11. Summary of forms to be utilized in claims filing and reimbursement

Service Provision	Forms Required
I. For Assistive Device Provision, Training and Rehabilitation	
Tranche 1: Assessment, prescription, casting and measurement of the assistive device	a. Pre-authorization Checklist and Request (photocopy) b. ME Form (photocopy) c. PhilHealth Benefit Eligibility Form or equivalent (e.g. PhilHealth CF1) d. PhilHealth CF2 e. Checklist of Requirements for Reimbursement f. Checklist of Mandatory Services g. Z Satisfaction Questionnaire (photocopy)
Tranche 2: Assistive device fitting, mobility training	a. PhilHealth CF2 b. Checklist of Requirements for Reimbursement c. Checklist of Mandatory Services d. Certificate of completed training on the safe and functional use of devices (photocopy) e. Z Satisfaction Questionnaire (photocopy)
Tranche 3: Rehabilitation service	a. PhilHealth CF2 b. Checklist of Requirements for Reimbursement c. Certificate of outcomes after rehabilitation sessions (photocopy) d. Z Satisfaction Questionnaire (photocopy)
II. For Assistive Device Repair, Replacement or Yearly Service Pre-requisite: patients should have previously availed of the Z Benefits for assistive device, training, and rehabilitation service. Repair, replacement and yearly services for assistive device may be availed until the patient is 17 years and 364 days	
Tranche 1 and, succeeding tranches for yearly services: Repair, Replacement or Yearly Service	a. PhilHealth Benefit Eligibility Form or equivalent (e.g. PhilHealth CF1) b. PhilHealth CF2 c. Checklist of Mandatory Services d. Checklist of Requirements for Reimbursements e. Z Satisfaction Questionnaire (photocopy)

5. Rules on late filing shall apply;

6. 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);

7. There shall be no direct filing of members;

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

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

Table 12. Description of services, amount of payment, filing schedule and maximum availment of benefits for prosthesis, orthosis, spinal bracing/orthosis.

Description per laterality	Tranche	Amount (Php)		Filing Schedule	Maximum Availment
		Device	PF*		
I. Upper Extremity Prosthesis					
A. Shoulder disarticulation	1	117,000.00	0.00	Within 60 calendar days after measurement	Upon enrolment, may be replaced every three years, maximum of five per limb
	2	0.00	13,000.00	Within 60 calendar days after the final fitting of the device	Upon enrolment, may be replaced every three years, maximum of five per limb
	3	0.00	2,300.00	Within 60 calendar days after the last day of rehabilitation service	Five sessions per set, maximum of one set every after fitting
B. AE	1	58,500.00	0.00	Within 60 calendar days after measurement	Upon enrolment, then every three years, maximum of five per limb
	2	0.00	6,500.00	Within 60 calendar days after the final fitting of the device	
	3	0.00	2,300.00	Within 60 calendar days after the last day of rehabilitation service	Five sessions per set, maximum of one set every after fitting
C. BE	1	40,500.00	0.00	Within 60 calendar days	Upon enrolment, then every three

Description per laterality	Tranche	Amount (Php)		Filing Schedule	Maximum Availment
		Device	PF*		
				after measurement	years, maximum of five per limb
	2	0.00	4,500.00	Within 60 calendar days after the final fitting of the device	
	3	0.00	2,300.00	Within 60 calendar days after the last day of rehabilitation service	Five sessions per set, maximum of one set every after fitting
D. One finger	1	13,500.00	0.00	Within 60 calendar days after measurement	Upon enrolment, then every three years, maximum of five per limb
	2	0.00	1,500.00	Within 60 calendar days after the final fitting of the device	Upon enrolment, then every three years, maximum of five per limb
	3	0.00	2,300.00	Within 60 calendar days after last day of rehabilitation service	Five sessions per set, maximum of one set every after fitting
E. Glove	1	18,000.00	0.00	Within 60 calendar days after measurement	Upon enrolment, then every three years, maximum of five per limb
	2	0.00	2,000.00	Within 60 calendar days after the final fitting of the device	
	3	0.00	2,300.00	Within 60 calendar days after the last day of rehabilitation service	Five sessions per set, maximum of one set every after fitting

* Tranche 2: PF for the device assessment, prescription and training
Tranche 3: PF for rehabilitation service (physical/occupational therapy fee

