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PHILHEALTH CIRCULAR
No. 2018-0010

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

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

I. RATIONALE

Visual loss has a significant impact on functionality that affects an individual's entire way of life. The Department of Health implements a national program on the prevention of blindness (Administrative Order No. 179 s. 2004) to address interventions on the health aspect. Prevention of childhood blindness is among the top three program priorities. Republic Act 7610 (Special Protection of Children Against Abuse, Exploitation and Discrimination Act), Republic Act 9262 (Anti-Violence Against Women and their Children Act 2004), and the Family Code of the Philippines define children as those less than 18 years old. The country is also a signatory to the Global Elimination of Avoidable Blindness: Vision 2020, committing to develop within the healthcare system, a sustainable mechanism to provide services that will ensure the best possible vision for all people.

A recent local modeling estimate suggests that 75,000 Filipinos less than 19 years old who have visual impairment could potentially benefit from assistive devices (PFP, 2016 [unpublished]). The figure approximates a projected prevalence of visual impairment done by Cubillan and Olivar-Santos in 2002. Due to the devastating effect of visual loss, early vision assessment among children is very important such that intervention can be provided the soonest time possible. This intervention could increase the chances of children with visual impairment to perform better at school and succeed in life. DOH by policy, regards vision preservation as a poverty alleviation strategy.

There is evidence that timely provision of electronic and non-electronic optical devices can improve reading performance. However, cost can be prohibitive especially among poor children. The need for early intervention among these children is even more pronounced. This will increase the likelihood for them to gain functional independence towards meaningful activities that can help them escape poverty.

The Philippine Health Insurance Corporation 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 the marginalized that are enrolled in the program while ensuring the provision of quality healthcare services. Thus, the benefit package for children with visual impairment is only limited to contracting health care institutions (HCIs) or facilities with visual disabilities specialists.

This Circular describes the benefit package for children with visual disabilities, covering services from assessment, provision of appropriate devices and rehabilitation, such that vision can be preserved and rehabilitated. A previously issued Circular on benefits for children with disability (PhilHealth Circular **2016-032**) provides an overarching guidance in the implementation of this policy.

II. OBJECTIVES

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

III. SCOPE

This Circular shall apply to all HCIs contracted to provide the Z Benefits for children with visual disabilities, and other relevant stakeholders involved in the implementation of the Z Benefits.

IV. DEFINITION OF TERMS

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

B. **Assistive device** - any item/equipment/product that is developed, modified or customized that is used to increase, maintain, or improve the functionality of a child with disabilities. This refers to the white canes, magnifiers, optical aids, and electronic devices allowing screen magnification and audio functions.

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

D. **Lost to follow-up** - means the patient has not come back as advised for immediate next rehabilitation visit or within four (4) weeks from last patient-attended clinic visit. Visiting the clinic for a treatment more than four (4) weeks from advised scheduled rehabilitation visit renders the patient "lost to follow-up".

E. **Low Vision** - refers to a child with an impairment of visual function even after treatment and/or standard refractive correction and has a visual acuity of less than 20/70 to no light perception.

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

G. **Rehabilitation for low vision**- refers to low vision rehabilitation therapy, which include activities which aim to restore and compensate for the loss of functioning in a child with visual disabilities, especially in terms of adapting to their environment, and training of the assistive device.

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

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

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

In this regard, PhilHealth shall initially engage with identified tertiary government HCIs that are training institutions for the provision of specialized multi- and interdisciplinary health care delivery for this Z benefit. The HCI should have specialists who are board certified ophthalmologists. Subsequent contracting of other capable government and private HCIs shall be done to expand benefit utilization and improve implementation efficiency. **PhilHealth Circular 2015-014** provides guidance on the contracting process.

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

The contracted HCI shall 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 low vision shall reflect the following mandatory services (Tables 1-6).

Table 1. Mandatory and other services for the initial assessment and intervention for the Z Benefits for children with Category 1 visual impairment

Mandatory Services	Other services
A. Low vision assessment with treatment plan: Routine tests for vision assessment: 1. Visual acuity testing 2. Retinoscopy/refraction 3. Functional vision assessment B. Appropriate assistive device 1. Optical aid 1: Low power distance, category 1 visual impairment eyeglasses + low power optical device; or 2. Optical aid 2: High power distance, category 1 visual impairment progressive eyeglasses + high optical device C. Referral to a visual disability rehabilitation facility	A. Other tests that may be done in combination with the routine test for vision assessment 1. Visual field testing 2. Contrast sensitivity testing 3. Color vision testing B. Optical aid 3: colored filter, category 1 visual impairment C. Other services for children with visual impairment 1. Assistive device prescription, as indicated, and the corresponding training on the use of the device 2. Training on activities of daily living, as part of rehabilitation 3. Visual skills training, as necessary 4. Environmental adaptation, as part of rehabilitation

Table 2. Mandatory and other services for the initial assessment and intervention for the Z Benefits for children with Categories 2, 3, and 4 visual impairment

Mandatory Services	Other services
A. Routine tests for vision assessment: 1. Visual acuity testing 2. Retinoscopy/refraction 3. Functional vision assessment	A. Other tests that may be done in combination with the routine test for vision assessment 1. Visual field testing 2. Contrast sensitivity testing

Mandatory Services	Other services
B. Appropriate assistive device 1. Optical aid 1: Low power distance, categories 2, 3 and 4 visual impairment eyeglasses + low power optical device; or 2. Optical aid 2: High power distance, categories 2, 3 and 4 visual impairment progressive eyeglasses + high optical device 3. Electronic assistive device C. Referral to a visual disability rehabilitation facility	3. Color vision testing B. Optical aid 3: colored filter, categories 2, 3, and 4 visual impairment C. Other services for children with visual impairment 1. Assistive device prescription, as indicated, and the corresponding training on the use of the device 2. Training on activities of daily living, as part of rehabilitation 3. Visual skills training, as necessary 4. Environmental adaptation, as part of rehabilitation

Table 3. Mandatory and other services for the initial assessment and intervention for the Z Benefits for children with Category 5 visual impairment

Mandatory Services	Other services
A. Routine tests for vision assessment: 1. Visual acuity testing 2. Functional vision assessment B. Appropriate assistive device 1. White cane 2. Electronic assistive device C. Referral to a facility for the blind	A. Other services for children with visual impairment: 1. Assistive device prescription, as indicated, and the corresponding training on the use of the device 2. Training on activities of daily living, as part of rehabilitation 3. Visual skills training, as necessary 4. Environmental adaptation, as part of rehabilitation

Table 4. Mandatory and other services for the yearly diagnostics for Categories 1, 2, 3 and 4 visual impairment after the first year of enrolment

Mandatory Services	Other services
Routine tests for vision assessment: A. Visual acuity testing B. Retinoscopy/refraction C. Functional vision assessment	Other tests that may be done in combination with the routine test for vision assessment A. Visual field testing B. Contrast sensitivity testing C. Color vision testing

Table 5. Mandatory and other services for the yearly diagnostics for Category 5 visual impairment after the first year of enrolment

Mandatory Services	Other services
Follow up consultations	Other tests, as necessary: a. slit lamp biomicroscopy b. funduscopy

Table 6. Mandatory services for the electronic device replacement and for provision of ocular prosthesis

Mandatory Services
Electronic assistive device replacement every 5 years
Ocular prosthesis

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

A. Assessment of patients

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

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

   b. Must fulfill <u>any of</u> the following:

      i. The child must have undergone a visual disabilities assessment from an ophthalmologist where the child was categorized into Category 1, 2, 3, 4, or 5 visual disability and determined to need assistive devices with prescribed appropriate rehabilitation plan.

      ii. Children needing an ocular prosthesis should fulfill <u>any of</u> the following criteria:
         a) The child has an enucleated eye
         b) Other clinical indications determined by ophthalmologists

The categorization of visual disabilities is based on the definitions as shown in Table 7.

