Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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PHILHEALTH CIRCULAR
No. 2023 - 0018

TO : **ALL PHILHEALTH MEMBERS, ACCREDITED HEALTH FACILITIES, PHILHEALTH REGIONAL OFFICES, AND ALL OTHERS CONCERNED**

SUBJECT : **Outpatient Benefits Package for Mental Health**

I. RATIONALE

Mental health (MH) is defined as the state of well-being, wherein an individual can realize his/her potential and live life fully. This means that an individual should be able to cope with the stresses of life, work productively and fruitfully, and contribute to society (World Health Organization, 2013). Thus, disturbances or disorders to MH and well-being can significantly affect an individual, his/her family, and the community, posing emotional, psychological, social, and financial burdens.

Republic Act (RA) No. 11036, otherwise known as the Mental Health Act, governs the compulsory treatment of certain people who have mental disorders. Under this mandate, the State commits to promoting the well-being of the people by ensuring that MH is valued, promoted, and protected; MH conditions are treated and prevented; timely, affordable, high-quality, and culturally appropriate MH case is made available to the public; MH service is free from coercion and accountable to the service users; and persons affected by MH conditions can exercise the full range of human rights, and participate fully in society and at work free from stigmatization and discrimination.

As the national strategic purchaser of health services, PhilHealth is mandated to provide health coverage to all Filipinos and improve their access to health services. Currently, PhilHealth only covers MH conditions, such as dementia, bipolar disorders, schizophrenia, and anxiety disorders under Mental and Behavioral Disorders through in-patient admission case rates, which amounts to Php 7,800. Given the new mandate of the government regarding MH and PhilHealth's commitment to improve its service and financial coverage, it is high time for PhilHealth to ensure that MH benefits cover the comprehensive inpatient and outpatient needs of people with mental health disorders. This undertaking is in fact well in line with the directive of RA No. 11223, otherwise known as the Universal Health Care (UHC) Act, to PhilHealth to review and enhance existing benefits and, where applicable, develop new ones.

With this, the PhilHealth Board of Directors, through the PhilHealth Board Resolution No. 2809 S. 2023[1], approved the development of an outpatient benefits package for MH covering the general and specialty MH services.

[1] Resolution Approving the Outpatient Mental Health Benefits Package

II. OBJECTIVES

This PhilHealth Circular aims to improve health outcomes, as well as the quality of life and productivity of Filipinos with MH conditions.

This policy shall:

A. Develop comprehensive PhilHealth benefits that ensure financial risk protection;

B. Enable access to care by adopting a responsive financing mechanism for the delivery of quality healthcare services;

C. Define the Outpatient Benefits Package for MH; and,

D. Provide specific guidelines on benefits availment, applicable payment mechanism, filing of claims, service delivery networks, reporting rules, and performance assessment.

III. SCOPE

This PhilHealth Circular covers the rules pertaining to the PhilHealth outpatient benefits package for MH in its transitional phase toward comprehensive outpatient and inpatient benefits packages as mandated by the UHC Act.

IV. DEFINITION OF TERMS

A. Co-payment – refers to a pre-determined amount agreed upon by the accredited health facilities and PhilHealth that will be charged to patients as their share for amenities or upgrades of services, or additional services unrelated to MH. Co-payments shall have a fixed limit or cap not to exceed the corresponding rate of the MH benefits package. The contracts of the health facilities shall stipulate the amount of co-payment.

B. Lost to follow-up – refers to a term used to characterize a patient who has not returned to or followed up at a health facility, as advised; however, in the context of the outpatient benefits package for MH, it refers to a situation wherein the patient has not come back, as advised, for the follow-up visits; Provided, that, the health facility should have completed the following number of consultation sessions for the specific tranche prior to declaring the patient lost to follow up and apply for claims reimbursement, to wit:

1. For general mental health services: completed at least four sessions of follow-up consultations
2. For neurologic cases: completed at least two sessions of follow-up consultations
3. For psychological cases: completed at least two sessions of follow-up consultations
4. For psychiatric cases: completed at least four sessions of follow-up consultations

C. Mental Health (MH) – refers to the state of well-being, wherein an individual can realize his/her potential and live life fully. This means that an individual should be able to cope with the stresses of life, work productively and fruitfully, and contribute to society (World Health Organization, 2013).