Description per laterality	Tranche	Amount (Php)		Filing Schedule	Maximum Availment
		Device	PF*		
II. Lower Limb Prosthesis					
A. Hip disarticulation	1	145,800.00	0.00	Within 60 calendar days after measurement	Upon enrolment, then every three years, maximum of five per limb
	2	0.00	16,200.00	Within 60 calendar days after the final fitting of the device	
	3	0.00	1,540.00	Within 60 calendar days after the last day of rehabilitation service	Five sessions per set, maximum of one set every after fitting
B. AKKD	1	54,400.00	0.00	Within 60 calendar days after measurement	Upon enrolment, then every three years, maximum of five per limb
	2	0.00	6,000.00	Within 60 calendar days after the final fitting of the device	Upon enrolment, then every three years, maximum of five per limb
	3	0.00	1,540.00	Within 60 calendar days after the last day of rehabilitation service	Five sessions per set, maximum of one set every after fitting
C. Below knee or ankle disarticulation	1	27,000.00	0.00	Within 60 calendar days after measurement	Upon enrolment, then every three years, maximum of five per limb
	2	0.00	3,000.00	Within 60 calendar days after the final fitting of the device	

* Tranche 2: PF for the device assessment, prescription and training
Tranche 3: PF for rehabilitation service (physical/ occupational therapy fee)

Description per laterality	Tranche	Amount (Php)		Filing Schedule	Maximum Availment
		Device	PF*		
	3	0.00	1,540.00	Within 60 calendar days after the last day of rehabilitation service	Five sessions per set, maximum of one set every after fitting
D. Partial foot	1	22,500.00	0.00	Within sixty (60) calendar days after measurement	Upon enrolment, then every three years, maximum of five per limb
	2	0.00	2,500.00	Within 60 calendar days after the final fitting of the device	
	3	0.00	1,540.00	Within 60 calendar days after the last day of rehabilitation service	Five sessions per set, maximum of one set every after fitting
III. Lower Extremity Orthosis					
A. Talipes Equinovarus (Clubfoot)	1	15,400.00	0.00	Within 60 calendar days after measurement	Once per year per limb until four years old with maximum of three replacements per limb
	2	0.00	1,710.00	Within 60 calendar days after the final fitting of the device	
	3	0.00	750.00	Within 60 calendar days after the last day of rehabilitation service	Two sessions per set, maximum of one set every after fitting
B. AFO	1	11,120.00	0.00	Within 60 calendar days after measurement	Maximum of 17 replacements per limb, until the age of 17 years and 364 days

* Tranche 2: PF for the device assessment, prescription and training
Tranche 3: PF for rehabilitation service (physical/occupational therapy fee)

Description per laterality	Tranche	Amount (Php)		Filing Schedule	Maximum Availment
		Device	PF*		
	2	0.00	1,240.00	Within 60 calendar days after the final fitting of the device	
	3	0.00	750.00	Within 60 calendar days after the last day of rehabilitation service	Two sessions per set, maximum of one set every after fitting
C. KAFO	1	25,610.00	0.00	Within 60 calendar days after measurement	Maximum of 17 replacements per limb, until the age of 17 years and 364 days
	2	0.00	2,850.00	Within 60 calendar days after the final fitting of the device	
	3	0.00	750.00	Within 60 calendar days after the last day of rehabilitation service	Two sessions per set, maximum of one set every after fitting
D. HKAFO	1	45,060.00	0.00	Within 60 calendar days after measurement	Maximum of 17 replacements per limb, until the age of 17 years and 364 days
	2	0.00	5,000.00	Within 60 calendar days after the final fitting of the device	
	3	0.00	750.00	Within 60 calendar days after the last day of rehabilitation service	Two sessions per set, maximum of one set every after fitting

* Tranche 2: PF for the device assessment, prescription and training
Tranche 3: PF for rehabilitation service (physical/occupational therapy fee)

Description per laterality	Tranche	Amount (Php)		Filing Schedule	Maximum Availment
		Device	PF*		
IV. Spinal Orthosis					
Spinal orthosis	1	28,290.00	0.00	Within 60 calendar days after measurement	Once upon enrolment. For Spinal Orthosis (Musculoskeletal): Every year until Risser 4, maximum of four replacements For Spinal Orthosis (Neuromuscular): Every year, maximum of nine replacements
	2	0.00	3,140.00	Within 60 calendar days after the final fitting of the device	
	3	0.00	750.00	Within 60 calendar days after the last day of rehabilitation service	Two sessions per set, maximum of one set every after fitting
V. Seating Device					
Seating device	1	13,690.00	0.00	Within 60 calendar days after the date of measurement of the seating device	Once upon enrolment for child six months to less than seven years old
	2	0.00	1,780	Within 60 calendar days after the final fitting of the seating device	

* Tranche 2: PF for the device assessment, prescription and training
Tranche 3: PF for rehabilitation service (physical/occupational therapy fee)

Description per laterality	Tranche	Amount (Php)		Filing Schedule	Maximum Availment
		Device	PF*		
VI. Wheelchair					
A. Basic wheelchair	1	7,170	0.00	Within 60 calendar days after the date of measurement of the wheelchair	Once upon enrolment for child seven to <18 years old
	2	0.00	1,780.00	Within 60 calendar days after the final fitting of the wheelchair	
	3	0.00	3,780.00	Within 60 calendar days after the last day of rehabilitation service	Ten sessions per set, per year, maximum of one set after fitting
B. Intermediate wheelchair	1	23,890.00	0.00	Within 60 calendar days after the date of measurement of the wheelchair	Once upon enrolment for child seven to <18 years old
	2	0.00	1,780.00	Within 60 calendar days after the final fitting of the wheelchair	
	3	0.00	3,780.00	Within 60 calendar days after the last day of rehabilitation service	Ten sessions per set, per year, maximum of one set after fitting