Table 7. Categories of visual impairment covered in the benefits

Category of Visual Impairment	Best-corrected Visual Acuity*		Equivalent - For non-verbal
	Worse than	Equal to or better than	
			A normal child can center, steady, and maintain Center – eye captures the stimuli Steady- eye focuses to the target Maintain – eye can track the target (the eye can do the following when it is presented with a stimuli)
Category 1 (Moderate)	20/70	20/200	Can center and steady Center – eye captures the stimuli Steady- eye focuses to the target Does not maintain
Category 2 (Severe)	20/200	20/400	Can only center Does not maintain, nor steady
Category 3 Profound vision loss	Counting fingers at 3 meters or 20/400	Counting fingers at 1 meter or 20/1200	Cannot center, maintain nor steady
	Or visual field of 10 degrees or less		
Category 4 Near total vision loss	Counting fingers at 1 meter of 20/1200	Light perception	Cannot center, maintain, nor steady
Category 5 Total vision loss	No light perception		Total blindness

* Best-corrected Visual Acuity is taken in the better eye and defined as visual acuity taken subsequent to refraction and correction with spectacles.

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

3. These children with visual disabilities must be eligible to avail of PhilHealth benefits at the time of pre-authorization.

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

B. Application for Pre-authorization

1. A 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 HCI 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 (180) calendar days from the date of approval by PhilHealth provided that the child has not turned 18 years of age. All contracted HCIs are responsible for tracking the validity of their approved pre-authorizations. The contracted HCI shall inform PhilHealth in cases when the validity has lapsed. When needed, a new Pre-authorization Checklist and Request may be submitted, if services were not provided at the end of the validity period of the prior request and if the child is still below 18 years old.

4. The member or the dependent should have at least one day remaining from the 45-annual benefit limit prior to submission of the Pre-authorization Checklist and Request. Five days shall be deducted from the 45-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 benefits 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 Member Empowerment Form or 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 parents or guardians/patients to be active participants in health care decision making by being educated and informed of the conditions, 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 visual disability are specified in the following tables:

Table 8. Package code and rates for initial assessment and intervention for the Z benefits for children with visual impairment

Z Code	Description	Rate (PhP)
Z019.1	Initial assessment and intervention (i.e. rehabilitation and training) for Category 1 Visual Impairment	25,920.00
Z019.2	Initial assessment and intervention (i.e. electronic assistive device, rehabilitation and training) for Categories 2, 3, and 4 Visual Impairment	31,920.00
Z019.3	Initial assessment and intervention (i.e. electronic assistive device, rehabilitation and training) for Category 5 Visual Impairment	9,070.00

Table 9. Description for add-on* assistive devices for children with visual disabilities

Z Code	Description	Rate (PhP)
Z019.41 OR	Optical Aid 1: Low Power Distance, Categories 1, 2, 3, and 4 visual impairment eyeglasses + low power optical device	7,350.00
Z019.42 WITH OR WITHOUT	Optical Aid 2: High Power Distance, categories 1, 2, 3, and 4 visual impairment progressive eyeglasses + high optical device	13,820.00
Z019.43	Optical Aid 3: Colored Filter, categories 1, 2, 3, and 4 visual impairment	2,940.00
Z019.44	White cane, category 5 visual impairment	1,000.00

*These add-on assistive devices are availed of on top of the benefits for initial assessment and intervention for the Z Benefits for visual disabilities in Table 8.

Table 10. Description for yearly diagnostics, after the first year of enrolment of children with visual disabilities

Z Code	Description	Rate (PhP)
Z019.5	Yearly diagnostics for Categories 1, 2, 3 and 4	3,220.00
Z019.6	Yearly follow-up consultation for Category 5	780.00

Table 11. Description for other benefits for children with visual disabilities

Z Code	Description	Rate (PhP)
Z019.7	Electronic aid replacement done every 5 years	6,000.00
Z019.8	Ocular prosthesis**	20,250.00

Ocular prosthesis may be availed of exclusively or with any of the benefits for visual disabilities if the child fulfills the inclusion criteria stated in **Item VII.A.1.c.

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

3. In cases where sedation is required to facilitate assessments, tests and other services done prior to the pre-authorization of the patient, all medicines, supplies and professional fees related to sedation are inclusive in the benefit package.

4. There shall be no out-of-pocket expenses for availment of the Z Benefits for visual disabilities for all member categories of PhilHealth, except for upgrades 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 HCIs.

5. 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 visual disabilities facility.

6. Rules on pooling of professional fees in government hospitals shall apply.

D. Claims Filing and Reimbursement

1. After receipt of the approved Pre-authorization Checklist and Request by the contracted HCI, the contracted HCI can only file a claim for reimbursement upon rendering all mandatory services specified in Section VI, Tables 1 to 6 of this Circular, within the context of a multi- and interdisciplinary approach to patient care.

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

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

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

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

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

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

e. Properly accomplished PhilHealth CF2 for all tranches;

f. Checklist of Mandatory Services for the corresponding tranches;

g. Corresponding Checklist of Requirements for Reimbursements; and

h. Photocopy of the accomplished Z Satisfaction Questionnaire;

i. Photocopy of Authenticity card.

Table 12. Summary of forms to be utilized in claims filing and reimbursement for Category 1

Benefit package	Forms Required
I. CATEGORY 1	
A. INITIAL ASSESSMENT AND INTERVENTION	
Tranche 1: Initial assessment	a. Checklist of Requirements for Reimbursement (Annex E) b. Photocopy of Pre-authorization Checklist and Request (Annex A) c. ME Form (Annex B) d. PhilHealth Benefit Eligibility Form or equivalent (e.g. PhilHealth CF 1) e. PhilHealth CF 2 f. Checklist of Mandatory Services (Annex C1.1) g. Photocopy of Z Satisfaction Questionnaire (Annex D) h. Photocopy of Authenticity card
Tranche 2: Appropriate assistive device (add-on)	a. Checklist of Requirements for Reimbursement (Annex E) b. PhilHealth CF 2 c. Checklist of Mandatory Services (Annex C2.1) d. Proof of device use e. Photocopy of Z Satisfaction Questionnaire (Annex D)
Tranche 3: Other services including training and rehabilitation	a. Checklist of Requirements for Reimbursement (Annex E) b. PhilHealth Claim Form 2 c. Certificate of Completed Training and Rehabilitation Sessions, as applicable (Annex J) d. Photocopy of Z Satisfaction Questionnaire (Annex D)
B. YEARLY DIAGNOSTICS	
Yearly diagnostics	a. Checklist of Requirements for Reimbursement (Annex E) b. PhilHealth Benefit Eligibility Form or equivalent (e.g. PhilHealth Claim Form 1) c. PhilHealth CF 2 d. Checklist of Mandatory Services (Annex C.3) e. Photocopy of Z Satisfaction Questionnaire (Annex D)