D. Mental Health Access Site – refers to a health facility where needed essential medicines for mental, neurologic and substance abuse (MNS) disorders are being provided to enrolled service users. Health facilities may be rural health units, district health centers or city health offices, private facilities, or public or private level 1 or level 2 hospitals without a trained full-time psychiatrist or neurologist, and can mostly provide outpatient services (DOH AO No. 2021-0012).

E. Mental Health Gap Action Programme (mhGAP) – refers to a training program developed by the World Health Organization (WHO) for primary care practitioners in non-specialized settings as an intervention guide in the treatment and management of MNS disorders and adapted for use in the Philippine context.

F. mhGAP Training – refers to a five-day course designed to train health workers in effectively managing and providing treatment to persons with MNS disorders using the algorithm for clinical decision-making as mandated by the mhGAP in a non-specialized setting.

G. Minimum Standards of Care - refers to essential services that health facilities are obliged to provide based on clinical practice guidelines or current best practices in the local setting.

H. Primary Care – refers to services at the primary care level that covers assessment, psychosocial services, basic laboratory tests, and pharmacological interventions. These services are mainly delivered by the primary care physician trained on mhGAP.

I. Referral System – refers to a two-way relationship between the referring and referral health facilities in ensuring continuity and complementation of health and services needed for MH.

J. Specialty Centers – refer to Level 2 or Level 3 hospitals or health facilities identified by the Department of Health (DOH) as referral hospitals for MH with trained full-time psychiatrists and neurologists that can deliver outpatient, inpatient, and emergency MH services 24/7.

V. POLICY STATEMENTS

A. PhilHealth's MH package is a progressive realization subject to implementation in phases depending on the available resources. Refer to Section V.M. for the coverage of this benefits package.

B. Essential medicines for MNS disorders are classified as individual-based health services.

C. While the Department of Health (DOH) procures essential medicines for MNS, the benefits package does not finance such procurement until such time that it is transitioned by the DOH.

D. Any proposal for PhilHealth coverage to include new technologies, such as drugs/medicines and biologicals not listed in the latest Philippine National

Formulary (PNF), diagnostic procedures, surgical interventions, and other treatment interventions, shall consider the Health Technology Assessment Council (HTAC) recommendation.

E. PhilHealth shall ensure that its beneficiaries receive the totality of care they need, by ensuring that basic essential medicines for MNS disorders, as identified by DOH, are available at accredited health facilities.

F. PhilHealth utilizes a case-based provider payment mechanism to reimburse health facilities for the minimum standards of care for mental health patients.

G. The benefits package shall contribute to the attainment of universal health coverage and financial risk protection for all members.

H. Accredited MH providers shall provide access to patients' records to PhilHealth during validation and monitoring activities of the Corporation.

I. Eligible members and their dependents can access health services from an accredited MH provider, either with no out-of-pocket or with a co-payment stipulated in the contract between PhilHealth and the accredited MH provider.

J. Patients shall not be charged co-payment by accredited MH providers for the minimum standards of care. Amenities, upgrades of services, or additional services unrelated to MH, shall be subject to co-payment, which shall be thoroughly discussed with the patient by the MH provider.

K. The co-payment shall have a fixed limit or cap not to exceed the corresponding rate of the MH package. The contract of the HF indicates the maximum allowable amount of co-payment of the patient.

L. Accreditation and Contracting Health Facilities

1. PhilHealth shall accredit MH providers that are capable of rendering the services for the MH benefits package (Annexes A.1 to A.4: Health Facilities Standards).

2. With the mandate of PhilHealth to provide financial risk protection against mental health illnesses and to pay for quality health care services, the Corporation can negotiate and enter contracts with health care institutions and professionals, among others, regarding the pricing and implementation of programs relevant to deliver quality health care services on behalf of its members. Thus, PhilHealth shall accredit health facilities which will be eligible to offer the outpatient benefits packages for MH.