* Tranche 2: PF for the device assessment, prescription and training
Tranche 3: PF for rehabilitation service (physical/occupational therapy fee)

Table 13. Description of services, amount of payment, filing schedule and maximum availment of benefits for yearly services and replacement

Description of Services	Tranche	Amount (Php)		Filing Schedule	Maximum Availment
		Device	PF		
I. Seating device / wheelchair					
Seating device yearly service	Six tranches (one tranche per year)	0.00	1,590.00/ tranche /year	Within 60 calendar days after provision of service	Maximum of six services from six months to less than seven years old
Intermediate wheelchair yearly service	Ten tranches (one tranche per year)	4,604.00	1,500.00	Within 60 days of completion of service	Once per year, maximum of ten services from seven to less than 18 years old
Seating device replacement (single tranche)	1	12,190.00	1,500.00	Within 60 calendar days after the date of measurement of the seating device	Once from ages four to less than seven years old
Basic wheelchair replacement	1	5,670.00	1,500.00	Within 60 calendar days of replacement	Every three years from 1st wheelchair, maximum of four replacements from seven to less than 18 years old

10. In the event that the patient expires or is declared "lost to follow-up" in the course of the rehabilitation sessions, the contracted HCI may still file claims for the payment of services rendered to PhilHealth. The contracted HCI should submit a sworn declaration for "lost to follow-up" and expired patients.

11. In instances that patients were declared "lost to follow-up" by the contracted HCI, claims for the succeeding tranches for this particular Z Benefit package shall be denied. This does not, however, automatically disqualify the patient for applying for availment for repair or replacement.

VIII. MONITORING AND POLICY REVIEW

The implementation of the benefit package implementation 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 Z Benefits Information and Tracking System (ZBITS).

Field monitoring of service provision by contracted HCIs 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 inform 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 parent or guardians 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

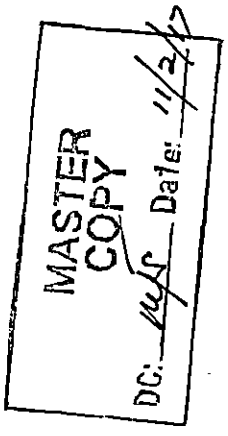
This Circular shall take effect after (15) fifteen days of complete publication in a newspaper of general circulation and shall thereafter be deposited with the National Administrative Register, University of the Philippines Law Center.

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

XII. **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 for Requirements for Reimbursement
F. HCI Standards as Providers for Children with Mobility Impairment
G. General process flow for provision of care for children with mobility impairment
H. Transmittal Form for the Z Benefits
I. Sample Claim Form 2
J. Certificate of completed training on the safe and functional use of devices
K. Certificate of outcomes after rehabilitation sessions

for: [signature]
DR. CELESTINA MA. JUDE P. DE LA SERNA
Interim/OIC President and CEO
Date Signed: 10-5-2017



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

Case No. _____

Annex "A – Mobility Impairment"

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 MOBILITY IMPAIRMENT

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 does NOT have any condition that will compromise safety and functionality with the use of prosthesis, orthosis, wheelchair or seating device.	
3.	On physical examination, the child has no fresh or non-healing wound on the body part of interest	
4.	If acquired amputation, the limb is at least 3 months post-surgery	
5.	The child presents with any of the following: ☐ Disorders resulting to mobility impairment: ☐ Musculoskeletal conditions characterized with any of the following: limb loss (amputation), limb deficiency, limb deformity and spine deformity (Cobb's angle of ≥ 20 degrees and Risser <4) classified into: ☐ Gross Motor Function Classification System (GMFCS) 1 and 2 for prosthesis and orthosis ☐ GMFCS 3, 4, and 5 for seating device, wheelchair, prosthesis and orthosis (Note: For seating device, a child must be six months to six years and 364 days), ☐ Talipes equinovarus (clubfoot)	

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	General Qualifications (Cont.)	Yes
	☐ Neuromuscular conditions characterized with any of the following: weakness or paralysis, imbalance, incoordination, sensory deficits classified into: ☐ GMFCS 1 and 2 for prosthesis and orthosis ☐ GMFCS 3, 4, and 5 for seating device, and wheelchair ☐ Cardiopulmonary, behavioral or cognitive conditions that impairs a child's mobility	