Table 13. Summary of forms to be utilized in claims filing and reimbursement for Categories 2, 3, and 4

Benefit package	Forms Required
II. CATEGORIES 2, 3 and 4	
A. INITIAL ASSESSMENT AND INTERVENTION	
Tranche 1: Initial assessment	a. Checklist of Requirements for Reimbursement (Annex E) b. Photocopy of Pre-authorization Checklist and Request (Annex A) c. ME Form (Annex B) d. PhilHealth Benefit Eligibility Form or equivalent (e.g. PhilHealth CF 1) e. PhilHealth CF 2 f. Checklist of Mandatory Services (Annex C1.2) g. Photocopy Z Satisfaction Questionnaire (Annex D) h. Photocopy of Authenticity card
Tranche 2: Appropriate assistive device (add-on)	a. Checklist of Requirements for Reimbursement (Annex A) b. PhilHealth CF 2 c. Checklist of Mandatory Services (Annex C2.2) d. Proof of device use e. Photocopy of Z Satisfaction Questionnaire (Annex D)
Tranche 3: Other services including training and rehabilitation	a. Checklist of Requirements for Reimbursement (Annex E) b. PhilHealth Claim Form 2 c. Certificate of Completed Training and Rehabilitation Sessions, as applicable (Annex J) d. Photocopy of Z Satisfaction Questionnaire (Annex D)
B. YEARLY DIAGNOSTICS	
Yearly diagnostics	a. Checklist of Requirements for Reimbursement (Annex E) b. PhilHealth Benefit Eligibility Form or equivalent (e.g. PhilHealth Claim Form 1) c. PhilHealth CF 2 d. Checklist of Mandatory Services (Annex C.3) e. Photocopy of Z Satisfaction Questionnaire (Annex D)
C. ELECTRONIC ASSISTIVE DEVICE REPLACEMENT	
Replacement of electronic assistive device	a. Checklist of Requirements for Reimbursement (Annex E) b. PhilHealth Benefit Eligibility Form or equivalent (e.g. PhilHealth CF 1) c. PhilHealth CF 2 d. Checklist of Mandatory Services (Annex C.4) e. Photocopy of Z Satisfaction Questionnaire (Annex D)

Table 14. Summary of forms to be utilized in claims filing and reimbursement for Category 5

Benefit package	Forms Required
III. CATEGORY 5	
A. INITIAL ASSESSMENT AND INTERVENTION	
Tranche 1: Initial assessment	a. Checklist of Requirements for Reimbursement (Annex E) b. Photocopy of Pre-authorization Checklist and Request (Annex A) c. ME Form (Annex B) d. PhilHealth Benefit Eligibility Form or equivalent (e.g. PhilHealth CF 1) e. PhilHealth CF 2 f. Checklist of Mandatory Services (Annex C1.3) g. Photocopy of Z Satisfaction Questionnaire (Annex D) h. Photocopy of Authenticity card
Tranche 2: Appropriate assistive device (add-on)	a. Checklist of Requirements for Reimbursement (Annex E) b. PhilHealth CF 2 c. Checklist of Mandatory Services (Annex C2.3) d. Proof of device use e. Photocopy of Z Satisfaction Questionnaire (Annex D)
Tranche 3: Other services including training and rehabilitation	a. Checklist of Requirements for Reimbursement (Annex E) b. PhilHealth Claim Form 2 c. Certificate of Completed Training and Rehabilitation Sessions, as applicable (Annex J) d. Photocopy of Z Satisfaction Questionnaire (Annex D)
B. YEARLY FOLLOW UP CONSULTATIONS	
Yearly follow-up	a. Checklist of Requirements for Reimbursement b. PhilHealth Benefit Eligibility Form or equivalent (e.g. PhilHealth Claim Form 1) c. PhilHealth CF 2 d. Checklist of Mandatory Services (Annex C.3) e. Photocopy of Z Satisfaction Questionnaire (Annex D)
C. ELECTRONIC ASSISTIVE DEVICE REPLACEMENT	
Replacement of electronic assistive device	a. Checklist of Requirements for Reimbursement b. PhilHealth Benefit Eligibility Form or equivalent (e.g. PhilHealth CF 1) c. PhilHealth CF 2 d. Checklist of Mandatory Services (Annex C.4) e. Photocopy of Z Satisfaction Questionnaire (Annex D)

3. Rules on late filing shall apply;

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

5. There shall be no direct filing of claims by members;

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

7. Terms of claims payment described in PhilHealth Circular 2015-035 Section X applies.

8. The description of services, tranche payment, amount, schedule of filing of tranches and the frequency of availment of the benefit packages for children with visual disabilities are described in the following tables (Tables 13 to 17):

Table 13. Description of service, tranche payment, amount, filing schedule and maximum availment for the Z Benefits for children with visual disabilities

Description	Tranche	Code	Amount (PhP)	Filing Schedule	Maximum Availment
Initial assessment, appropriate assistive device and referral to a visual rehabilitation facility (Category 1)	1	Z019.11	3,570.00	Within 60 calendar days after initial assessment	Once upon enrolment
	2	(Refer to table 15)	Will be based on the rate of the assistive device provided (reference: Table 9)	Within 60 calendar days after provision of the device	Once upon enrolment
	Four tranches (as needed)	Z019.13 Z019.14 Z019.15 Z019.16	745.00 x no. of sessions	Within 60 days after the last session completed every three months	Maximum of 30 sessions within one year after enrolment

Description	Tranche	Code	Amount (PhP)	Filing Schedule	Maximum Availment
Initial assessment, appropriate assistive device including electronic device and referral to a visual rehabilitation facility (Categories 2, 3, and 4)	1	Z019.21	9,570.00	Within 60 calendar days after initial assessment	Once upon enrolment
	2	(Refer to table 15)	Will be based on the rate of the assistive device provided (reference: Table 9)	Within 60 calendar days after provision of the device	Once upon enrolment
	Four tranches (as needed)	Z019.23 Z019.24 Z019.25 Z019.26	745.00 x no. of sessions	Within 60 days after the last session completed every 3 months	Maximum of 30 sessions within one year after enrolment
Initial assessment, appropriate assistive device including electronic device and referral to a facility for the blind (Category 5)	1	Z019.31	8,070.00	Within 60 calendar days after initial assessment	Once upon enrolment
	2	(Refer to Table 15)	1,000.00 (reference: Table 9)	Within 60 calendar days after provision of the device	Once upon enrolment
	3	Z019.33 Z019.34	1,000.00 (computed as 500.00 x two consultations)	Within 60 days after the last consultation	Once within one year after enrolment

Table 14. Yearly diagnostics/follow-up consultations, tranche amount, filing schedule and maximum availment for the Z Benefits for children with visual impairment