3. Two (2) types of health facilities shall provide the outpatient benefits packages for MH, namely:

   a. Identified rural health units, city/municipal health offices, Levels 1 and 2 hospitals, DOH Medicine Access Program - Mental Health Access Sites, freestanding facilities and other facilities with trained family medicine, internal medicine, general practitioners, pediatrician including MHOs based

on mhGAP may provide the services under the general MH service package; and,

b. Level 3 hospitals, Level 2 hospitals with psychiatrists, neurologists and psychologists, custodial care facilities and DOH identified national specialty centers for mental health may provide the services for the specialty mental health service package.

4. Accredited health facilities shall have a MOA with the referral center to ensure the continuity of care of the patient.

5. Coordination and collaboration with the reference health facility and among accredited MH providers shall be required for operational and administrative purposes, such as but not limited to patient referrals, clearance from referring MH providers prior to transfer to other MH providers, and patient tracking, among others. Refer to Section V.P. for the guidelines for referral of patients.

M. Services Covered

1. The Outpatient Benefits Packages for MH shall cover individual-based health services, including initial and follow-up consultations, assessment, diagnostics, and psychosocial interventions. There are two packages offered, the general and the specialist MH service package, respectively (Annex B: Mental Health Benefits Package).

2. If the patient is discharged from a referral center, the referring health facility shall ensure that there are available MNS medicine for the continuation of treatment.

N. Eligibility Criteria

1. Eligibility checks shall be implemented to determine the eligible beneficiaries of the MH Package;

2. All Filipinos shall be eligible to avail of PhilHealth's Outpatient Benefits Packages for MH provided that they meet the following age criteria:
   a. For psychiatric cases: At least 10 years old; and,
   b. For neurologic cases: All ages from children to elderly.

3. Eligible beneficiaries shall be duly screened and assessed by an mhGAP-trained health worker who is any one of the following:
   a. General MH Services
      Primary Care Physician (i.e., municipal health officer or community health officer or Internal Medicine or Family Medicine doctor or Pediatric Doctor or General Practitioner)

   b. Specialty MH Services
      b.1. Psychiatrist;
      b.2. Psychologist;
      b.3. Neurologist

O. Registering Beneficiaries in the Mental Health Registry

1. All eligible beneficiaries shall be registered to the MH registry;

2. PhilHealth shall establish a registry of MH patients for the following purposes:
   a. reinforce access to psychiatric and psychosocial services across the country,
   b. monitor the utilization of the benefits package; and,
   c. systematically collect and analyze data on MH.

3. PhilHealth shall harmonize the MH registry with existing national registries in order to align the data to be collected from patients who availed of the benefits package; Provided, that, such information and data shall be used in informing future policies and improve patient's outcomes.

4. All accredited PhilHealth MH providers shall be required to implement the MH registry as a requirement for the processing of claims applications for the benefits package.

5. The MH registry shall likewise provide baseline and continuous real-time data in the utilization of the services and compliance with the set standards for MH through an electronic passport (MH e-passport).

6. Pending the availability of the MH registry, the accredited health facility shall submit a mental health registry matrix (Annex C) of their patients to their corresponding PhilHealth Regional Offices (PRO).

7. Pending the availability of the MH e-passport, the accredited mental health providers shall provide all patients with an MH Passport (Annex D). This document shall serve as the patient log of services. MH Passports shall only be issued to patients registered for the MH outpatient benefits package.

P. Referral and Transfer of Patients

1. Accredited MH facilities shall establish an effective referral system/s to ensure continuity and complementation of health and services needed for MH.

2. MH providers who need to transfer their patient to another MH provider shall accomplish a Letter of Intent for the Transfer of MH Care to a Referral MH Provider (Annex E) in triplicate. As proof of patient transfer, the MH provider shall submit this letter to the Benefits Administration Section of the PhilHealth Regional Office whose jurisdiction is within the referring MH provider. The patient shall, likewise, present the letter to the referral MH provider. The referring MH provider shall keep the last copy and attach it to the medical record of the patient.

3. The referring accredited MH providers shall properly accomplish a Checklist of Patient Transfer (Annex F) to be submitted along with the Letter of Intent for the Transfer of MH Care. The MH Passport shall likewise be required for referrals to other accredited MH providers to give information on the MH services that are already rendered to the patient.