Place a (✓) on the box for the appropriate assistive device that will be given to the child:		
Upper Extremity Prosthesis (GMFCS 1, and 2)	☐ Shoulder disarticulation ☐ Above elbow ☐ Below elbow ☐ Hand glove (2 or more fingers) ☐ Finger (1 finger)	Laterality ☐ Right ☐ Left ☐ Both
Lower Extremity Prosthesis (GMFCS 1, and 2)	☐ Hip disarticulation ☐ Above knee or with knee disarticulation ☐ Below knee or ankle disarticulation ☐ Partial foot	Laterality ☐ Right ☐ Left ☐ Both
Orthosis (GMFCS 1, and 2)	☐ Talipes Equinovarus (Club Foot) ☐ Ankle foot orthosis (AFO) ☐ Knee ankle foot orthosis (KAFO) ☐ Hip knee ankle foot orthosis (HKAFO)	Laterality ☐ Right ☐ Left ☐ Both
	☐ Spinal bracing / orthosis	
Seating Device (GMFCS 3,4, and 5)	For ages 6 months to < 7 years old ☐ Seating device	
Wheelchair (GMFCS 3,4, and 5)	For ages seven to 17 years and 364 days old ☐ Basic Wheelchair ☐ Intermediate Wheelchair	

Conforme by Patient/Parent/Guardian:

Printed name and signature

Attested by Rehabilitation Medicine Specialist

Printed name and signature

PhilHealth Accreditation No. [ ][ ][ ][ ] - [ ][ ][ ][ ][ ][ ] - [ ]

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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.

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PRE-AUTHORIZATION REQUEST
Z BENEFITS FOR CHILDREN WITH MOBILITY IMPAIRMENT

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z benefit package for _____ (NAME OF PATIENT) in _____ (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)

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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 hundred eighty (180) calendar days 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*

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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[c] (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.*	

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D. Edukasyon ng Miyembro *D. Member Education*		
Lagyan ng tsek (√) ang angkop na sagot o NA kung hindi naaukol *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.*		

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Lagyan ng tsek (√) ang angkop na sagot o NA kung hindi naaukol *Put a check mark(√) opposite appropriate answer or NA 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*		

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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.

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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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Case No. _____

Annex "C – Mobility Impairment"

CHECKLIST OF MANDATORY SERVICES
Z BENEFITS FOR CHILDREN WITH MOBILITY IMPAIRMENT
YEARLY SERVICES AND REPLACEMENT

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

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

I. YEARLY SERVICES
☐ Yearly services for seating device, for ages six months to less than seven years old (to be given minimum of one year after provision of the seating device until less than seven years old)
☐ Yearly services for intermediate wheelchair, for ages seven to less than 18 years old (to be given minimum of one year after provision of the intermediate wheelchair until less than 18 years old)

II. REPLACEMENT
☐ Seating device replacement for ages four to less than seven years old
☐ Basic wheelchair replacement, for ages seven to less than 18 years old

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

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

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Annex "C1 – Mobility Impairment"

CHECKLIST OF MANDATORY SERVICES
Z BENEFITS FOR CHILDREN WITH MOBILITY IMPAIRMENT

ASSESSMENT AND PRESCRIPTION
Tranche 1

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 or write NA if not applicable

MANDATORY SERVICES
I. ASSESSMENT
☐ Assessment done by a rehabilitation medicine specialist

II. PRESCRIPTION		
Place a (✓) on the box for the appropriate assistive device that was prescribed to the child:		
Upper Extremity Prosthesis	☐ Shoulder disarticulation ☐ Above elbow ☐ Below elbow ☐ Hand glove (2 or more fingers) ☐ Finger (1 finger)	Laterality ☐ Right ☐ Left ☐ Both
Lower Extremity Prosthesis	☐ Hip disarticulation ☐ Above knee or with knee disarticulation ☐ Below knee or ankle disarticulation ☐ Partial foot	Laterality ☐ Right ☐ Left ☐ Both
Orthosis	☐ Talipes Equinovarus (Club Foot) ☐ Ankle foot orthosis (AFO) ☐ Knee ankle foot orthosis (KAFO) ☐ Hip knee ankle foot orthosis (HKAFO)	Laterality ☐ Right ☐ Left ☐ Both
	☐ Spinal bracing / orthosis	

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Place a (✓) on the box for the appropriate assistive device that was prescribed to the child:	
Seating Device for ages 6 months to less than 7 years old	☐ Seating device
Wheelchair for ages 7 to 17 years and 364 days old	☐ Basic Wheelchair ☐ Intermediate Wheelchair

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Rehabilitation 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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Annex "C2 – Mobility Impairment"

