*Republic of the Philippines*
**PHILIPPINE HEALTH INSURANCE CORPORATION**
Citystate Centre, 709 Shaw Boulevard, Pasig City
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UNIVERSAL HEALTH CARE
KALUSUGAN AT KASINGA PARA SA LAHAT

**PHILHEALTH CIRCULAR**
No. 2022-0031

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

**SUBJECT** : **Z Benefits for Mobility, Orthosis, Rehabilitation, and Prosthesis Help (ZMORPH) Package for the Fitting of External Lower Limb Prosthesis Below the Knee *(Revision 1)***

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## I. RATIONALE

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

Aligned with the mission of Republic Act 7277 or the Magna Carta for Disabled Persons, PhilHealth seeks to mainstream and reintegrate persons with physical disabilities into the community by rendering prosthetic services available.

Cognizant of the United Nations Convention on the Rights of Persons with Disabilities' vision of full and equal enjoyment of human rights by persons with disabilities, PhilHealth shall ensure *the* protection of their inherent dignity through prosthetic devices that are safe, appropriate, accessible, and of quality.

In fulfillment of the aforementioned, PhilHealth Board Resolution No.1678, s-2012 and PhilHealth Circular *(PC)* No. *2021-0022 "The Guiding Principles of the Z Benefits (Revision 1),"* the following are the services and rates for the ***ZMORPH*** package for the fitting of external lower limb prosthesis *with amputations* below the knee.

## *II. OBJECTIVES*

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

## *III. SCOPE*

*This PhilHealth Circular shall apply to all PhilHealth members requiring prosthetic management of either the foot, symes or below knee levels of amputation and to all contracted health facilities (HFs) to deliver the defined mandatory services for ZMORPH and other relevant stakeholders involved in its implementation.*

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## IV. DEFINITION OF TERMS

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

**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. Member Empowerment (ME) Form** – *a document showing that the patient is fully informed of their Z Benefits package, treatment options, treatment schedule 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.*

**D. 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.*

**E. Z Benefit Coordinator** – *a designated staff member of the contracted healthcare provider for the Z benefit package who is responsible for guiding and navigating Z benefit patients, encoding pertinent clinical information and coordinating with PhilHealth on matters pertaining to the availment of the Z benefits.*

**F. ZMORPH** – *Z benefits for the fitting of external lower limb prosthesis below the knee*

## V. POLICY STATEMENTS

A. *ZMORPH shall cover the initial fitting of the right and/or left lower limb prosthesis below the knee following the selection criteria indicated in the policy.*

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 ZMORPH benefits package.*

C. *Contracted HFs shall submit a properly accomplished pre-authorization checklist and request form (Annex A) 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 of the 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 healthcare professional/s in the contracted HF and the patient for enrolment in the ZMORPH. The ME Form aims to support*

*patients to be active participants in healthcare decision-making by being educated and informed of the conditions and management options. Further, the ME Form encourages the attending healthcare 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 mandatory services for ZMORPH are the minimum standards of care (Table 2) that must be provided to all patients by contracted HFs. Updates in standards of care are discussed during regular policy reviews in collaboration with pertinent stakeholders.*

I. *The Reference and contracted HFs for 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 prosthesis materials, supplies, or other similar initiatives.*

J. *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 prosthetic components or upgrade of prosthesis not covered by the Z Benefits package.*

K. *The contracted HF and the patient shall indicate the amount of co-payment* in the *ME* Form *to document their agreement* for any *upgrade of the prosthetic component/s.*

L. *PhilHealth members shall not be charged any co-payment for lower limb prostheses that use standard materials as specified in the individual HF contract.*

M. *The maximum allowable co-pay should not exceed the package rate for the ZMORPH and shall apply to the upgrade of prosthetic materials, additional prosthetic components, or extra services not covered by the Z Benefits and indicated in the contract.*

N. *The contracted HF shall administer the Z Satisfaction Questionnaire (Annex D) to all Z patients before the final discharge disposition from the contracted HF. These are validated during field monitoring by PhilHealth and inputs for benefits enhancement, policy research, and quality improvement purposes.*



