Republic of the Philippines
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UNIVERSAL HEALTH CARE

PHILHEALTH CIRCULAR
No. 0019 - 0019

TO : **ALL CONTRACTED HEALTH *FACILITIES* FOR THE *EXPANDED ZMORPH* AND ALL OTHERS CONCERNED**

SUBJECT : **Expanded Z *Benefits* for Mobility, Orthosis, Rehabilitation, Prosthesis Help (Expanded ZMORPH) *(Revision 1)***

I. RATIONALE

The Philippine Health Insurance Corporation *(PhilHealth)* recognizes the potential towards functional independence and productivity of persons with disabilities *(PWDs)*, particularly those with spinal or limb loss, deficiency or deformity once they are provided with affordable prostheses or orthoses.

Aligned with the mission of Republic Act 7277 or Magna Carta for Disabled Persons, PhilHealth therefore seeks to mainstream *PWDs* into the community by ensuring functionality through integration of prosthetic and orthotic devices provision with rehabilitation services.

Cognizant of the United Nations Convention on the Rights of Persons with Disabilities vision of full and equal enjoyment of PWDs' human rights, PhilHealth shall ensure the protection of their inherent dignity by ensuring provision of prosthetic and orthotic devices which are safe, appropriate, accessible, and of quality.

Supportive of the Department of Health Administrative Order 2015-0004 (Revised National Policy on Strengthening the Health and Wellness Program for PWDs) that aims to remove barriers to health care access, PhilHealth expands scope of assistive technology from below the knee prosthesis to all levels of limb loss or deficiency and limb or spinal deformity with integrated rehabilitation services.

Pursuant to PhilHealth Board Resolution No. 2124 s. 2016, the ZMORPH shall be expanded to include benefits for prostheses, orthoprostheses and orthoses.

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II. *OBJECTIVES*

This PhilHealth Circular aims to define the policies and procedures for implementing the Z Benefits package for Expanded ZMORPH and ensure quality service delivery by contracted health facilities (HF).

III. *SCOPE*

This PhilHealth Circular shall apply to all contracted HFs to deliver the defined mandatory services for the Z Benefits Package for Expanded ZMORPH and other relevant stakeholders involved in its implementation.

IV. *DEFINITION OF TERMS*

A. Assistive Device – *any device designed, made, and adapted to help an individual perform tasks. For this benefits package, an assistive device refers to an appropriately measured, fabricated, and fitted prosthesis, orthosis, orthoprosthesis, or spinal orthosis that aims to improve the individual's activity, functioning, and social participation.*

B. Co-Payment – *a pre-determined amount agreed upon by the contracted health facility and PhilHealth that will be charged to patients as their share for amenities, or any additional or upgrade of services per cycle of care of the Z Benefits beyond the covered services. Co-payments shall have a fixed limit or cap not to exceed the corresponding rate of the Z Benefits package. The contracts of the health facilities should stipulate the amount of co-payment.*

C. Contracted Health Facility (HF) – *a PhilHealth-accredited health facility that enters into a contract with PhilHealth for the provision of specialized care.*

D. Lost to Follow Up – *a term used to characterize a patient who has not returned to or followed up at a health facility as advised. The specific definition varies across the Z benefit packages. In the context of the Expanded ZMORPH, "lost to follow up" means the patient has not come back as advised for the immediate next rehabilitation treatment visit or within two (2) weeks after giving the prosthetic/orthotic prescription. As such, visiting the clinic for rehabilitation services more than two weeks from the advised scheduled treatment visit renders the patient "lost to follow up."*

E. Member Empowerment (ME) Form – *a document showing that the patient is fully informed of their Z Benefits package, treatment options, schedule of treatment and follow-up visits, roles, and responsibilities. The ME Form also documents that the contracted health facility provided education, counseling, and other pertinent courses of action. The beneficiary or their guardian or representative and the attending healthcare provider in charge jointly sign the ME form.*

F. Pre-Authorization – *an approval process of PhilHealth that gives the contracted HF the information that the patient fits the definition for the minimum selection criteria for the availment of the Z Benefits.*

V. *POLICY STATEMENTS*

A. PhilHealth shall cover all services in the benefits package for Expanded ZMORPH for cases that fulfill the selection criteria.

B. Contracted HFs shall be responsible for developing an efficient process for patient assessment to ensure that PhilHealth members can fully access the needed services in the Expanded ZMORPH benefits package.

C. Contracted HFs shall submit a properly accomplished pre-authorization checklist and request form (Annexes A.1 to A.3) for approval by PhilHealth before providing services. A designated

liaison of the contracted HF shall submit the original copy of the accomplished pre-authorization form to the Local Health Insurance Office (LHIO) or the PhilHealth Regional Office.

D. The approved pre-authorization checklist and request (Annex A) shall be valid for 180 calendar days from the date of approval by PhilHealth. All contracted *HFs* are responsible for tracking the validity of all approved pre-authorization. *Therefore,* contracted *HFs should* inform PhilHealth and submit a new pre-authorization checklist and request if the validity period of the prior request *has already lapsed to ensure the timely provision of services to PhilHealth members.*

E. While the *original copy of the* pre-authorization *checklist and* request is submitted manually, *it shall be submitted with the photocopy and* properly accomplished Member Empowerment Form or ME Form (Annex B). *The documents may also be scanned and emailed to the respective PROs for approval. In addition, PhilHealth will generate a unique case number for every pre-authorization request submitted once the pre-authorization system is developed and fully functioning.*

F. The ME Form shall be accomplished together by the attending health care professional/s in the contracted *HFs* and the patient *for enrolment* in the Expanded ZMORPH. The ME Form aims to support patients to be active participants in health care *decision-making* by being educated and informed of the conditions *and* management options. Further, the ME Form *encourages* the attending health care professionals in the contracted *HFs* to dedicate adequate time to discuss with patients to achieve better health outcomes and patient satisfaction.

G. PhilHealth members and their qualified dependents must be eligible to avail of PhilHealth benefits at the time of pre-authorization *approval.*

The eligibility of the member is determined by the contracted HF upon application for pre-authorization of the patient availing of this benefits package.

H. The minimum standards of care for Expanded ZMORPH cover the entire management from pre-prosthetic /orthotic assessment up to the conduct of rehabilitation or occupational therapy sessions. These are based on current standards of practice and may be updated depending on valid medical evidence applicable to the local setting. *Updates in standards of care are discussed* during regular policy reviews in collaboration with pertinent stakeholders.