CHECKLIST OF MANDATORY SERVICES
Z BENEFITS FOR CHILDREN WITH MOBILITY IMPAIRMENT

MEASUREMENT, CASTING, FABRICATION AND FITTING
Tranche 2

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 or NA if not applicable

MANDATORY SERVICES
I. MEASUREMENT
☐ Measurement done by a prosthetist/orthotist or wheelchair professional Indicate date of measurement: _____
II.CASTING (FOR PROSTHESIS/ORTHOSIS)
☐ Casting done by a prosthetist/orthotist Indicate date of casting: _____
III. FABRICATION
☐ Fabricated prosthesis or orthosis done ☐ Fabricated wheelchair/ seating device done
IV. FITTING
☐ Fitting of prosthesis/orthosis / wheelchair / seating device done Indicate date of fitting: _____

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

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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

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

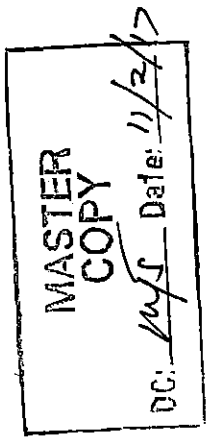
7. In your opinion, by how much has your HCI expenses been lessened by availing of the Z benefit package?
   - ☐ less than half
   - ☐ by half
   - ☐ more than half
   - ☐ don't know

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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Annex "E – Mobility Impairment"

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

Mobility Impairment- Yearly Services and Replacement

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E1- Mobility Impairment)	
2. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
3. Checklist of Mandatory Services for Mobility Impairment (Annex C – Mobility Impairment)	
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 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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Annex "E1 – Mobility Impairment"

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)

Mobility Impairment

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E1- Mobility Impairment)	
2. Photocopy of approved Pre–Authorization Checklist & Request (Annex A- Mobility Impairment)	
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 Services for Mobility Impairment (Tranche 1) (Annex C1 – Mobility Impairment)	
6. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
DATE COMPLETED :	
DATE FILED :	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Rehabilitation 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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Annex "E2 – Mobility Impairment"

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)
Mobility Impairment

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E2- Mobility Impairment)	
2. Completed PhilHealth Claim Form 2 (CF2)	
3. Checklist of Mandatory Service for Mobility Impairment (Tranche 2) (Annex C2 – Mobility Impairment)	
4. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
5. Certificate of completed training on the safe and functional use of devices (photocopy)	
DATE COMPLETED :	
DATE FILED :	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Rehabilitation 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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Annex "E3 – Mobility Impairment"

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 3)
Mobility Impairment

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E3- Mobility Impairment)	
2. Completed PhilHealth Claim Form 2 (CF2)	
3. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
4. Certificate of outcomes after rehabilitation sessions (photocopy)	
DATE COMPLETED :	
DATE FILED :	

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

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

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 (✖) if the same is not available in the HCI.
2. For outsourced services, put an (✖) 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	**Hospital License and Accreditation**					
1.1	The HCI has an updated DOH License to Operate					
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:					
2.1.1	General					
	i. Outpatient consultation for mobility disabilities					
	ii. Physical examination and neurologic examination for mobility					
	iii. Pre- and post-prosthetic evaluation for limb loss and deficiency					
	iv. Provision of prosthesis, orthosis, seating device, and wheelchair					
2.1.2	Rehabilitation Medicine Unit with service areas for:					
	i. Pediatric area for mobility & seating assessment					
	ii. Therapy area for Physical Therapy and Occupational therapy management					
	iii. Prosthetic/orthotic wheelchair and seating devices workshop for casting, fabrication, assembly, fitting & repairs					
	iv. Mobility training area with even/uneven surface, ramp and stairs.					

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	REQUIREMENTS	HCI		PHIC		REMARKS
		Yes	No	Yes	No	
	v. Accessible toilet and bath compliant to BP 344					
	vi. Referral system in place for other rehabilitation needs					
	vii. Patient and caregiver's waiting area					
2.1.3	Diagnostics					
	i. Musculoskeletal x-ray for hip, extremities and spine (or referral for x-ray services)					
	ii. EMGNCV, CT-Scan, MRI (or with existing MOA for referral for these)					
2.1.4	Workshop and Storage Area					
	i. For prosthetic/orthotic workshop for screening, casting, fabrication, assembly, fitting and repairs					
	ii. Wheelchair assembly, modifications, maintenance & repair					
	iii. Storage Area for prosthetic & orthotic wheelchair, seating devices' components, tools, supplies and wheelchairs					
2.1.5	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" especially: i. Ramps ii. Restroom for PWDs					
3	**Equipment and tools**					
3.1	Equipment for Prosthetic and Orthotic Workshop					
	Assessment, Casting and Fitting Tools - Plinth - Basin - Stepping stool - Goniometer - Steel and flexible tape measure - Flexible tape measure - Bandage & tailor scissors - Stump / body calipers - Rulers: 12 inch-ruler + 1 meter steel ruler - Cutter with replaceable blade - Pencil markers/indelible pencils - Cling wrap - Casting tubes - Plaster of Paris rolls/bandage (4 and 6 inches) - Stockings/Cling wrap to be applied on residual limb for casting - Vaseline - Disposable gloves - Disposable masks					