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

P. *The contracted HF shall file claims within 60 calendar days after fitting the prosthesis.*

Q. *The ZMORPH allots 20% of the package rate as professional fees for services rendered by medical and allied health professionals.*

R. All rates are inclusive of government taxes.

S. *Contracted HFs should monitor in the next six (6) months their enrolled patients for the ZMORPH for return to productivity or community reintegration as an outcome (Annex G). In addition, contracted HFs should properly document patients lost to follow-up. Evaluation of outcomes may be outsourced by PhilHealth.*

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

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

V. *Criteria for Inclusion, Minimum Standards of Care, and Package Rate for ZMORPH for the Fitting of External Lower Limb Prosthesis Below the Knee*

1. The overall package code for the *ZMORPH* is Z010.
2. The package *codes* for the laterality of the lower limbs *are the following*:
   a. *Z010.xA* for the right lower limb
   b. *Z010.xB* for the left lower limb
   c. *Z010.xC* for the right and left lower limbs

| ***Package code*** | ***Description*** | ***Package rate*** |
|---|---|---|
| *Z010.1* | *Partial foot* | *Php 15,000.00* |
| *Z010.2* | *Symes* | |
| *Z010.3* | *Below the knee or transtibial (Below the knee)* | |

*Table 1: Package Code, Description and Package Rate for the Fitting of External Lower Limb Prosthesis Below the Knee*

3. *Selection* Criteria:
   *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*

The *ZMORPH* for the fitting of external lower limb prosthesis below the knee shall reflect the following mandatory and other services *(Table 2)*:



| **Mandatory Services *or Minimum Standards of Care*** | **Other Services** |
|---|---|
| 1. Pre-prosthetic assessment by a board-certified physician of the Philippine Board of Rehabilitation Medicine;<br>2. Prosthetic measurement, fabrication and check-out by *a graduate of a Bachelor of Science in Prosthetics and Orthotics Course or higher;*<br>3. Final discharge disposition by a board-certified physician of the Philippine Board of Rehabilitation Medicine.<br><br>**Note:** The reference and contracted *HFs shall be responsible for conducting their own credentialing* of physicians, prosthetists, and physical therapists. | *Physical therapy services* |

*Table 2: Mandatory and Other Services for the Fitting of External Lower Limb Prosthesis Below the Knee*

4. *The package rate per limb laterality is* ***fifteen thousand pesos*** **(Php15,000) or** ***thirty thousand pesos*** **(Php30,000)** ***for*** **both limbs.** *The package covers* the entire prosthetic management of either the foot, symes, or *below-knee amputation levels, paid as a single tranche after the provision of* all mandatory services.

| Mode of Payment | *Package Rate* (Php) | Filing Schedule | Frequency *of Availment* |
|---|---|---|---|
| Single tranche | 15,000.00 per limb | Within 60 days after *fitting the lower limb prosthesis* | *Every five years, maximum of two in a lifetime* |

*Table 3: Mode of Payment and Filing Schedule of Claims for the Fitting of External Lower Limb Prosthesis Below the Knee*

W. *Claims Filing for ZMORPH*

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 HF shall attach the following documents for claims submission to PhilHealth:*

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

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

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

   d. *PhilHealth Benefit Eligibility Form (PBEF) printout as proof of eligibility during the pre-authorization process*

      A PBEF *indicating a "Yes" is sufficient to mean that the patient is eligible. PhilHealth does not require the submission of additional documents not indicated in this policy, such as the Member Data Record (MDR).*