Description	Tranche	Code	Amount (PhP)	Filing Schedule	Maximum Availment
For categories 1, 2, 3, and 4	Four tranches (as needed)	Z019.51 Z019.52 Z019.53 Z019.54	805.00 / set x number of sets completed every three months	Within thirty (30) days of provision of service	Maximum of four sets a year
For category 5 Includes: Visual Acuity Testing	Two tranches (as needed)	Z019.61 Z019.62	390.00 x number of tests completed for the year	Within thirty (30) days of provision of service	Maximum of two sets a year

Table 15. Description of visual disabilities assistive device, tranche amount, filing schedule and maximum availment for the Z Benefits for children with visual impairment (Categories 1, 2, 3 and 4)

Description	Code	Amount	Filing Schedule	Maximum Availment
<u>For Categories 1, 2, 3 and 4</u> Optical aid: Low Power OR	Z019.412	7,350.00	Within thirty (30) days of provision of service	Replacement every two years as necessary
Optical aid: High Power	Z019.422	13, 820.00	Within thirty (30) days of provision of service	Replacement every two years as necessary
WITH OR WITHOUT Optical aid: Filter	Z019.432	2,940.00	Within thirty (30) days of provision of service	Once
<u>For Category 5</u> White cane	Z019.442	1,000.00	Within thirty (30) days of provision of service	Earliest issuance at 5 years old, and next issuance at least 5 years after, up to 2 issuances

Table 16. Description of service, tranche amount, filing schedule and maximum availment for the replacement of electronic assistive device

Description	Code	Amount	Filing Schedule	Maximum Availment
<u>Only for Categories 2, 3, 4, and 5</u> Electronic assistive device replacement	Z019.7	6,000.00	Within thirty (30) days of provision of service	At least every 3 years from enrolment

Table 17. Description of service, tranche amount, filing schedule and maximum availment for the Z Benefits for children needing an ocular prosthesis

Description	Code	Amount	Filing Schedule	Maximum Availment
Ocular prosthesis	Z019.8	20,250.00 per eye	Within thirty (30) days of provision of service	One time availment per eye

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

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

VIII. MONITORING AND POLICY REVIEW

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 ZBITS.

Field monitoring of service provision by contracted HCI shall also be conducted. It shall follow the guidelines, 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 caregivers as active participants in health care decision making. **PhilHealth Circular 2015-035 Section XIII** specifies guidance to this end.

X. REPEALING CLAUSE

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

XI. EFFECTIVITY

This Circular shall take effect after fifteen (15) days of complete publication in a newspaper of general circulation and shall 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 of Requirements for Reimbursement
F. HCI Standards as Providers for Children with Visual Disabilities
G. General process flow for the provision of care for a child with visual disability
H. Transmittal Form for the Z Benefits
I. Sample CF2
J. Certificate of completed training and rehabilitation session

DR. CELESTINA MA. JUDE P. DE LA SERNA
Interim/OIC President and CEO

Date signed: 7/27/18

MASTER COPY
DC: Date: 7/10/18

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

Case No. _____

Annex "A – Visual Disabilities"

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (answer only 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 VISUAL DISABILITIES

Place a (✓) in the status column if yes or NA if not applicable

	General Qualifications	Status
1.	The child's chronological age is 0 to 17 years and 364 days old (required for all)	
2.	The child must have undergone a visual disabilities assessment from an ophthalmologist where the child was categorized into Category 1, 2, 3, 4, or 5 visual disability and determined to need assistive devices with prescribed appropriate rehabilitation plan Child's best-corrected visual acuity in the better eye (please tick one): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	
3.	The child needs an ocular prosthesis. Please tick corresponding box: ☐ The child has an enucleated eye ☐ Other clinical indications determined by ophthalmologists specify: _____	

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Conforme by Patient/Parent/Guardian:

_____
Printed name and signature

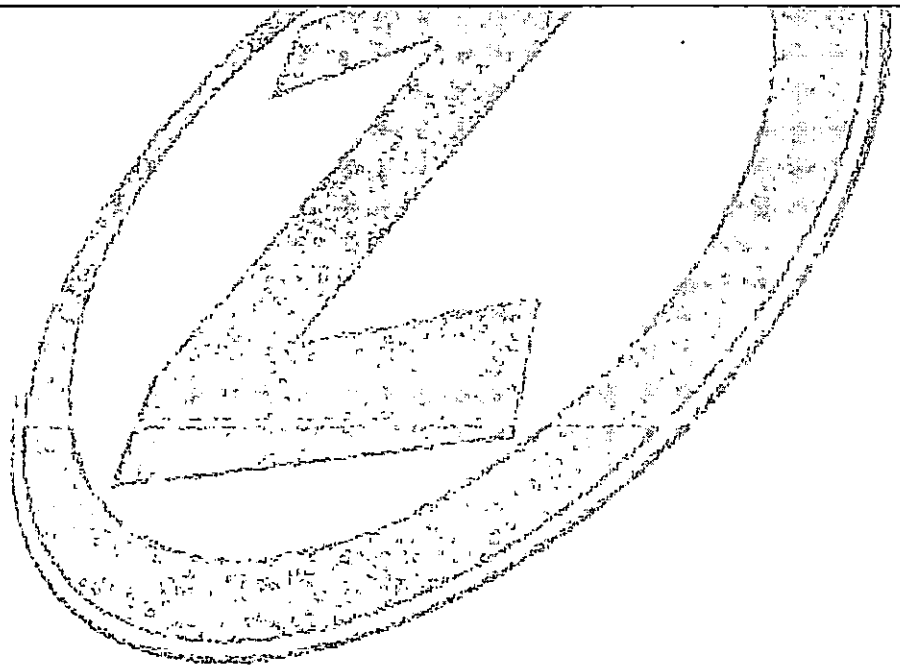
Attested by Attending Ophthalmologist

_____
Printed name and signature

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

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

There is no need to attach assessment/diagnostic 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 VISUAL DISABILITIES

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 Ophthalmologist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No.	PhilHealth Accreditation No.

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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)

INITIAL APPLICATION		
Activity	**Initial**	**Date**
Received by LHIO/BAS:		
Endorsed to BAS (if received by LHIO):		
☐ Approved ☐ Disapproved		
Released to HCI:		
This pre-authorization is valid for one hundred eighty (180) calendar days from date of approval of request.		