I. The *mandatory services* for the Expanded ZMORPH are the *minimum standards of care covered by PhilHealth that contracted HFs must provide to all PhilHealth members enrolled under the Z benefits.*

J. The Reference and contracted HFs for Expanded ZMORPH shall be required to coordinate and collaborate for quality improvement and operational purposes, such as training, patient audits, referrals, monitoring, education, patient empowerment, procurement of implants, medicines, supplies, or other similar initiatives.

K. The contracted HF should thoroughly discuss the co-payment with the patient during the administration of the ME form to inform them of any additional charges covering the share for any extra or upgrade of services not covered by the Z Benefits package.

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L. *There will be no co-payment for the provision of services for the standard materials indicated in the Z Benefits for Expanded ZMORPH for upper and lower limb prostheses, lower limb orthosis, and spinal orthosis. However, co-pay shall apply for the upgrade of prosthetic materials, additional prosthetic components, or extra services not covered by the Z Benefits, which the HFs' contracts specify.*

M. *The maximum allowable co-payment should not exceed the package rate for the Expanded ZMORPH.*

N. *The contracted HF shall file all claims for the Expanded ZMORPH* according to the schedules set by PhilHealth.

O. *The contracted HF shall file claims within 60 calendar days from the last day of the covered period specified in the tranche schedules in Table 3, "Mode of payment and filing schedule for Expanded ZMORPH."*

P. All mandatory and other services specific to the Expanded ZMORPH, *which* ensure the safety and *the materials* used, shall be provided to the patient according to the approved standards the *contracted* reference *HF sets.*

Q. *PhilHealth will reimburse the contracted HFs within 60 days from the indicated filing date in the claims application forms.*

R. *The Expanded ZMORPH allots 10% of the package rate as professional fees for services rendered by medical and allied health professionals.*

S. All rates are inclusive of government taxes.

T. In cases when the patient expires or is lost to follow-up *anytime during service provision, PhilHealth will only reimburse the corresponding tranche for the specific phase as long as the patient received the scheduled services. After that, however, PhilHealth will not pay the subsequent tranches.*

1. *Suppose the* patient has not come back within *four (4)* weeks after the agreed follow up *visit* after casting and measurement or after fitting and alignment *but* would require additional re-casting and measurement: *In that case,* the patient may *still access* the succeeding *schedule of* services for the Z Benefits. *However,* the *contracted HF* may collect additional fees for casting and measurement, *which the patient will share as out-of-pocket.*

2. *A* patient will only be allowed a maximum of one *fiscal* year to avail of the Z benefits from casting to rehabilitation services.

U. Contracted *HF* shall submit to PhilHealth a sworn declaration that a patient is expired or lost to follow up when filing *a* claim for *a* specific treatment phase.

V. *Contracted HFs should monitor in the next six (6) months their enrolled patients for the Expanded ZMORPH for return to productivity or community reintegration as an outcome. In addition, contracted HFs should properly document patients lost to follow-up and provide the appropriate study and analysis in the context of quality healthcare.*

W. Contracted *HFs shall be required to designate at least one (1) Z Benefits Coordinator for the Expanded ZMORPH following the current guiding principles of the Z Benefits.*

X. *Pertinent provisions in PhilHealth Circular 2021-0022 "Guiding Principles of the Z Benefits (Revision 1), including annexes, apply to this benefits package.*

Y. Criteria for Inclusion, Minimum Standards of Care for Expanded ZMORPH

The overall package code for the Z *Benefits* for Expanded ZMORPH is Z015. The following are the corresponding descriptions, selection criteria, frequency, and *package* rates:

1. Upper and Lower Limb Prostheses
   a. Age ≥ 18 years old
   b. At least three *(3)* months post-amputation, if acquired
   c. Wheelchair-independent, community-ambulator with or without crutches, cane or walker
   d. On physical examination: no fresh or non-healing wound, neuroma or painful residual limb, no motor strength of <4/5 and limitation of motion of upper and/or lower limbs, no incoordination or poor balance

2. Lower limb orthosis
   The following are the general criteria:
   a. At least three *(3)* months post-onset
   b. Upper limbs ≥ 4 with fair trunk control and full range of motion, if bilateral
   c. Unaffected limbs ≥ 3 with fair trunk control and *a* full range of motion, if unilateral
   d. Ambulatory with *an* assistive device
   e. No fresh or non-healing wound

   The following are the additional criteria for the specified sub-packages:

   2.1. Ankle foot orthoses
      2.1.1. Weakness or absence of dorsiflexors *and/*or plantarflexors, +/- grade 1-2 spasticity with full range of motion achieved passively
      2.1.2. Equinovarus +/- foot rotation and +/- grade 1-2 spasticity with full range of motion achieved passively
      2.1.3. Pain & Instability secondary to *a* sensory or structural deficit in a Charcot Arthropathy

   2.2. Knee ankle foot orthoses

      Quadriceps MMT of <3 +/- sensory loss, +/- instability (genu recurvatum) with hip/knee flexion contracture <20 degrees

   2.3. Hip knee ankle foot orthoses

      Hip, knee, ankle & foot muscles MMT <3 +/- sensory loss, +/- instability, with hip /knee flexion contracture <20 degrees

3. Spinal orthosis
The following are the general criteria:
   a. Age ≥ 18 years old
   b. Upon diagnosis *and/* or post-operative clearance
   c. No sensory deficit over body segment of application
   d. Upper and lower limb manual muscle strength of ≥ 3

The following are the additional criteria for the specified sub-package:

3.1. Thoracolumbosacral custom molded spinal orthosis
   3.1.1. Thoracolumbar (T12-L2) spinal fractures involving posterior elements
   3.1.2. Primary or metastatic lesions to the thoracolumbosacral spine

3.2. Lumbosacral custom molded spinal orthosis
The following are the additional criteria for the specified sub-package:
   3.2.1. Lumbosacral fractures (L1-L3)
   3.2.2. Primary or metastatic lesions to the lumbosacral spine

3.3. Cervicothoracic custom molded spinal orthosis
The following are the additional criteria for the specified sub-package:
   3.3.1. Cervical spine fractures (C3-C7) without neurologic deficit
   3.3.2. Torticollis
   3.3.3. Metastatic lesions without neurologic deficit

Z. Package Code and Rates

The following are the package codes and corresponding rates per laterality:

Description	Package Code			Package Rate (Php) per laterality
	Right	Left	Both	
I. Prosthesis[a]				
A. Above knee/ knee disarticulation (AKKD)	Z0151A	Z0151B	Z0151C	75,000.00
B. Hip disarticulation (HD)	Z0152A	Z0152B	Z0152C	135,000.00
C. Below elbow (BE)	Z0153A	Z0153B	Z0153C	50,000.00
D. Above elbow (AE)	Z0154A	Z0154B	*Z0154C*	70,000.00
E. Van Ness Rotationplasty	Z0155A	Z0155B	Z0155C	85,000.00
II. Ortho/prostheses[b]				
A. Ankle foot	Z0156A	Z0156B	Z0156C	17,500.00
III. Orthoses[b]				
A. Knee ankle foot	Z0157A	Z0157B	Z0157C	35,000.00
B. Hip knee ankle foot	Z0158A	Z0158B	Z0158C	80,000.00

Table 1: Package Codes and Rates for Expanded ZMORPH- Prostheses/Orthoprostheses

[a] For cases involving more than one amputation, the patient is not allowed to claim two prostheses simultaneously with the same laterality in either the upper

(i.e. BE, AE) or in the lower (AKKD, HD) limb. To illustrate this, please refer to Table *4*.