	REQUIREMENTS	HCI		PHIC		REMARKS
		Yes	No	Yes	No	
	Rectification - Metal table with mandrel holder - Sandbox for setting plaster molds - Sink with plaster trap - Plaster of Paris powder with container - Bucket - Heavy duty balloon wisp for mixing plaster - Plaster mixing bowl - Spatula - Staple gun - Surforms for shaping/shaving positive mold (flat, half round, and round) - Wire screen/mesh Sandpaper p240 - Tubes for positive mold					
	Fabrication Equipment and tools - Oven with socket frame - Router - Vacuum Forming Stations (Vacuum Pump & Connection Kit & Enveloping Suction Tubes) - Air Compressor - Dust aspirator and filter - Work benches with bench vise & vise grip - Sewing machine - Hand Drill - Cast cutter - Jigsaw and steel hacksaw - Heat Gun - Anvil - Riveting bar - Soldering iron - Pipe Cutter Heavy Duty for Steel Pipes 1/8" To 2" - Deburring Tool - Ballpen Hammer ½ - 1Lb - Set of metric Allen keys - Rubber Mallet M10 450G - Center/hole punch - Contouring Instruments for orthoses 4-6Mm 7-9mm - Halfround, round & flat files W/ Handle - Protective eyeglass - Ear muffs/ plugs - Thermal gloves - Sanding Cone & Drum					

	REQUIREMENTS	HCI		PHIC		REMARKS
		Yes	No	Yes	No	
	- Pliers - Screwdrivers - Water/bubble Level					
	Consumables - Sanding sleeve with varying grit - Polypropylene/polyethylene plastics - Different foams and sizes (3mm, 6mm, 12mm) - Ethylvinyl acetate - Rugby - Industrial mask - Industrial gloves - Velcros - Webbings/straps - Rivets - Buckles - Stockinettes (cotton and nylon, sizes: 2, 3, 4, 5, 6 inches) - Prosthetic components					
3.2	For wheelchair assessment, prescription, and fitting: Clinical Area					
	Fixed equipment / gadget Low Assessment Bed and Foot blocks (set of 4, surface 400 mm x 300 mm. Heights: Varied from 15-150 mm) Workbench - Therapy Floor Mat - Metal Tape Measure - Goniometers - Privacy screen - Catalogue of sample wheelchairs					
3.3	For Wheelchair assembly, modification, maintenance & repair					
	Set of metric combination spanners (8 mm to 22 mm) Set of imperial combination spanners Long-stem types are best – preferably with a T-bar handle Foam cutting instruments: Hacksaw blade/ kitchen knife/Electric kitchen knife Wrench Long nose Pliers Large scissors Safety glasses Hand wood and metal Saw Flat or Half round File Rubber Mallet Hammer					

	REQUIREMENTS	HCI		PHIC		REMARKS
		Yes	No	Yes	No	
	Screwdrivers (Philips and Flat) Tire Pump Tire Gauge L-square (90°) ruler Spirit/bubble level Electric jigsaw Electric Drill Drill bit for wood & metal Pop riveter Spoke key Contact glue for wood and foam (for intermediate services) 1 sheet each of ¾ inch and 1 inch Marine Plywood (for intermediate services) 10 pcs Blocks of Firm/Chip Foam (for intermediate services) 10 Wedges of Firm/Chip Foam (for intermediate services) 10 webbing buckles that match 1 inch and 2 inches webbing straps (for intermediate services)					
	1 roll each of 1 inch and 2 inches webbing straps (for intermediate services) Metal Brackets (offset and L-brackets) (for intermediate services) Directory of wheelchairs available in the area that conform to the ISO 7176, 16840 standards Catalogue of available cushions in the area Wheelchair Repair Kit (Tire Pump, wrench, tire repair kit)					
4	**Human Resources**					
4.1	Rehabilitation Medicine Specialist who is a Diplomate of the Philippine Board of Rehabilitation Medicine with:					
	i. Valid PRC License					
	ii. PhilHealth Accreditation					
4.2	Occupational Therapist/Physical Therapist					
	Valid PRC License					
4.3	Prosthetist and Orthotist Clinician graduate of a 4-5 year BS Prosthesis & Orthosis course)					
4.4	Prosthetic and Orthotic Non-clinician (Technician)					
4.5	Wheelchair Professional certified by the Philippine Society of Wheelchair Professionals as an Intermediate Wheelchair Assessor and Provider)					
4.6	Wheelchair Technician under supervision of Wheelchair Professional					
4.7	Z-Benefit Coordinator					
4.8	Medical Social Service					
5	**General algorithm of care**					
	Presence of policy adopting the general algorithm of care					