COMPLIANCE TO REQUIREMENTS		
☐ APPROVED ☐ DISAPPROVED (State reason/s)		
Activity	**Initial**	**Date**
Received by BAS:		
☐ 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/yyy)*	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*

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

Lagyan ng tsek (√) ang angkop na sagot o NA kung hindi nauukol *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 1.1 – Visual Disabilities"

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

INITIAL ASSESSMENT

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (answer only 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

LOW VISION ASSESSMENT	
MANDATORY SERVICES	**OTHER SERVICES, AS NEEDED**
Routine tests: Visual acuity testing Retinoscopy/refraction Functional vision Assessment	Other tests that may be done in combination with the routine tests: Visual field testing Contrast sensitivity testing Color vision testing

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

MASTER COPY Date: 5/10/18
DC:

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Case No. _____

Annex "C2.1 – Visual Disabilities"

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

APPROPRIATE ASSISTIVE DEVICE

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (answer only 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	OTHER SERVICES, AS NEEDED
Any one of the following: Optical aid 1: Low power distance, category 1 visual impairment eyeglasses + low power optical device; or Optical aid 2: High power distance, category 1 visual impairment progressive eyeglasses + high optical device	Optical aid 3: colored filter, category 1 visual impairment Ocular prosthesis

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Ophthalmologist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	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 "C.3 – Visual Disabilities"

CHECKLIST OF MANDATORY SERVICES
Z BENEFITS FOR VISUAL DISABILITIES, CATEGORIES 1, 2, 3, 4 and 5

YEARLY DIAGNOSTICS/FOLLOW UP CONSULTATION

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (answer only 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	OTHER SERVICES, AS NEEDED
For Categories 1, 2, 3 and 4	
Routine tests: Visual acuity testing Retinoscopy/refraction Functional vision Assessment	Other tests that may be done in combination with the routine tests: Visual field testing Contrast sensitivity testing Color vision testing
For Category 5	
Follow up consultations	Other tests, as necessary Slit lamp biomicroscopy Fundoscopy

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

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

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Case No. _____

Annex "C1.2 – Visual Disabilities"

CHECKLIST OF MANDATORY SERVICES
Z BENEFITS FOR VISUAL DISABILITIES, CATEGORIES 2, 3 and 4

INITIAL ASSESSMENT

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (answer only 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

LOW VISION ASSESSMENT	
MANDATORY SERVICES	**OTHER SERVICES, AS NEEDED**
Routine tests: Visual acuity testing Retinoscopy/refraction Functional vision Assessment	Other tests that may be done in combination with the routine tests: Visual field testing Contrast sensitivity testing Color vision testing

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Ophthalmologist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	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 "C2.2 – Visual Disabilities"

CHECKLIST OF MANDATORY SERVICES
Z BENEFITS FOR VISUAL DISABILITIES, CATEGORIES 2, 3 and 4

APPROPRIATE ASSISTIVE DEVICE

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (answer only 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	OTHER SERVICES, AS NEEDED
Any one of the following: Optical aid 1: Low power distance, category 2,3 and 4 visual impairment eyeglasses + low power optical device; or Optical aid 2: High power distance, category 2, 3 and 4 visual impairment progressive eyeglasses + high optical device Electronic assistive device Description: _____ _____	Optical aid 3: colored filter, category 2, 3 and 4 visual impairment Ocular prosthesis

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Ophthalmologist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐–☐☐☐☐☐☐☐–☐	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 "C.4 – Visual Disabilities"

CHECKLIST OF MANDATORY SERVICES
Z BENEFITS FOR VISUAL DISABILITIES, CATEGORIES 2, 3 and 4

ELECTRONIC AID REPLACEMENT

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (answer only 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 SERVICE
Electronic aid replaced Description_____ _____

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Ophthalmologist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐–☐☐☐☐☐☐☐–☐	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 "C2.3 – Visual Disabilities"

CHECKLIST OF MANDATORY SERVICES
Z BENEFITS FOR VISUAL DISABILITIES, CATEGORY 5

APPROPRIATE ASSISTIVE DEVICE

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐ - ☐
MEMBER (answer only 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
☐ White cane ☐ Electronic Assistive Device

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

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

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

3. Sex of respondent
   - ☐ male
   - ☐ female

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

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

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

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

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

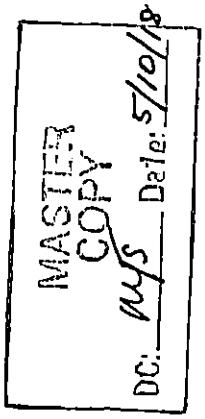
8. Overall patient satisfaction (PS mark) is:
   - ☐ excellent
   - ☐ satisfactory
   - ☐ unsatisfactory
   - ☐ don't know

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

   _____

   _____

   _____



Thank you. Your feedback is important to us!

_____

Signature of Patient/ Parent/ Guardian

Date accomplished: _____

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Case No. _____

Annex "E1.1 – Visual Disability"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 1)
Visual Disability, Category 1

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E1.1)	
2. Photocopy of approved Pre–Authorization Checklist & Request (Annex A)	
3. Photocopy of completely accomplished ME FORM (Annex B)	
4. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)	
5. PhilHealth Claim Form2 (CF2)	
6. Checklist of Mandatory Service for Visual Disabilities (Tranche 1) (Annex C1.1)	
7. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
8. Photocopy of Authenticity card	
DATE COMPLETED :	
DATE FILED :	

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

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

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Case No. _____

Annex "E2.1 – Visual Disability"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2)
Visual Disability, Category 1

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E2.1)	
2. PhilHealth Claim Form2 (CF2)	
3. Checklist of Mandatory Service for Visual Disabilities (Tranche 2) (Annex C2.1)	
4. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
5. Proof of device use	
DATE COMPLETED :	
DATE FILED :	

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

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

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Case No. _____

Annex "E3.1 – Visual Disability"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 3)
Visual Disability, Category 1

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E3.1)	
2. PhilHealth Claim Form2 (CF2)	
3. Certificate of Completed Training and Rehabilitation sessions, as applicable (Annex J)	
4. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
DATE COMPLETED :	
DATE FILED :	

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

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

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Case No. _____

Annex "E.4– Visual Disability"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT

Visual Disability, Yearly Diagnostics or Follow up Consultations

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E.4)	
2. PhilHealth Benefit Eligibility Form or equivalent or Claim Form1	
3. PhilHealth Claim Form2 (CF2)	
4. Checklist of Mandatory Service (Annex C.3)	
5. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
DATE COMPLETED :	
DATE FILED :	

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

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

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Case No. _____

Annex "E1.2 – Visual Disability"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 1)

Visual Disability –Categories 2, 3, and 4

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E1.2)	
2. Photocopy of approved Pre–Authorization Checklist & Request (Annex A)	
3. Photocopy of completely accomplished ME FORM (Annex B)	
4. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)	
5. PhilHealth Claim Form 2	
6. Checklist of Mandatory Service for Visual Disabilities (Tranche 1) (Annex C1.2)	
7. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
8. Photocopy of Authenticity Card	
DATE COMPLETED :	
DATE FILED :	

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

MASTER COPY Date: 5/10/18

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Annex "E2.2 – Visual Disability"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2)

Visual Disability, Categories 2, 3, and 4

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E2.2)	
2. PhilHealth Claim Form2 (CF2)	
3. Checklist of Mandatory Service for Visual Disabilities (Tranche 2) (Annex C2.2)	
4. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
5. Proof of device use	
DATE COMPLETED :	
DATE FILED :	

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

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

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Case No. _____

Annex "E3.2– Visual Disability"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 3)
Visual Disability, Categories 2, 3 and 4

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E3.2)	
2. PhilHealth Claim Form2 (CF2)	
3. Certificate of Completed Training and Rehabilitation sessions, as applicable (Annex J)	
4. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
DATE COMPLETED :	
DATE FILED :	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Ophthalmologist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐–☐☐☐☐☐☐–☐	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 "E1.3 – Visual Disability"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 1)
Visual Disability –Category 5