[b] For cases involving more than one amputation, the patient is not allowed to claim two orthoses simultaneously with the same laterality.

Description	Package Code	Package Rate (Php)
Spinal		
A. Thoracolumbosacral	Z0159	40,000.00
B. Lumbosacral	Z01510	30,000.00
C. Cervicothoracic	Z01511	45,000.00

Table 2: Package Codes and Rates for Expanded ZMORPH- Spinal Orthoses

AA. *Mandatory services or the* minimum standards of care *covered by the Expanded ZMORPH*

1. Pre-prosthetic /orthotic assessment by a board-certified physician of the Philippine Board of Rehabilitation Medicine;
2. *Prosthesis measurement, fabrication, and fitting by* a *graduate of a Bachelor of Science in Prosthetics and Orthotics Course or higher;*
3. Post-prosthetic/orthotic fitting prescription for six *(6)* physical therapy or occupational therapy sessions by board-certified physician of the Philippine Board of Rehabilitation Medicine;
4. *Provision* of six *(6)* physical therapy or occupational therapy sessions by *Profession Regulation Commission* (PRC)-licensed physical therapist or occupational therapist; *and*
5. Final discharge disposition by a board-certified physician of the Philippine Board of Rehabilitation Medicine.

BB. Filing Schedule *and Tranche Payment*

The payment for Expanded ZMORPH shall be given in tranches with the corresponding amounts and filing schedule with the allowed frequency of availment as follows:

Description	Tranche	Amount (Php)	Filing Schedule	Frequency
I. Prosthesis				
A. Above knee/ knee disarticulation	1	65,000.00	Within 60 calendar *days* after Prosthetic /Orthotic fabrication *and* check-out by *a graduate of a Bachelor of Science in Prosthetics and Orthotics course or higher*	Every *five* (5) years; maximum of *two* (2) in a lifetime
	2	10,000.00	Within 60 calendar days after the last	

Description	Tranche	Amount (Php)	Filing Schedule	Frequency
			physical therapy or occupational therapy session	
B. Hip disarticulation	1	120,000.00	Within 60 calendar *days* after Prosthetic /Orthotic fabrication *and* check-out by *a graduate of a Bachelor of Science in Prosthetics and Orthotics course or higher*	Every 5 years; maximum of 2 in a lifetime
	2	15,000.00	Within 60 calendar days after the last physical therapy or occupational therapy sessions	
C. Below elbow	1	40,000.00	Within 60 calendar *days* after Prosthetic /Orthotic fabrication *and* check-out by *a graduate of a Bachelor of Science in Prosthetics and Orthotics course or higher*	Every 5 years; maximum of 2 in a lifetime
	2	10,000.00	Within 60 calendar days after the last physical therapy or occupational therapy session	
D. Above elbow	1	60,000.00	Within 60 calendar *days* after Prosthetic /Orthotic fabrication *and* check-out by *a graduate of a Bachelor of Science in Prosthetics and Orthotics course or higher*	Every 5 years; maximum of 2 in a lifetime
	2	10,000.00	Within 60 calendar days after the last physical therapy or occupational therapy session	
E. Van Ness Rotationplasty	1	71,000.00	Within 60 calendar *days* after Prosthetic	Every 5 years;

Description	Tranche	Amount (Php)	Filing Schedule	Frequency
			/Orthotic fabrication *and* check-out by *a graduate of a Bachelor of Science in Prosthetics and Orthotics course or higher*	maximum of 2 in a lifetime
	2	14,000.00	Within 60 calendar days after the last physical therapy or occupational therapy session	
II. Ortho/ prostheses				
A. Ankle Foot	1	13,000.00	Within 60 calendar *days* after Prosthetic /Orthotic fabrication *and* check-out by *a graduate of a Bachelor of Science in Prosthetics and Orthotics course or higher*	Every 5 years; maximum of 2 in a lifetime
	2	4,500.00	Within 60 calendar days after the last physical therapy or occupational therapy session	
III. Orthoses				
A. Knee ankle foot	1	28,000.00	Within 60 calendar *days* after Prosthetic /Orthotic fabrication *and* check-out by *a graduate of a Bachelor of Science in Prosthetics and Orthotics course or higher*	Two in a lifetime
	2	7,000.00	Within 60 calendar days after the last physical therapy or occupational therapy session	
B. Hip Knee Ankle Foot	1	70,000.00	Within 60 calendar *days* after Prosthetic /Orthotic fabrication *and* check-out by *a graduate of a Bachelor of*	Two in a lifetime

Description	Tranche	Amount (Php)	Filing Schedule	Frequency
			Science in Prosthetics and Orthotics course or higher	
	2	10,000. 00	Within 60 calendar days after the last physical therapy or occupational therapy session	
IV. Spinal				
A. Thoracolumbo-sacral	1	32,000.00	Within 60 calendar *days* after Prosthetic /Orthotic fabrication *and* check-out by *a graduate of a Bachelor of Science in Prosthetics and Orthotics course or higher*	Two in a lifetime
	2	8,000.00	Within 60 calendar days after the last physical therapy or occupational therapy session	
B. Lumbosacral	1	22,000. 00	Within 60 calendar *days* after Prosthetic /Orthotic fabrication *and* check-out by *a graduate of a Bachelor of Science in Prosthetics and Orthotics course or higher*	Once in a lifetime
	2	8,000.00	Within 60 calendar days after the last physical therapy or occupational therapy session	
C. Cervico-thoracic	1	*37,000.00*	Within 60 calendar *days* after Prosthetic /Orthotic fabrication *and* check-out by *a graduate of a Bachelor of Science in Prosthetics and Orthotics course or higher*	Once in a lifetime
	2	8,000.00	Within 60 calendar days after the last	

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Description	Tranche	Amount (Php)	Filing Schedule	Frequency
			physical therapy or occupational therapy session	

Table 3: Mode of Payment and Filing Schedule for Expanded ZMORPH

CC. Claims Filing & Reimbursement

1. The contracted *HFs* shall file claims according to *the* existing policies of PhilHealth.

2. All claims shall be filed by the contracted *HFs on* behalf of the patients. There shall be no direct filing by members.