      *A PBEF indicating a "No" should prompt the contracted HF to coordinate with the PhilHealth CARES assigned in their facility to validate the eligibility of the patient or present 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). PhilHealth will disseminate a separate issuance for the SOA for the Z Benefits.*

   g. *Discharge Checklist of Services (Annex C);*

   h. *Photocopy of completely accomplished Z Satisfaction Questionnaire (Annex D);*

   i. *Checklist of requirements for reimbursement (Annex E).*

4. *Rules on late filing shall apply.*

5. *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.*

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

X. *Marketing and Promotion*

*PhilHealth shall inform/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.*

Y. *Monitoring and Evaluation*

*1. Utilization and Compliance*

*Monitoring of the implementation of ZMORPH shall be conducted by PhilHealth.*

*Field monitoring of service provision by contracted HFs shall also be conducted. It shall follow the guidance, tools, and consent forms provided in the Guiding Principles of the Z Benefits (PC 2021-0022).*

*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 in the relevant monitoring policies of the Corporation.*

*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 PROs, shall take the lead in the policy review process. The review results shall guide policy decisions regarding future benefits enhancements and rate adjustments.*

Z. *Annexes*

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

1. *Annex A: Pre-authorization Checklist and Request*
2. *Annex B: Member Empowerment Form*
3. *Annex C: Discharge Checklist for ZMORPH*
4. *Annex D: Z Satisfaction Questionnaire*
5. *Annex E: Checklist of Requirements for Reimbursement*
6. *Annex F: HF Standards as Providers for the ZMORPH/Expanded ZMORPH*
7. *Annex G: List of Quality Indicators for ZMORPH/Expanded ZMORPH*
8. *Annex H: Transmittal Form of Claims for the Z Benefits*

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## *VI. PENALTY CLAUSE*

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

## *VII. TRANSITORY CLAUSE*

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

*B. Claims filed prior to the date of the effectivity of this PhilHealth Circular shall follow the provisions of PhilHealth Circular No. 2021-0022 entitled "The Guiding Principles of the Z Benefits (Revision 1).*

## *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 PhilHealth Circular repeals PhilHealth Circular No. 0019 s. 2013 entitled Z Benefit Rate for Mobility, Orthosis, Rehabilitation, Prosthesis Help (Z MORPH) package for the fitting of external lower limb prosthesis below the knee and Annexes A – and C – ZMORPH of PC No. 2021-0022 entitled The Guiding Principles of the Z Benefits (Revision 1).*

## 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.*

**EMMANUEL R. LEDESMA, JR.**
Acting President and Chief Executive Officer (CEO)

Date signed: 12/20/2022

MASTER COPY Dated 12/29/22

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

**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 ZMORPH FITTING OF EXTERNAL LOWER LIMB PROSTHESIS BELOW THE KNEE

Place a check mark (✓) on the appropriate lower limb:
☐ Right lower limb ☐ Left lower limb ☐ Right & left lower limbs

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

| QUALIFICATIONS | |
|---|---|
| 1. Age | ☐ *≥18 years* |
| 2. Status of post-amputation | ☐ at least three months post-amputation, if acquired |
| 3. Wheelchair independent, community-ambulator (Any of the following) | ☐ with or without crutches<br>☐ cane or walker |
| 4. Absence of the following on physical examination | ☐ fresh or non-healing wound<br>☐ neuroma or painful residual limb |
| 5. Tick involved limb | ☐ right limb ☐ left limb ☐ both limb |

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

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

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# PRE-AUTHORIZATION REQUEST FOR ZMORPH FITTING OF EXTERNAL LOWER LIMB PROSTHESIS BELOW THE KNEE

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z benefit 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 Benefit Package.

The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the benefit 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)<br>Attending Rehabilitation Medicine Specialist | (Printed name and signature)<br>Executive Director/Chief of Hospital/<br>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 | | |
|---|---|---|
| **Activity** | **Initial** | **Date** |
| Received by LHIO/BAS: | | |
| Endorsed to BAS (if received by LHIO): | | |
| ☐ Approved ☐ Disapproved | | |
| Released to *HF:* | | |
| **This pre-authorization is valid for one hundred eighty (180) calendar days from date of approval of request.** | | |

| COMPLIANCE TO REQUIREMENTS | | |
|---|---|---|
| ☐ APPROVED<br>☐ DISAPPROVED (State reason/s) | | |
| **Activity** | **Initial** | **Date** |
| Received by BAS: | | |
| ☐ Approved ☐ Disapproved | | |
| Released to *HF:* | | |