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

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Ophthalmologist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐–☐☐☐☐☐☐☐–☐	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 "E2.3 – Visual Disability"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2)
Visual Disability, Category 5

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E2.3)	
2. PhilHealth Claim Form2 (CF2)	
3. Checklist of Mandatory Service for Visual Disabilities (Tranche 2) (Annex C2.3)	
4. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
5. Proof of device use	
DATE COMPLETED :	
DATE FILED :	

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

MASTER COPY Date: 5/10/18 DC: mjs

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Case No. _____

Annex "E3.3 – Visual Disability"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 3)
Visual Disability, Category 5

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E3.3)	
2. PhilHealth Claim Form2 (CF2)	
3. Certificate of Completed Training and Rehabilitation sessions, as applicable (Annex J)	
4. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
DATE COMPLETED :	
DATE FILED :	

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

MASTER COPY Date: 5/10/18 DC: 14/S

Annex "F – Visual Disabilities"

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

Name of HCI: _____

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

Directions for the HCI:

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

	REQUIREMENTS	HCI		PHIC		REMARKS
		Yes	No	Yes	No	
1	**Hospital License and Accreditation**					
1.1	The HCI has an updated DOH License					
1.2	The HCI has an updated PhilHealth Accreditation					
2	**Minimum Service Capability**					
2.1	Mandatory Services as stated in PhilHealth Circular _____ OR with formal referral process to a licensed referral facility:					
2.1.2	Low Vision Assessment or Diagnostics					
	i. Visual acuity testing					
	ii. Visual field testing					
	iii. Contrast sensitivity testing					
	iv. Color vision testing					
	v. Retinoscopy/refraction					
	vi. Functional vision assessment					
2.1.3	Provision of optical aids for low vision					
	i. Hand held magnifiers					
	ii. Dome magnifiers					
	iii. Stand magnifiers					
	iv. Hand-held monocular telescopes					
	v. Spectacle magnifiers					
	vi. Specialized process lenses (includes spectacles, contact lenses and/ or telescope)					

	REQUIREMENTS		HCI		PHIC		REMARKS
			Yes	No	Yes	No	
	vii.	Frames					
	viii.	Electronic devices for low vision					
	ix.	Access to mobile applications for low vision					
	x.	White canes					
	xi.	Ocular prosthesis					
2.1.4	Low Vision Rehabilitation Unit that would provide a rehabilitation plan consisting of, but not limited to:						
	i.	Assistive device prescription when required and training					
	ii.	Environmental adaptation (e.g. visual and tactile cues)					
	iii.	Visual skills training as necessary (e.g. visual training modules)					
	iv.	Training on activities of daily living (e.g. kitchen, bathroom, dining and communication)					
	v.	Orientation and mobility training					
3	**Equipment**						
	i.	Visual field test					
	ii.	Indirect ophthalmoscope (portable)					
	iii.	Ophthalmoscope (portable, detached)					
	iv.	Retinoscope (portable, detached)					
	v.	Tonometer (portable)					
	vi.	Slit lamp (portable)					
	vii.	Keratometer (portable)					
	viii.	Lensometer					
	ix.	Pupillary Distance (PD) meter					
	x.	Test for depth perception (e.g. stereo fly)					
	xi.	Prism bar					
	xii.	Loose prisms					
	xiii.	Lenses: 20D, 28D and 40D					
	xiv.	Visual acuity charts (e.g. LEA screening kit					
	xv.	Contrast sensitivity chart					
	xvi.	Color vision chart					
	xvii.	Functional vision assessment tools					
4	**Human Resources**						
4.1	Ophthalmologist or optometrist with Low Vision Training						

Annex "F – Visual Disabilities"

	REQUIREMENTS	HCI		PHIC		REMARKS
		Yes	No	Yes	No	
4.2	Trained personnel on low vision rehabilitation					
4.3	Medical social worker					
4.4	Z- Benefit Coordinator					
5	**General algorithm of care**					
	Presence of policy adopting the general algorithm of care					
6	**Z Benefit Program Implementation**					
6.1	Full awareness of the PhilHealth Z benefit program including No Balance Billing (NBB) and maximum co- payments					
6.2	Action plan/ commitment of the HCI to abide with the NBB policy					
6.3	Conduct advocacy programs/seminars at least annually					
6.4	Submit report on patient outcomes, and other statistical reports					
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

Figure 1: General Process Flow for the Provision of Care for a Child with Visual Disabilities (Category 1)