3. The contracted *HFs* shall submit a claim application per completed tranche.

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

Example	Decision	Explanation
(Left) AKKD and (Left) HD	Deny	Same laterality in the same level of amputation (lower level). This will involve the same prostheses in the lower limb.
(Left) AKKD and (Left) BE	Pay	Same laterality but different levels of amputation (AKKD at the lower level and BE at the upper level). Patient is ambulatory with assistive device.
(Left) AKKD and (Left) AE	Pay	Same laterality but different levels of amputation (AKKD at the lower level and AE at the upper level). Patient is ambulatory with assistive device.
(Left) AKKD and (Right) HD	Pay	Different laterality.
(Left) BE and (Left) AE	Deny	Same laterality in the same level of amputation (lower level). This will involve the same prostheses in the upper limb.

Table 4: Examples of Cases Involving Two Levels of Amputations

5. For the initial *claims* application (i.e., tranche 1), the following *documents* shall be attached:

   a. Transmittal Form (Annex H) of all claims for *the* Expanded ZMORPH for submission to PhilHealth, per claim or per batch of claims;

   b. Photocopy of the approved Pre-authorization Checklist and Request *while the claims submission is not yet automated;*

   c. *Photocopy* of the properly accomplished ME Form;

d. PhilHealth Benefit Eligibility Form (PBEF) *shall be the primary proof of benefit eligibility* during the pre-authorization *process.*

A PBEF *with a "Yes" indication is sufficient to mean that the patient is eligible. Submission of other documents, such as Member Data Record (MDR) and PhilHealth Claim Form 1 (CF1) shall no longer be required;*

A "No" indication on the PBEF should prompt the contracted HF to coordinate with the PhilHealth CARES assigned in their facility to validate the eligibility of the patient, or present a proof of contributions or duly accomplished CF1.

e. Properly accomplished Claim Form 2 *(CF2)*

f. Original or certified true copy (CTC) of the Statement of account (SOA);

g. Discharge Checklist of Services (Annex C) for the corresponding tranches;

h. Photocopy of completely accomplished Z Satisfaction Questionnaire *for services received in Tranche 1* (Annex D); *and*

i. Tranche Requirements Checklist (Annex E).

6. For succeeding claims, the Transmittal Form, *CF2*, the Discharge Checklist Services (Annex C), Photocopy of Z Satisfaction Questionnaire (Annex D) *for services received in succeeding tranches,* and the Tranche Requirements Checklist for the Z Benefits (Annex E) shall be submitted.

7. The Z Satisfaction Questionnaire (Annex D) shall be administered to all Z patients prior to final discharge disposition from the contracted *HF.* These are validated during field monitoring by PhilHealth and shall be used as the basis of the Corporation for benefits enhancement, policy research, and quality improvement purposes.

8. Rules on late filing shall apply.

9. If the delay in the filing of claims is due to natural calamities or other fortuitous events, the current guidelines of PhilHealth on the provision of special privileges to those affected by fortuitous events shall apply;

10. There shall be no direct filing of claims by PhilHealth members.

DD. Monitoring

1. Utilization and Compliance

Monitoring of the implementation of the Z benefits package for Expanded ZMORPH shall be conducted by PhilHealth.

Field monitoring of service provision by contracted HFs may be conducted. It shall follow the guidance, tools, and consent forms provided in the guiding principles of the Z Benefits.

The performance indicators and measures to monitor compliance with the policies of this Circular shall be established in collaboration with relevant stakeholders and experts. These shall be incorporated into the relevant monitoring policies of PhilHealth.

2. Policy Review

PhilHealth will conduct a regular policy review of this benefit package. The Benefits Development and Research Department (BDRD) of the Health Finance Policy Sector (HFPS) of the Corporation, in collaboration with all relevant stakeholders, experts, and representatives from the PhilHealth Regional Offices (PROs), shall take the lead in the policy review process. The review results shall guide policy decisions regarding future benefits enhancements and rate adjustments.

EE. Marketing and Promotion

PhilHealth shall educate the general public, increase awareness of the Z Benefits, and promote informed decision-making among patients, and participation of healthcare professionals, health facilities, and other stakeholders following the integrated marketing and communication plan of PhilHealth.

FF. Annexes

The following annexes may be downloaded from the PhilHealth website: www.philhealth.gov.ph

1. *Annex A: Pre-authorization Checklist and Request*
   a. *Annex A.1: EMORPH Pre-Authorization Checklist: Upper and Lower Limb Prosthesis*
   b. *Annex A.2: EMORPH Pre-Authorization Checklist: Lower Limb Orthosis*
   c. *Annex A.3: EMORPH Pre-Authorization Checklist: Spinal Orthosis*

2. *Annex B: Member Empowerment Form*

3. *Annex C: Discharge Checklist for Expanded ZMORPH*
   a. *Annex C.1: EMORPH Discharge Checklist (Tranche 1)*
      a.1. Annex C.1.1: EMORPH Discharge Checklist: Lower Limb Prosthesis
      a.2. Annex C.1.2: EMORPH Discharge Checklist: Upper Limb Prosthesis
      a.3. Annex C.1.3: EMORPH Discharge Checklist: Lower Limb Orthosis
   b. *Annex C.2: EMORPH Discharge Checklist (Tranche 2)*

4. *Annex D: Z Satisfaction Questionnaire*

5. *Annex E: Checklist of Requirements for Reimbursement*
   a. Annex E.1: Tranche 1 Requirements for Reimbursement
   b. Annex E.2: Tranche 2 Requirements for Reimbursement

6. *Annex F: Self-assessment/Survey Tool for the Z Benefits Package for ZMORPH and Expanded ZMORPH Providers*

7. *Annex G: Outcome Indicators for ZMORPH and Expanded ZMORPH*

8. *Annex H: Transmittal Form of Claims for the Z Benefits*

VI. *PENALTY CLAUSE*

Any violations of this PhilHealth Circular shall be dealt with and penalized in accordance with the pertinent provisions of RA No. 11223, other relevant laws, and R.A. No. 7875, as amended by RA Nos. 9241 and 10606, and their respective Implementing Rules and Regulations.

VII. *TRANSITORY CLAUSE*

Upon publication of this PhilHealth Circular, PhilHealth shall disseminate this information to contracted HFs, and ensure the availability of revised forms on the website and deployment of necessary IT enhancements in the claims system.