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**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-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 pagpapaparami 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.***

| |
|---|
| PANGALAN NG OSPITAL<br>*HEALTH FACILITY (HF)* |
| ADRES NG OSPITAL<br>*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 maksikinabang) (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)<br>*Birthday (mm/dd/yyyy)* | Edad<br>*Age* | Kasarian<br>*Sex* |
|---|---|---|
| Numero ng Telepono<br>*Telephone Number* | Numero ng Cellphone<br>*Mobile Number* | Email Address<br>*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**<br>***B. Clinical Information*** | |
|---|---|
| 1. Paglalarawan ng kondisyon ng pasyente<br>*Description of condition* | |
| 2. Napagkasunduang angkop na plano ng gamutan sa ospital<br>*Applicable Treatment Plan agreed upon with healthcare provider* | |
| 3. Napagkasunduang angkop na alternatibong plano ng gamutan sa ospital<br>*Applicable alternative Treatment Plan agreed upon with health care provider* | |
| **C. Talatakdaan ng Gamutan at Kasunod na Konsultasyon**<br>***C. Treatment Schedule and Follow-up Visit/s*** | |
| 1. Petsa ng unang pagkakaospital o konsultasyon [a] (buwan/araw/taon)<br>*Date of initial admission to HF or consult[a] (mm/dd/yyyy)*<br>[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.<br>*[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)<br>*Tentative Date/s of succeeding admission to HF or consult[b] (mm/dd/yyyy)*<br>[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.<br>*[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)<br>*Tentative Date/s of follow-up visit/s[c] (mm/dd/yyyy)*<br>[c] Para sa ZMORPH/ mga batang may kapansanan, ito ay tumutukoy sa rehabilitasyon ng external lower limb post-prosthesis.<br>*[c] For ZMORPH/CWD, this refers to the external lower limb post-prosthesis rehabilitation consult.* | |