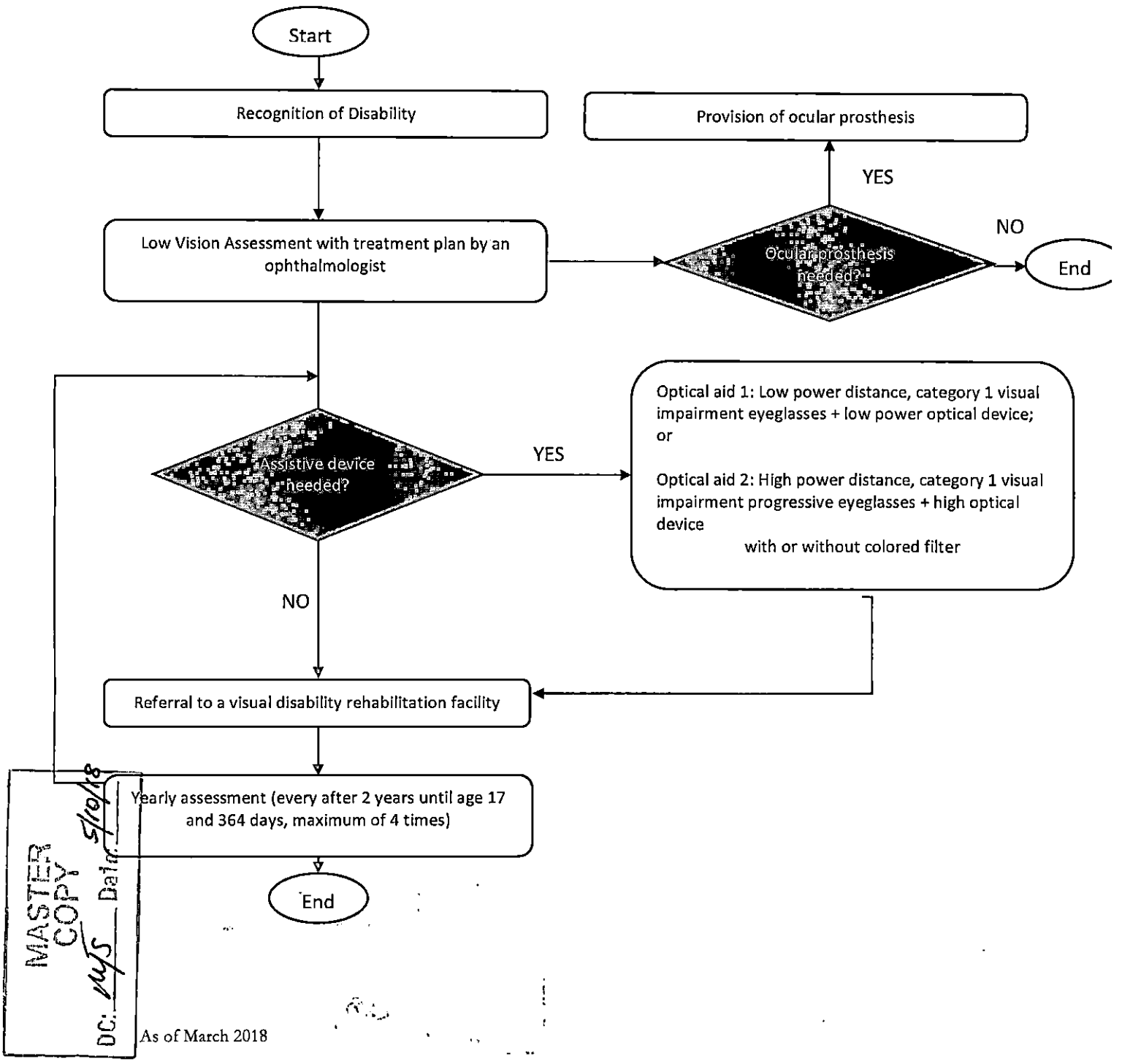
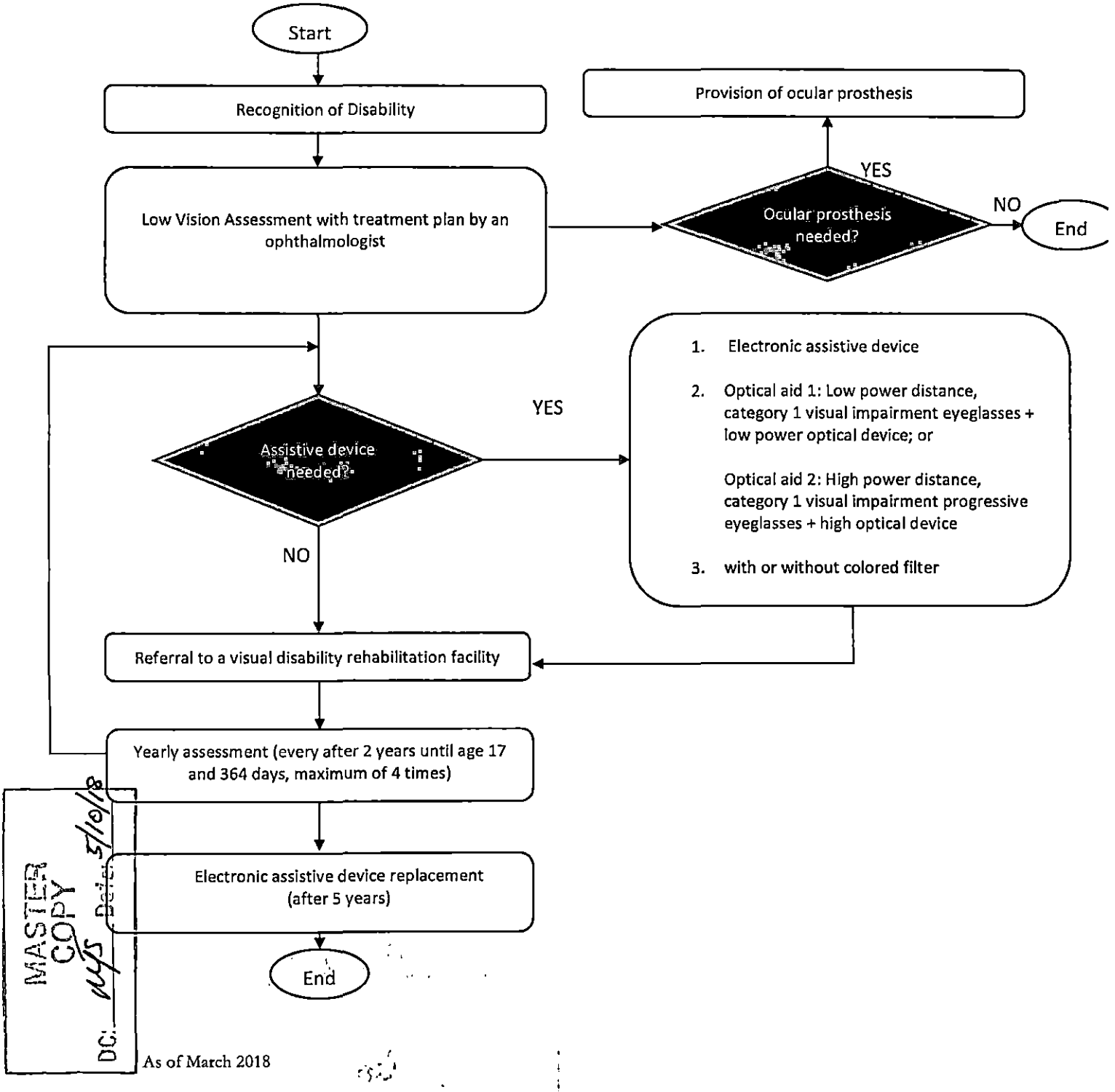
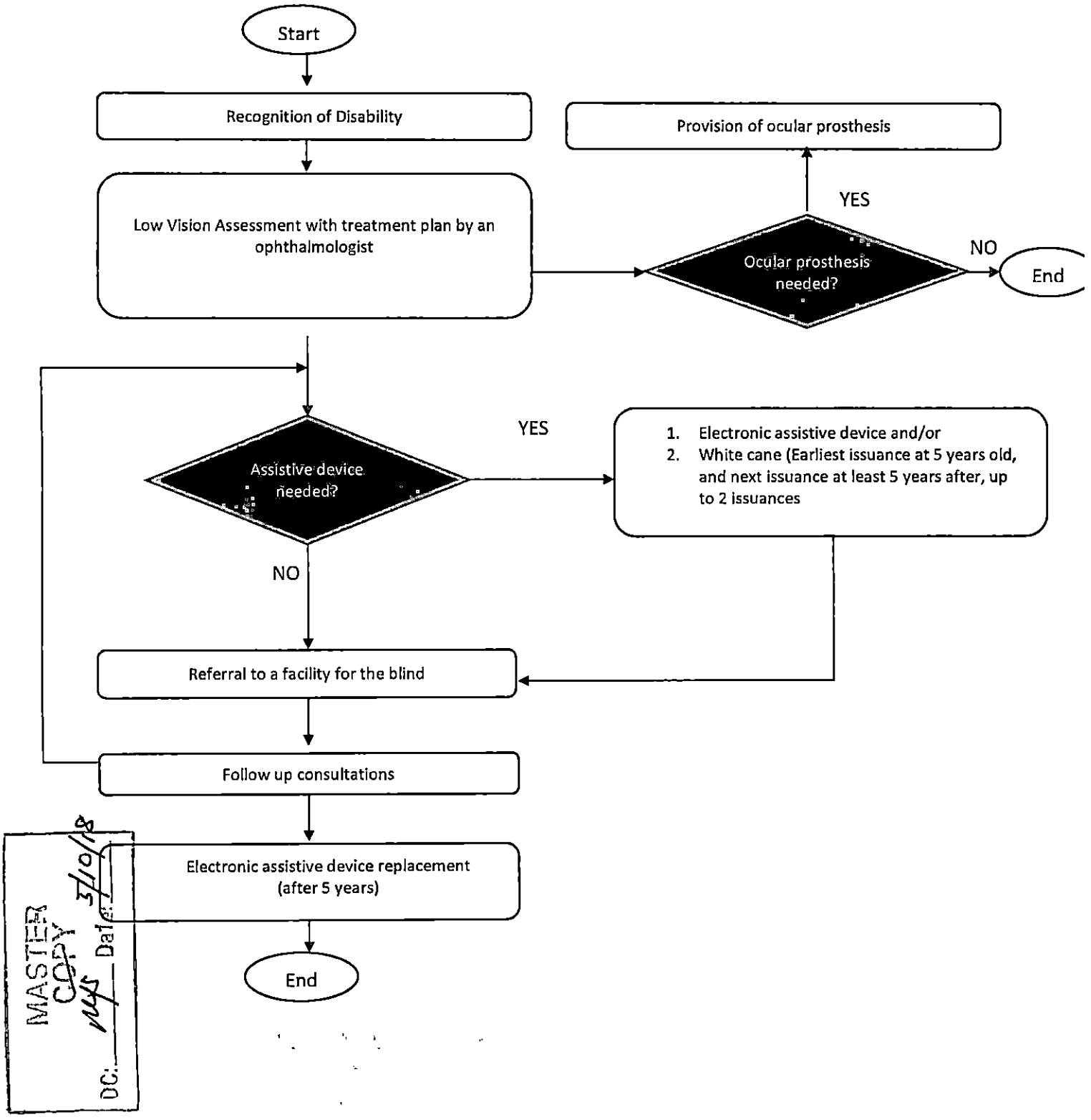