VIII. *SEPARABILITY CLAUSE*

In the event that a part or provision of this PhilHealth Circular is declared unconstitutional or rendered invalid by any Court of Law or competent authority, those provisions not affected by such declaration shall remain valid and effective.

IX. *REPEALING CLAUSE*

This policy repeals PhilHealth Circular No. 2016-0033 entitled Expanded Z Benefit for Mobility, Orthosis, Rehabilitation, Prosthesis Help Package (Expanded ZMORPH).

X. *DATE OF EFFECTIVITY*

This PhilHealth Circular shall take effect fifteen (15) days after its publication in the Official Gazette or in any newspaper of general circulation. A copy shall thereafter be deposited to the Office of the National Administrative Register (ONAR) at the University of the Philippines Law Center.

ATTY. ELI DINO D. SANTOS
Officer-in-Charge, Office of the President and CEO

Date signed: 10/13/22

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Annex A.1: EMORPH Pre-Authorization Checklist: Upper and Lower Limb Prosthesis

Revised as of September 2022

Republic of the Philippines
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UNIVERSAL HEALTH CARE

Case No. _____

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

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

PRE-AUTHORIZATION CHECKLIST FOR EXPANDED ZMORPH
Upper and Lower Limb Prosthesis

Place a (✓) if yes or NA if not applicable

QUALIFICATIONS	
a. Age ≥ 18 years old	
b. At least three months post-amputation, if acquired	
c. Wheelchair independent, community-ambulator with or without crutches, cane or walker	
d. On physical examination: no fresh or non-healing wound, neuroma or painful residual limb, no motor strength of <4/5 and limitation of motion of upper and/or lower limbs, no incoordination or poor balance	

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

Z Benefits*	Right	Left	Both
I. Lower limb			
A. Above knee/ knee disarticulation			
B. Hip disarticulation			
C. Van Ness Rotationplasty			
II. Upper limb			
A. Below elbow			
B. Above elbow			

* For cases involving more than one amputations, the patient cannot claim for two prostheses with the same laterality in either the same limb.

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

Conforme by Patient/Parent/Guardian:

Printed name and signature

Attested by Attending Rehabilitation Medicine Specialist

Printed name and signature

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

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

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

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UNIVERSAL HEALTH CARE

PRE-AUTHORIZATION REQUEST FOR EXPANDED ZMORPH
Upper and Lower Limb Prosthesis

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z *Benefits* package for

_____ in _____
(Patient's last, first, suffix, middle name) (Name of *HF*)
under the terms and conditions as agreed for availment of the Z *Benefits* Package.

The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the *benefits* package (please tick appropriate box):
☐ Without co-payment
☐ With co-payment, for the purpose of: _____

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Rehabilitation Medicine Specialist	(Printed name and signature) Executive Director/ Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐
	(Printed name and signature) Patient/Parent/Guardian

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

_____
(Printed name and signature)
Head or authorized representative, Benefits Administration Section (BAS)

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

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DC: 1493 Date: 9/25/22

Annex A.2: EMORPH Pre-Authorization Checklist: Lower Limb Orthosis

Revised as of September 2022

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UNIVERSAL HEALTH CARE

Case No. _____

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

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

PRE-AUTHORIZATION CHECKLIST FOR EXPANDED ZMORPH
Lower Limb Orthosis

Place a (✓) if yes or NA if not applicable

	GENERAL QUALIFICATIONS	Yes
1.	Age ≥ 18 years old	
2.	At least 3 months post-onset	
3.	Upper limbs ≥ 4 with fair trunk control and full range of motion, if bilateral	
4.	Unaffected limbs ≥ 3 with fair trunk control and full range of motion, if unilateral	
5.	Ambulatory with assistive device	
6.	No fresh or non-healing wound	

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Place a (✓) if yes or NA if not applicable

	QUALIFICATIONS SPECIFIC TO ANKLE FOOT ORTHOSIS	Yes
1.	Weakness or absence of dorsiflexors *and/* or plantarflexors, +/- grade 1-2 spasticity with full range of motion achieved passively	
2.	Equinovarus +/- foot rotation and +/- grade 1-2 spasticity with full range of motion achieved passively	
3.	Pain & Instability secondary to sensory or structural deficit in a Charcot Arthropathy	

Place a (✓) if yes or NA if not applicable

QUALIFICATIONS SPECIFIC TO KNEE ANKLE FOOT ORTHOSIS	Yes
Quadriceps MMT of <3 +/- sensory loss ,+/- instability (genu recurvatum) with hip/knee flexion contracture <20 degrees	

Place a (✓) if yes or NA if not applicable

QUALIFICATIONS SPECIFIC TO HIP KNEE ANKLE FOOT ORTHOSIS	Yes
Hip, knee, ankle & foot muscles MMT <3 +/- sensory loss, +/- instability, with hip /knee flexion contracture <20 degrees	

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

Z Benefits	Right	Left	Both
Ankle Foot Orthosis			
Knee Ankle Foot Orthosis			
Hip Knee Ankle Foot Orthosis			

Conforme by Patient/Parent/Guardian:

Printed name and signature

Attested by Attending Rehabilitation Medicine Specialist

Printed name and signature

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

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Note:
Once approved, the contracted *health facility* shall print the approved pre-authorization form and have this signed by the patient, parent or guardian and health care providers, as applicable. This form shall be submitted to the Local Health Insurance Office (LHIO) or the PhilHealth Regional Office (PRO) when filing the first tranche.
There is no need to attach laboratory results. However, these should be included in the patient's chart and may be checked during the field monitoring of the Z Benefits. Please do not leave any item blank.

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UNIVERSAL HEALTH CARE

PRE-AUTHORIZATION REQUEST FOR EXPANDED ZMORPH
Lower Limb Orthosis

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z *Benefits* package for

_____ in _____
(Patient's *last, first, suffix, middle name*) (Name of *HF*)
under the terms and conditions as agreed for availment of the Z *Benefits* Package.