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| **D. Edukasyon ng Miyembro**<br>***D. Member Education*** | | |
|---|---|---|
| Lagyan ng tsek (√) ang angkop na sagot o NA kung hindi naaukol<br>*Put a check mark (√) opposite appropriate answer or N/A if not applicable.* | OO<br>*YES* | HINDI<br>*NO* |
| 1. Ipinaliwanag ng kinatawan ng ospital ang uri ng aking karamdaman.<br>*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]<br>*My health care provider explained the treatment options/ intervention[d].*<br><br>[d] Para sa ZMORPH, ito ay ukol sa pangangailangan ng pagbibigay at rehabilitasyon para sa pre at post-device.<br>*[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.<br>*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.<br>*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.<br>*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.<br>*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.<br>*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.*<br><br>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.<br>*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<br>*Put a check mark(√) opposite appropriate answer or NA if not applicable.* | OO<br>*YES* | HINDI<br>*NO* |
|---|---|---|
| 8. Binigyan ako ng ospital ng talaan ng mga susunod kong pagbisita.<br>*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.<br>a. Sangay ng pamahalaan (Hal.: PCSO, PMS, LGU, etc.)<br>b. Civil society o non-government organization<br>c. Patient Support Group<br>d. Corporate Foundation<br>e. Iba pa (Hal. Media, Religious Group, Politician, etc.)<br>*My health care provider gave me information where to go for financial and other means of support, when needed.*<br>*a. Government agency (ex. PCSO, PMS, LGU, etc.)*<br>*b. Civil society or non-government organization*<br>*c. Patient Support Group*<br>*d. Corporate Foundation*<br>*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.<br>*I have been furnished by my health care provider with a list of other contracted HF's 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:<br>*I have been fully informed by my health care provider of the PhilHealth membership policies and benefit availment on the Z Benefits:*<br><br>a. Kaalipikado ako sa mga itinakdang batayan para sa aking kondisyon/kapansanan.<br>*I fulfill all selections criteria for my condition/disability.* | | |
| b. Ipinaliwanag sa akin ang polisiya hinggil sa "No Balance Billing" (NBB)<br>*The "no balance billing" (NBB) policy was explained to me.*<br><br>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).<br>*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.**<br>***For sponsored, indigent, household help, senior citizens and iGroup members with valid GPC and their qualified dependents, answer c, d and e.***<br>c. Nauunawaan ko na sakaling hindi ako gumamit ng NBB ay maaari akong magkaroon ng kaukulang gastos na aking babayaran.<br>*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**<br>***E. Member Roles and Responsibilities*** | | |
|---|---|---|
| Lagyan ng (√) ang angkop na sagot o NA kung hindi nauukol<br>*Put a (√) opposite appropriate answer or N/A if not applicable* | OO<br>*YES* | HINDI<br>*NO* |
| 1. Nauunawaan ko ang aking tungkulin upang masunod ang nararapat at nakatakda kong gamutan.<br>*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.<br>*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.<br>*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**<br>***F. Printed Name, Signature, Thumb Print and Date*** | | |
|---|---|---|
| Pangalan at Lagda ng pasyente:*<br>*Printed name and signature of patient**<br><br>*Para sa mga menor de edad, ang magulang o tagapag-alaga ang pipirma o maglalagay ng thumb print sa ngalan ng pasyente.<br>* *For minors, the parent or guardian affixes their signature or thumb print here on behalf of the patient.* | Thumb Print<br>(kung hindi makakasulat ang pasyente)<br>*(if patient is unable to write)* | Petsa<br>(buwan/ araw/ taon) |
| Pangalan at lagda ng nangangalagang Doktor:<br>*Printed name and signature of Attending Doctor* | | Petsa (buwan/araw/taon)<br>*Date (mm/dd/yyyy)* |
| Mga Saksi:<br>*Witnesses:* | | |
| Pangalan at lagda ng kinatawan ng ospital:<br>*Printed name and signature of HF staff member* | | Petsa (buwan/araw/taon)<br>*Date (mm/dd/yyyy)* |
| Pangalan at lagda ng asawa/ magulang / pinakamalapit na kamag-anak/awtorisadong kinatawan<br>*Printed name and signature of spouse/ parent/ next of kin / authorized guardian or representative*<br>☐ walang kasama/ *no companion* | | Petsa (buwan/araw/taon)<br>*Date (mm/dd/yyyy)* |

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

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

| I. Pahintulot sa pagsusuri sa talaan ng pasyente<br>***I. Consent to access patient record*** | J. Pahintulot na mailagay ang *medical data* sa Z benefit information and tracking system (ZBITS)<br><br>***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<br>*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.<br>*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*<br>*Printed name and signature of patient**<br><br>* Para sa mga menor de edad, ang magulang o tagapag-alaga ang pipirma o maglalagay ng thumb print sa ngalan ng pasyente.<br>** For minors, the parent or guardian affixes their signature or thumb print here on behalf of the patient.* | Thumb print<br>(Kung hindi na makasusulat)<br>*(if patient is unable to write)* | Petsa (buwan/araw/taon)<br>*Date (mm/dd/yyyy)* |
|---|---|---|
| Buong pangalan at lagda ng kumakatawan sa pasyente<br>*Printed name and signature of patient's representative*<br>☐ walang kasama/ *no companion* | | Petsa (buwan/araw/taon)<br>*Date (mm/dd/yyyy)* |
| Relasyon ng kumakatawan sa pasyente (Lagyan ng tsek ang angkop na kahon)<br>*Relationship of representative to patient (tick appropriate box)*<br><br>☐ asawa *spouse* ☐ magulang *parent* ☐ anak *child* ☐ kapatid *next of kin* ☐tagapag-alaga *guardian* ☐ walang kasama *no companion* | | |