Figure 2: General Process Flow for the Provision of Care for a Child with Visual Disabilities (Category 2, 3, 4)



As of March 2018

Figure 3: General Process Flow for the Provision of Care for a Child with Visual Disabilities (Category 5)



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Annex "H"

TRANSMITTAL FORM OF CLAIMS FOR THE Z BENEFITS

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

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

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

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

MASTER COPY Date: 5/10/18 DC: MJS

SAMPLE CLAIM FORM 2 FOR VISUAL DISABILITIES (TRANCHE 1)

PhilHealth
Your Partner In Health

This form may be reproduced and is NOT FOR SALE

CF2
(Claim Form 2)
revised November 2013

Series #

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

PART I - HEALTH CARE INSTITUTION (HCI) INFORMATION

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

PART II - PATIENT CONFINEMENT INFORMATION

1. Name of Patient: DELA CRUZ (Last Name) JUAN (First Name) JR. (Name Extension (JR/SR/III)) MASIPAG (Middle Name) (example: DELA CRUZ JUAN JR SIPAG)
2. Was patient referred by another Health Care Institution (HCI)? ☑ NO ☐ YES
   Name of Referring Health Care Institution | Building Number and Street Name | City/Municipality | Province | Zip Code
3. Confinement Period: a. Date Admitted: 10 (month) 01 (day) 2017 (year) b. Time Admitted: ( ) : ( ) ☐ AM ☐ PM (hour / min)
   c. Date Discharged: 10 (month) 01 (day) 2017 (year) d. Time Discharged: ( ) : ( ) ☐ AM ☐ PM (hour / min)
4. Patient Disposition: (select only 1)
   ☑ a. Improved
   ☐ b. Recovered
   ☐ c. Home/Discharged Against Medical Advise
   ☐ d. Absconded
   ☐ e. Expired, Date: ( ) (month) ( ) (day) ( ) (year) Time: ( ) (hour) : ( ) (min) ☐ AM ☐ PM
   ☐ f. Transferred/Referred
   Name of Referral Health Care Institution
   Building Number and Street Name | City/Municipality | Province | Zip Code
   Reason/s for referral/transfer:
5. Type of Accommodation: ☐ Private ☐ Non-Private (Charity/Service)
6. Admission Diagnosis/es:

Indicate the diagnosis of the child

7. Discharge Diagnosis/es (Use additional CF2 if necessary):

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

8. Special Considerations:
   a. *For the following repetitive procedures, check box that applies and enumerate the procedure/session dates [mm-dd-yyyy]. For chemotherapy, see guidelines.*
   ☐ Hemodialysis ☐ Peritoneal Dialysis ☐ Radiotherapy (LINAC) ☐ Radiotherapy (COBALT) ☐ Blood Transfusion ☐ Brachytherapy ☐ Chemotherapy ☐ Simple Debridement
   b. *For Z-Benefit Package* Z-Benefit Package Code: Z019.1 Tranche 1
   c. *For MCP Package (enumerate four dates [mm-dd-yyyy] of pre-natal check-ups)*
   1 ____ 2 ____ 3 ____ 4 ____
   d. *For TB DOTS Package* ☐ Intensive Phase ☐ Maintenance Phase
   e. *For Animal Bite Package (write the dates [mm-dd-yyyy] when the following doses of vaccine were given)* NOTE: Anti Rabies Vaccine (ARV), Rabies Immunoglobulin (RIG)
   Day 0 ARV ____ Day 3 ARV ____ Day 7 ARV ____ RIG ____ Others (Specify) ____
   f. *For Newborn Care Package* ☐ Essential Newborn Care ☐ Newborn Hearing Screening Test ☐ Newborn Screening Test For Newborn Screening, *please attach NBS Filter Sticker here*
   For Essential Newborn Care, (check applicable boxes)
   ☐ Immediate drying of newborn ☐ Timely cord clamping ☐ Weighing of the newborn ☐ BCG vaccination ☐ Hepatitis B vaccination
   ☐ Early skin-to-skin contact ☐ Eye prophylaxis ☐ Vitamin K administration ☐ Non-separation of mother/baby for early breastfeeding initiation
   g. *For Outpatient HIV/AIDS Treatment Package* Laboratory Number: ____
9. PhilHealth Benefits
   ICD 10 or RVS Code: a. First Case Rate ____ b. Second Case Rate ____

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Date of initial consult/ assessment

Date of completion of assessment

Write OUTPATIENT in lieu of time admitted & discharged

Tick YES if the patient was referred by another HCI

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

Indicate the 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	25,920.00
Total Professional Fees	
Grand Total	25,920.00

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)*

MASTER COPY Date: 9/10/18

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 2 0 1 7 (month day year)

Affix signature of HCI representative

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Case No. _____

Annex "J – Visual Disabilities"

Z BENEFITS FOR CHILDREN WITH VISUAL DISABILITIES

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

CERTIFICATE OF COMPLETED TRAINING AND REHABILITATION SESSIONS

This certifies that patient _____, has completed the following training and rehabilitation for children with visual disabilities as needed:

- Training on the use of the device
- Training on activities of daily living
- Visual skills training
- Environmental adaptation
- Others, specify_____

Remarks (if any): _____

_____

MASTER COPY Date: 5/10/18 DC: 445

Conforme by Patient/Parent/Guardian:

_____
Printed name and signature

Certified by:

_____
Printed name and signature
Attending therapist