The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the *benefits* package (please tick appropriate box):
☐ Without co-payment
☐ With co-payment, for the purpose of: _____

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

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

_____
(Printed name and signature)
Head or authorized representative, Benefits Administration Section (BAS)

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

MASTER COPY Date: 10/25/22 DC: mjs

Annex A.3: EMORPH Pre-Authorization Checklist: Spinal Orthosis

Revised as of September 2022

Republic of the Philippines

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UNIVERSAL HEALTH CARE

Case No. _____

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

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

PRE-AUTHORIZATION CHECKLIST FOR EXPANDED EMORPH
Spinal Orthosis

Place a (✓) if yes or NA if not applicable

	General Qualifications	Yes
1.	Age ≥ 18 years old	
2.	Upon diagnosis and/or post-operative clearance	
3.	No sensory deficit over body segment of application	
4.	Upper and lower limb manual muscle strength of ≥ 3	

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Place a (✓) if yes or NA if not applicable

	Qualifications for Thoracolumbosacral Spinal Orthosis	Yes
1.	Thoracolumbar (T12-L2) spinal fractures involving posterior elements	
2.	Primary or metastatic lesions to the thoracolumbosacral spine	

Place a (✓) if yes or NA if not applicable

	Qualifications for Lumbosacral Spinal Orthosis	Yes
1.	Lumbosacral fractures (L1-L3)	
2.	Primary or metastatic lesions to the lumbosacral spine	

Place a (✓) if yes or NA if not applicable

	Qualifications for Cervicothoracic Spinal Orthosis	Yes
1.	Cervical spine fractures (C3-C7) without neurologic deficit	
2.	Torticollis	
3.	Metastatic lesions without neurologic deficit	

Tick the box corresponding to the type of spinal orthosis to be given to the patient:

☐ Thoracolumbosacral custom molded spinal orthosis
☐ Lumbosacral custom molded spinal orthosis
☐ Cervicothoracic custom molded spinal orthosis

Conforme by Patient/Parent/Guardian:

Printed name and signature

Attested by Attending Rehabilitation Medicine Specialist

Printed name and signature

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

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

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

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DC: MJS Date: 10/25/22

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UNIVERSAL HEALTH CARE

PRE-AUTHORIZATION REQUEST FOR EXPANDED ZMORPH
Spinal Orthosis

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z *Benefits* package for

_____ in _____
(Patient's last, first, suffix, middle name) (Name of *HF*)
under the terms and conditions as agreed for availment of the Z *Benefits* Package.

The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the *benefits* package (please tick appropriate box):

☐ Without co-payment
☐ With co-payment, for the purpose of: _____

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

Conforme by:
(Printed name and signature) Patient/Parent/Guardian

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☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

_____
(Printed name and signature)
Head or authorized representative, Benefits Administration Section (BAS)

MASTER COPY Date: 10/25/22
DC: 1425

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

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UNIVERSAL HEALTH CARE

Numero ng kaso: _____
Case No.

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 in 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 facility (HF) providing specialized care.
6. Dalawang kopya ng ME form ang kailangang ibigay ng kinontratang ospital. Ang mga kopyang nabanggit ay ilalaan para sa pasyente at sa ospital.
   Duplicate copies of the ME form shall be made available by the contracted HF—one for the patient and one as file copy of the contracted HF providing the specialized care.
7. **Para sa mga pasyenteng gagamit ng Z Benefit for 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 lower limb prosthesis, or Z Benefits for children with disabilities, write N/A for items B2, B3 and D6 and for PD First Z Benefits, write N/A for items B2 and B3.

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PANGALAN NG OSPITAL *HEALTH FACILITY (HF)*
ADRES NG OSPITAL *ADDRESS OF HF*

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

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

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

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

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

PERMANENTENG TIRAHAN
PERMANENT ADDRESS

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

Kategorya bilang Miyembro:
Membership Category:

Direct contributor
Direct contributor

- ☐ Empleado ng pribadong sector
  Employed private
- ☐ Empleado ng gobyerno
  Employed government
- ☐ May sariling pinagkakakitaan
  Self earning
  - ☐ Indibidwal
    Individual
  - ☐ Sole proprietor
    Sole proprietor
  - ☐ Group enrollment scheme
    Group enrollment scheme
- ☐ Kasambahay / *Household Help*
- ☐ Tagamaneho ng Pamilya/ *Family driver*
- ☐ Filipinong Manggagawa sa ibang bansa
  Migrant Worker/ OFW
  - ☐ Land-based *Land-based*
  - ☐ Sea-based *Sea-based*
- ☐ Habambuhay na kaanib/ *Lifetime Member*
- ☐ Filipino na may dalawang pagkamamamayan/Nakatira sa ibang bansa
  Filipino with Dual Citizenship/Living abroad
- ☐ Foreign national/*Foreign national*

Indirect contributor
Indirect contributor

- ☐ Listahanan
  Listahanan
- ☐ 4Ps/MCCT
  4Ps/MCCT
- ☐ Nakatatandang mamamayan
  Senior Citizen (RA 10645)
- ☐ PAMANA
  PAMANA
- ☐ KIA/KIPO
  KIA/KIPO
- ☐ Bangsamoro/Normalization
- ☐ Inisponsuran ng LGU
  LGU-sponsored
- ☐ Inisponsuran ng NGA
  NGA-*sponsored*
- ☐ Inisponsuran ng pribadong sector
  Private-sponsored
- ☐ Taong may kapansanan
  Person with disability

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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 HF 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 HF 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 naaangkop *Put a check mark (√) above appropriate answer or N/A 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] 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 HF of my choice and that preferring another contracted HF 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 HF 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 HF 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 N.A if not applicable.*	OO *YES*	HINDI *NO*
8. Binigyan ako ng ospital ng talaan ng mga susunod kong pagbisita. *My health care provider gave me the schedule/s of my follow-up visit/s.*		
9. Ipinaalam sa akin ng ospital ang impormasyon tungkol sa maaari kong hingan ng tulong pinansiyal o ibang pang suporta, kung kinakailangan. a. Sangay ng pamahalaan (Hal.: PCSO, PMS, LGU, etc.) b. Civil society o non-government organization c. Patient Support Group d. Corporate Foundation e. Iba pa (Hal. Media, Religious Group, Politician, etc.) *My health care provider gave me information where to go for financial and other means of support, when needed.* *a. Government agency (ex. PCSO, PMS, LGU, etc.)* *b. Civil society or non-government organization* *c. Patient Support Group* *d. Corporate Foundation* *e. Others (ex. Media, Religious Group, Politician, etc.)*		
10. Nabigyan ako ng kopya ng listahan ng mga kinontratang ospital para sa karampatang paggagamot ng aking kondisyon o karamdaman. *I have been furnished by my health care provider with a list of other contracted HFs 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 nakaayon 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 nagpalipat sa mas magandang kuwarto ayon sa aking kagustuhan *o tumanggap ng karagdagang serbisyo na hindi kasama sa benepisyo*, 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 to upgrade my room accommodation or avail of additional services that are not included in the benefit package, 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:* ☐ Paglipat ko sa mas magandang kuwarto; o *I choose to upgrade my room accommodation; or* ☐ anumang karagdagang serbisyo, tukuyin _____ *additional services, specify* _____ * Ito ay tinantiyang halaga lamang na gagabay sa pasyente kung magkano ang kanyang babayaran at hindi dapat gawing batayan para sa pagtutuos ng kuwenta ng nagugol na gastusin sa pagkakaospital na babayaran ng PhilHealth. *This is an estimated amount that guides the patient on how much the out of pocket may be and should not be a basis for auditing claims reimbursement.*		
Ang mga sumusunod na katanungan ay para sa mga miyembro ng formal at informal economy at kanilang mga kalipikadong makikinabang ***The following are applicable to formal and informal economy and their qualified dependents*** g. Naiintindihan ko na maaari akong magkaroon ng babayaran para sa halagang hindi sakop ng benepisyo sa PhilHealth. *I understand that there may be an additional payment on top of my PhilHealth benefits.* h. Pumapayag akong magbayad ng hanggang sa halagang PHP _____* para sa aking gamutan na hindi sakop ng benepisyo ng PhilHealth. *I agree to pay as much as PHP _____* as additional payment on top of my PhilHealth benefits.* * Ito ay tinantiyang halaga lamang na gagabay sa pasyente kung magkano ang kanyang babayaran at hindi dapat gawing batayan para sa pagtutuos ng kuwenta ng nagugol na gastusin sa pagkakaospital na babayaran ng PhilHealth. *This is an estimated amount that guides the patient on how much the out of pocket may be and should not be a basis for auditing claims reimbursement.*		
12. Limang (5) araw lamang ang babawasan mula sa 45 araw na palugit sa benepisyo sa isang taon para sa buong gamutan sa ilalim ng Z benefits. *Only five (5) days shall be deducted from the 45 confinement days benefit limit per year for the duration of my treatment/intervention under the Z Benefits.*		