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

**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 ZMORPH FITTING OF EXTERNAL LOWER LIMB PROSTHESIS BELOW THE KNEE

Place a check mark (✓) on the appropriate lower limb prosthesis:
☐ Right lower limb ☐ Left lower limb ☐ Right and left lower limbs

Place a check (✓) mark

| CRITERIA FOR DISCHARGE | Yes |
|---|---|
| 1. External below knee lower limb prosthesis provided is as prescribed with appropriate pressure tolerant & sensitive areas, well-fitting socket, good suspension, aligned shank and stable prosthetic foot while standing and walking. | |
| 2. The below knee stump is free of pain, blister, vascular compromise, hypersensitivity after 30 minutes of prosthetic weight bearing while standing & / or walking. | |
| 3. Prosthesis user ambulates on even and uneven surfaces within expected gait parameters and steps up & down five (5) steps with or without assistive device. | |
| 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)<br>Attending Rehabilitation Medicine Specialist | (Printed name and signature)<br>Executive Director/ Chief of Hospital/<br>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)<br>Patient/Parent/Guardian |
| Date signed (mm/dd/yyyy) |

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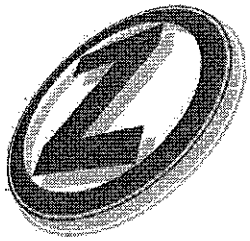
PhilHealth



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 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 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 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

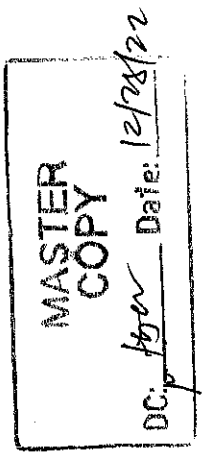
7. In your opinion, by how much has your HF expenses been lessened by availing of the Z benefit package?
   - ☐ less than half
   - ☐ by half
   - ☐ more than half
   - ☐ don't know

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!




_____
Signature of Patient/ Parent/ Guardian

Date accomplished: _____

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

**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 ZMORPH

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

| | |
|---|---|
| Certified correct by: | Certified correct by: |
| (Printed name and signature)<br>Attending Rehabilitation Medicine Specialist | (Printed name and signature)<br>Executive Director/Chief of Hospital/<br>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)<br>Patient/Parent/Guardian |
| Date signed (mm/dd/yyyy) |

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KALUSUGAN AT KALINGA PARA SA LAHAT

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

## Self-assessment / Survey Tool for Z Benefit 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 patients and their family/caregiver | | | | | |
| | C. Conduct advocacy programs/ seminars at least annually | | | | | |
| | *D. Availability of rehabilitation services (rehabilitation medicine 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 | | | | | |

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| REQUIREMENTS | | HF | | PHIC | | REMARKS |
|---|---|---|---|---|---|---|
| | | YES | NO | YES | NO | |
| | 2. Out-patient clinic for pre & post-prosthetic/orthotic assessment and 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 | | | | | |

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| | REQUIREMENTS | *HF* | | PHIC | | REMARKS |
|---|---|---|---|---|---|---|
| | | YES | NO | YES | NO | |
| | g. stump gauge | | | | | |
| | *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, prescription and fitting/ check-out | | | | | |
| | C. Occupational Therapist (OT) | | | | | |
| | i. Valid PRC license (OTRP) | | | | | |

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| REQUIREMENTS | | *HF* | | PHIC | | REMARKS |
|---|---|---|---|---|---|---|
| | | YES | NO | YES | NO | |
| | ii. Attended an orientation for prosthetic and orthotic assessment, prescription 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 |
|---|---|---|
| | | |
| | | |
| | | |

**HF Management Team**

| Names of Management Team | Designation | Signature |
|---|---|---|
| | | |
| | | |
| | | |

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*Republic of the Philippines*
**PHILIPPINE HEALTH INSURANCE CORPORATION**
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www.philhealth.gov.ph

UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

## 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
KALUSUGAN AT BAGONG PAG-ASA SA LAHAT

## 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 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. | | | | | |

MASTER COPY Date: 12/28/22 by: [illegible]

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