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	REQUIREMENTS	HCI		PHIC		REMARKS
		Yes	No	Yes	No	
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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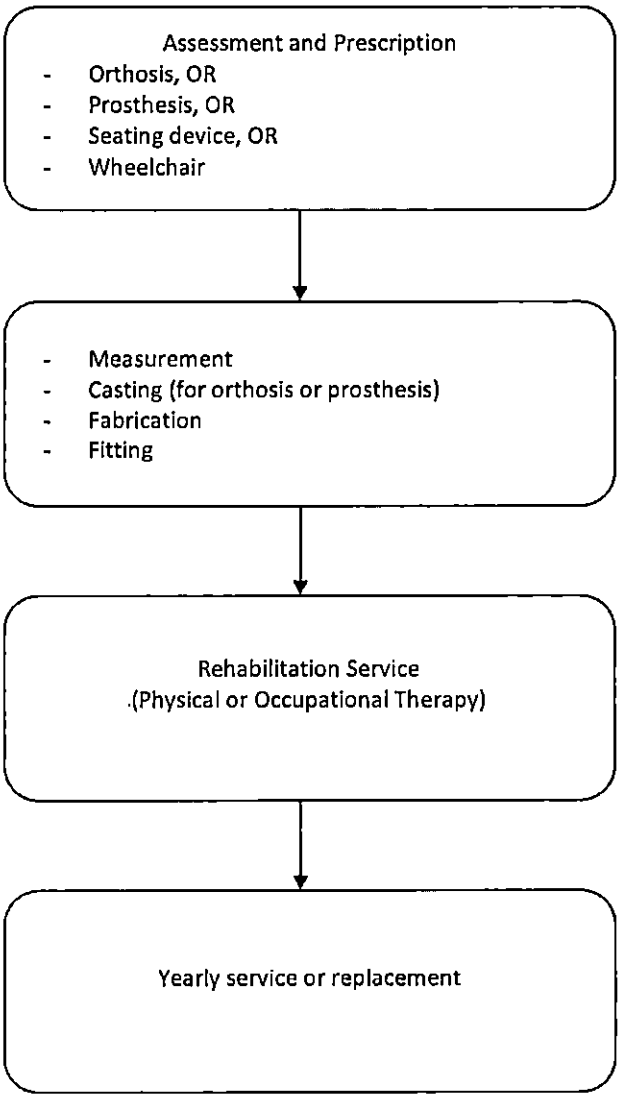
Annex "G – Mobility Impairment"

General Process Flow for the Provision of Care for a Child with Mobility Impairment



Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

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

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
	Designation	Received by Local Health Insurance Office (LHIO)		
Printed Name and Signature	Date signed (mm/dd/yyyy)	Received by the Benefits Administration Section (BAS)		

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SAMPLE CLAIM FORM 2 FOR MOBILITY IMPAIRMENT (TRANCHE 1)

PhilHealth
Your Partner in Health

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
   c. Date Discharged: 1 0 - 1 5 - 2 0 1 7 (month - day - year) d. Time Discharged: : ☐ AM ☐ PM (hour : min)
   OUTPATIENT
4. Patient Disposition: (select only 1)
   ☑ a. Improved ☐ e. Expired, Date: Time: AM PM
   ☐ b. Recovered ☐ f. Transferred/Referred
   ☐ c. Home/Discharged Against Medical Advise
   ☐ d. Absconded
   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 ☐ Blood Transfusion
   ☐ Peritoneal Dialysis ☐ Brachytherapy
   ☐ Radiotherapy (LINAC) ☐ Chemotherapy
   ☐ Radiotherapy (COBALT) ☐ Simple Debridement
   b. *For Z-Benefit Package* Z-Benefit Package Code: Z1804A 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

MASTER COPY Date: 11/2/17 DC: MLS

Date of initial consult/ assessment

Date of completion of measure-ment

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 laterality

Indicate the diagnosis

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.

	Total Actual Charges*
Total Health Care Institution Fees	13,500.00
Total Professional Fees	
Grand Total	13,500.00

Tick this box if patient has NO out of pocket payment

☐ 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				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.)

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

Indicate date signed

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: 1 0 19 2017 month day year

Affix signature of HCI representative

MASTER COPY
DC: _____ Date: 11/2/17

Case No. _____

Annex "J – Mobility Impairment"

Z BENEFITS FOR CHILDREN WITH MOBILITY IMPAIRMENT

PATIENT (Last name, First name, Middle name, Suffix)	BIRTHDAY (mm/dd/yyyy)
ADDRESS	
CONTACT NUMBER	

CERTIFICATE OF COMPLETED TRAINING ON THE SAFE AND FUNCTIONAL USE OF THE DEVICE

This certifies that patient _____, has completed the training on the safe and functional use of the device _____ _____.