E. Tungkulin at Responsabilidad ng Miyembro ***E. Member Roles and Responsibilities***		
Lagyan ng (✓) ang angkop na sagot o NA kung hindi naaangkop. *Put a (✓) check in 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 HF 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 HF

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** * 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 na makasusulat) *(if patient is unable to write)*	Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*
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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Annex C.1.1: EMORPH Discharge Checklist: Lower Limb Prosthesis

Revised as of September 2022

Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center: (02) 8441-7442 | Trunkline: (02) 8441-7444
www.philhealth.gov.ph

UNIVERSAL HEALTH CARE

Case No. _____

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

DISCHARGE CHECKLIST FOR EXPANDED ZMORPH
Lower Limb Prosthesis
Tranche 1

Place a check (✓) mark

CRITERIA FOR DISCHARGE	Yes
1. External lower limb prosthesis provided is as prescribed with appropriate pressure tolerant and sensitive areas, well-fitting socket, good suspension, proper alignment and stable prosthetic foot while standing and walking	
2. The lower limb stump is free of pain, blister, vascular compromise, hypersensitivity after 30 minutes of prosthetic weight-bearing while standing and/or walking	
3. Prosthesis user ambulates within expected gait parameters and steps up and down five (5) steps with assistive device	
4. Prosthesis user possesses competent skill and knowledge regarding prosthesis donning, doffing, cleaning, precautions and falling techniques	

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

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

Republic of the Philippines
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UNIVERSAL HEALTH CARE

Case No. _____

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

DISCHARGE CHECKLIST FOR EXPANDED ZMORPH
Upper Limb Prosthesis
Tranche 1

Place a (✓) or NA if not applicable

CRITERIA FOR DISCHARGE	Yes
1. External upper limb prosthesis provided is as prescribed with properly aligned and fitted socket, suspension, cable systems and terminal device	
2. The upper limb stump is free of pain, blister, vascular compromise, hypersensitivity after 30 minutes of use	
3. Upper limb prosthesis provides at the minimum body image completion and maximally assisted upper extremity gross motions	
4. Prosthesis user possesses competent skill and knowledge regarding prosthesis donning, doffing, cleaning, precautions and falling techniques	

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

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

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UNIVERSAL HEALTH CARE

Case No. _____

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

DISCHARGE CHECKLIST FOR EXPANDED ZMORPH
Lower Limb Orthosis
Tranche 1

Place a check (✓) mark

CRITERIA FOR DISCHARGE	Yes
1. External lower limb orthosis provided is as prescribed with appropriate alignment and fit	
2. The lower limb is free of blisters, vascular compromise, pain, hypersensitivity after 30 minutes of orthosis weight-bearing while standing and/or walking	
3. Lower limb orthosis allows safe ambulation with or without assistive device	
4. Orthosis user possesses competent skill and knowledge regarding donning, doffing, cleaning, precautions and falling techniques	

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

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

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UNIVERSAL HEALTH CARE

Case No. _____

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

DISCHARGE CHECKLIST FOR EXPANDED Z MORPH
Tranche 2

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

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

Rehabilitation Sessions	Dates Performed					
Physical therapy OR						
Occupational therapy						

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

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

PhilHealth

Benefits

Annex D: Z Satisfaction Questionnaire

Revised as of September 2022

Share your opinion with us!

We would like to know how you feel about the services that pertain to the Z *Benefits* 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 facility or you may contact PhilHealth call center at 8441-7442. Your responses will be kept confidential and anonymous.

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

1. Z *Benefits* 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 disability
   - ☐ Children with hearing impairment

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

3. Sex of respondent
   - ☐ male
   - ☐ female

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

4. How would you rate the services received from the *health facility (HF)* 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 HF 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!

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_____
Signature of Patient/ Parent/ Guardian

Date accomplished: _____

Annex E.1: EMORPH Tranche 1
Requirements for Reimbursement
Revised as of September 2022

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www.philhealth.gov.ph

UNIVERSAL HEALTH CARE

Case No. _____

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 1)
Expanded ZMORPH

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E.1-EMORPH)	
2. Photocopy of approved Pre - Authorization Checklist & Request (Annex A-EMORPH)	
3. Photocopy of completely accomplished ME FORM (Annex B)	
4. *Original or certified true copy of the Statement of Account (SOA)*	
5. *Properly accomplished* PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
6. Discharge Checklist for Expanded ZMORPH (Tranche 1) (Annex C.1-EMORPH)	
7. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	

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

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

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UNIVERSAL HEALTH CARE

Case No. _____

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2)
Expanded ZMORPH

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E.2-EMORPH)	
2. Photocopy of approved Pre-Authorization Checklist & Request (Annex A-EMORPH)	
3. Photocopy of completely accomplished ME FORM (Annex B)	
4. *Original or certified true copy of the Statement of Account (SOA)*	
5. *Properly accomplished* PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
6. Discharge Checklist for Expanded ZMORPH (Tranche 2) (Annex C.2-EMORPH)	
7. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	

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

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

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UNIVERSAL HEALTH CARE

PHILHEALTH-PC 14 S.2015-F04.Revision 1

Self-assessment / Survey Tool for the Z Benefits Package for ZMORPH and Expanded ZMORPH Providers

Name of HF: _____

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

Direction:

1. Put a check (√) in the YES column if the requirement is available.
2. Put an (X) in the NO column if the same is not available in the *HF*.
3. Encode in the REMARKS column the reason of non-availability or non-compliance of requirements.