Remarks (if any): _____ _____

Conforme by Patient/Parent/Guardian:

_____
Printed name and signature

Certified by:
☐ Attending Medical Specialist
☐ Rehabilitation Therapy Specialist

_____
Printed name and signature

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

MASTER COPY Date: 11/2/17 DC: MS

Z BENEFITS FOR CHILDREN WITH MOBILITY IMPAIRMENT
Attachment to Annex J

IMPORMASYON NG PASYENTE
PATIENT INFORMATION

Petsa ng Kapanganakan (Buwan/Araw/Taon) *Birthday (mm/dd/yyyy)*	Kasarian *Sex* ☐ Lalaki *Male* ☐ Babae *Female*
☐ Prosthetic User ☐ Primary User	☐ Orthotic User ☐ Established User
Pinanggalingan ng Impormasyon: *Source of information:*	☐ Magulang *Parent* ☐ Tagapag-alaga *Guardian*

TALATANUNGAN (QUESTIONNAIRE)

Panuto: Punan ng angkop na impormasyon ang bawat patlang. Lagyan ng tsek (✓) ang kahon na tumutukoy sa inyong opinion ng serbisyo sa klinika. Sumangguni sa kahulugan ng mga sagot sa ibaba.
Direction: Answer the following items by putting check marks (✓) on the box that corresponds to your answer. Refer to the items below for the interpretation of answers.

4: Lubos na Nasisiyahan *(Very Satisfied)*
3: Nasisiyahan *(Satisfied)*
2: Hindi Nasisiyahan *(Dissatisfied)*
1: Lubos na Hindi Nasisiyahan *(Very Dissatisfied)*

Gaano ka nasisiyahan sa mga sumusunod? *How satisfied are you with the following?*	4	3	2	1
I. Prosthesis or Orthosis (Device)				
1. Pagiging komportable ng iyong prosthesis/orthosis tuwing ginagamit ito ng mahabang oras *Comfort of your device when used for a long period of time*				
2. Panlabas na anyo ng iyong prosthesis/orthosis *Visual appearance of your device*				
3. Sukat ng prosthesis/orthosis *Fit of your device*				
4. Pagsuot at pagtanggal ng prosthesis/orthosis *Ease of donning and doffing of your device*				
5. Bigat ng prosthesis/orthosis *Weight of your device*				

Gaano ka nasisiyahan sa mga sumusunod? *How satisfied are you with the following?*	4	3	2	1
II. Serbisyo (Services)				
6. Pakikitungo ng prosthetist/orthotist *Treatment of the Prosthetist/ Orthotist*				
7. Pagpapaliwanag ng prosthetist/orthotist sa mga proseso sa klinika *Explanation of the Prosthetist/ Orthotist about the clinic process*				
8. Pagbibigay ng tagubilin ng prosthetist/orthotist ukol sa paggamit ng prosthesis/orthosis *Instructions provided by Prosthetist/ Orthotist when using prosthesis/ orthosis*				
9. Paggawa ng mga desisyon ng prosthetist/orthotist patungkol sa prosthesis/orthosis *Prosthetist/ Orthotist's decision about my prosthesis/ orthosis*				
10. Pagsasaalang-alang ng prosthesist/orthotist sa inyong mga opinion at desisyon *Prosthetist/ Orthotist's consideration about your own opinions and decisions*				
11. Pakikipag-ugnayan ng prosthetist/orthotist sa ibang mga propesyonal ukol sa inyong serbiyo-medikal? (Doktor, Physical Therapist, Occupational Therapist, etc.) *Prosthesist/ Orthotist's coordination with other healthcare professionals in regards to your treatment plan? (Doctor, Physical Therapist, Occupational Therapist, etc.)*				
12. Pagiging mabait at magalang ng mga tauhan *Courteousness and respectfulness of the staff*				
13. Pagbibigay halaga ng mga tauhan para sa iyong karapatang pang-pribado *Privacy rights provided in the clinic*				
Pasilidad (Facility)				
14. Pasilidad ng klinika *Facilities of the clinic*				
15. Pagkakaroon ng sapat na mga rampa, elevator, at palikuran para sa mga Persons with Disabilities (PWDs) *Availability of ramps, elevators and comfort rooms for Persons with Disabilities (PWDs)*				
16. Kabuuang serbisyong iyong natanggap *Overall service that was provided*				

Karagdagang mga komento o suhestiyon:
Further comments or suggestions:

_____

_____

_____

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

Case No. _____

Annex "K – Mobility Impairment"

Z BENEFITS FOR CHILDREN WITH MOBILITY IMPAIRMENT

PATIENT (Last name, First name, Middle name, Suffix)	AGE
PRECRIBED DEVICE/S (with laterality as applicable	

CERTIFICATE OF OUTCOMES AFTER REHABILITATION SESSIONS

Date of MD Consult	Date of Therapy Sessions		Name & Signature of Patient/ Accompanying Person	Name & Signature of Attending Physician/Therapist
	Physical Therapy	Occupational Therapy		

MASTER COPY Date: 11/2/17
DC: MJS