	REQUIREMENTS	*HF*		PHIC		REMARKS
		YES	NO	YES	NO	
1	**Hospital Accreditation**					
	A. The *HF* has an updated DOH license					
	B. The *HF* has an updated PhilHealth Accreditation					
	In addition, the contracted *HF* shall comply with the following:					
2	**Minimum Service Capability**					
	Mandatory Services as stated in PhilHealth Circular 19 s. 2013 and / or PhilHealth Circular 33 s. 2016 ***OR*** *with a formal referral process to a referral facility.*					
	A. Patient education and family support activities					
	B. Educational materials available for patientsand their family/ caregiver					
	C. Conduct advocacy programs/ seminars at least annually					
	D. Availability of rehabilitation services (rehabilitationmedicine doctor, physical therapist and/ or occupational therapist)					
	E. Pre-prosthetic/ orthotic rehabilitation					
3	**Technical Standards**					
	A. General Infrastructure					
	1. Dedicated **Prosthetic / Orthotic Work Shop** area, minimum 60 sq. meter floor area, containing the following:					
	i. *Oven, router, rectification, assessment and casting area*					
	ii. Work tables for preparation of the prosthesisandorthosis					
	iii. Vacuum forming station					
	2. Out-patient clinic for pre & post-prosthetic/orthotic assessment and					

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REQUIREMENTS		HF		PHIC		REMARKS
		YES	NO	YES	NO	
	referrals					
	3. Ventilation/exhaust system					
	4. Adequate power source					
	5. Adequate water supply					
	6. Toilet					
	7. Wash area					
	8. Adequate signage (entrance, exit and smoking prohibition)					
	9. Designated area for MDT meetings					
	10. Storage area for supplies					
	B. Equipment/ Supplies					
	1. Prosthetic Orthotic Production					
	i. ethylvinyl acetate foam					
	ii. velcro webbings					
	iii. oscillating saw					
	iv. Plaster of Paris powder					
	v. Plaster of Paris bandage					
	vi. jigsaw					
	vii. heatgun					
	viii. hand drill					
	ix. surform, round, flat and half flat,with or without handle					
	x. Bench vise					
	xi. anvil					
	xii. pipes (1/8" to 2") for positive mold					
	xiii. pencil markers					
	xiv. carpentry & mechanical tools (pliers, screwdrivers, wrench, hammer, etc)					
	xv. scissors for cutting through cement					
	xvi. rasps for shaping / shaving mold					
	xvii. sewing machine					
	xviii. ballpen hammer & rubber mallet					
	xix. pipe cutter for steel					
	xx. measuring tools					
	a. body calipers					
	b. tape measure					
	c. goniometer					
	d. ruler					
	e. water level					
	f. plumb line					
	g. stump gauge					

	REQUIREMENTS	*HF*		PHIC		REMARKS
		YES	NO	YES	NO	
	xxi. rectification tools					
	a. plaster mixing bowl					
	b. cutter with disposable blades					
	c. spatula					
	d. basin					
	e. whisk					
	f. sand box					
	g. pail					
	2. Personal Protective Equipment (PPE)					
	i. Goggles					
	ii. Individual masks					
	iii. Apron					
	iv. Thermal gloves					
	3. Utilities					
	i. Sink with plaster trap					
	ii. Fire extinguisher					
	iii. First aid kit					
	4. Waste segregation system					
	5. Accessibility					
	i. Ramps					
	ii. Elevators (as needed)					
	iii. Hand rails					
	6. Physical Therapy area for pre & post prosthetic-orthotic training					
4	**Human Resource**					
	The *HF* shall have a multi-disciplinary/inter-disciplinary team (MDT) with the following:					
	A. Rehabilitation Medicine Doctor					
	i. Diplomate, Philippine Board of Rehabilitation Medicine					
	ii. Attended an orientation for prosthetic and orthotic assessment, prescription and fitting/ check-out					
	iii. Valid PRC license					
	iv. Valid PhilHealth accreditation					
	B. Physical Therapist					
	i. Valid PRC license (PTRP)					
	ii. Attended an orientation for prosthetic and orthotic assessment, prescriptionand fitting/ check-out					
	C. Occupational Therapist (OT)					
	i. Valid PRC license (OTRP)					
	ii. Attended an orientation for prosthetic and orthotic assessment, prescription					

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	REQUIREMENTS	HF		PHIC		REMARKS
		YES	NO	YES	NO	
	and fitting/ check-out					
	D. Prosthetist/Orthotist					
	i. Graduate of 4 year Bachelor of Science in Prosthetics and Orthotics Course or its equivalent					
	E. Z Benefit Coordinator					
	i. With skills in spreadsheet, word processor etc. (e.g Microsoft Office)					
	ii. With experience in public relations					
	iii. With organizational skills					
	iv. At least vocational graduate					
5	**Z Benefit program implementation**					
	A. Process flow for the provision of the services for Z MORPH and expanded ZMORPH are available					
	B. Action Plan for No balance billing and fixed co-payment implementation					
	C. Submission of outcomes evaluation, including untoward incidence (e.g. accidents, patient's non-compliance to instructions)					
	D. Patient record indicating status of device provided in terms of alignment, fit, comfort, function and after care					

PhilHealth Survey Team

Surveyor's Name	Designation	Signature

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HF Management Team

Names of Management Team	Designation	Signature

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

UNIVERSAL HEALTH CARE

OUTCOME INDICATORS FOR ZMORPH AND EXPANDED ZMORPH

I. Community participants and inclusion

A. Return to work or self-employment
B. Schooling (degree or vocational courses)
C. Avocational pursuits (sports, leisure)
D. Independent living
E. Safe and functional mobility within home or community environment
F. Body image completion

II. Device

A. Comfortable fit
B. Proper alignment
C. Appropriate prescription
D. Safe and functional use

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UNIVERSAL HEALTH CARE

TRANSMITTAL FORM OF CLAIMS FOR THE Z BENEFITS

NAME OF CONTRACTED HEALTH *FACILITY*	ADDRESS OF *HF*

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 *Benefits* 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.

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DC: wys

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

Certified correct by authorized representative of the *HF*		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)		