4. The patient is allowed to transfer from one accredited MH provider to another accredited MH provider twice within a fiscal year. If the referring MH provider has rendered all the mandatory services for tranche 1, PhilHealth shall pay the full tranche amount, otherwise, 50% of the corresponding tranche amount of the package shall be reimbursed (Annex G: Patient Referral).

5. The referral MH provider shall be reimbursed 50% of the amount of tranche 1 and the full amount of the succeeding tranche provided that the provision of mandatory services has been given to the patient.

Q. Benefits Availment

1. Access to the specified MH services shall be based on the health needs of the patients.

2. Eligible beneficiaries shall only avail of the MH benefit from PhilHealth accredited MH providers.

3. Non-accredited MH providers serving mental patients who are currently receiving MH services shall not be reimbursed. Non-accredited MH providers are encouraged to refer their patients to accredited MH facilities for the benefits package and apply for accreditation to PhilHealth.

4. Any transfer to a non-accredited MH provider shall tantamount to patient's waiver of MH benefit; Provided, that, any claims filed for any MH package with such provider shall not be reimbursed by PhilHealth.

5. All accredited MH providers shall initially check whether the eligibility criteria for availment of PhilHealth stipulated in Section V.N. are met.

R. Package Rate, Code, and Tranche Filing Schedule

1. The general package code for the outpatient benefits package for mental health is **MH**.

2. The corresponding reimbursement rate for the MH package per patient in a given fiscal year are as follows:
   a. General Mental Health Services - Php 9,000.00
   b. Specialty Mental Health Services - Php 16,000.00

3. The following are the corresponding descriptions, rates and filing schedule of the package per tranche:

Package Code	Description	Package Rate (Php)	Filing Schedule
General Mental Health Services			
MHG1	General Mental Health Services - Tranche 1	5,400.00	60 days after the 6th follow up visit

Package Code	Description	Package Rate (Php)	Filing Schedule
General Mental Health Services			
MHG2	General Mental Health Services - Tranche 2	3,600.00	60 days after the last follow up visit for the fiscal year

Table 1: Package Code, Description, Package Rates and filing schedule per Tranche for General Mental Health Services

Package Code	Description	Package Rate (Php)	Filing Schedule
Specialty Mental Health Services			
MHS1	Specialty Mental Health Services - Tranche 1	9,600.00	a. For psychiatric cases, 60 days after the 6th follow - up visits; b. For neurologic cases, 60 days after the 3rd follow-up visit; and, c. For psychological cases: 60 days after the 3rd follow-up visit
MHS2	Specialty Mental Health Services - Tranche 2	6,400.00	a. For psychiatric cases, 60 days after the last follow-up visit for the fiscal year; b. For neurologic cases,60 days after the last follow-up visit for the fiscal year; and c. For psychological cases: 60 days after the last follow-up visit for the fiscal year

Table 2: Package Code, Description, Package Rates and filing schedule per Tranche for Specialty Mental Health Service

S. Claims Filing and Reimbursement

1. All accredited MH providers shall file claims manually or through the e-claims system once available;

2. Before filing a claim, all accredited MH facilities must render all mandatory and other services covered under these benefits packages.

3. To file a claim, the accredited health facility shall accomplish and submit the following to the PhilHealth Regional Office - Benefits Administration Section (PRO-BAS):

   a. Transmittal form for claims application (Annex H) per completed tranche using the manual or through e-claims system once available;
   b. Accomplished PhilHealth CF 2 (for manual) (see Annex I) for the sample CF2)
   c. Checklist of mandatory and other services (Annexes J.1 to J.4);
   d. MH Satisfaction Questionnaire (Annex K);
   e. Checklist of Requirements for Reimbursement (Annex L);
   f. MH Passport; and
   g. Original or certified true copy (CTC) of the Statement of Account

4. The rules on late filing shall apply.

5. If the delay in the filing of claims shall be due to natural calamities or other fortuitous events, the existing guidelines of the Corporation on the provisions of special privileges to those affected by fortuitous events shall apply.

6. 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 for subsequent tranches.

7. If the patients who were declared lost to follow-up and returned to the accredited MH provider, the patient may be registered for re-availment as long as the patient complies with the eligibility criteria.

T. Evaluation of Claims

1. All claims shall be processed by PhilHealth within 60 days from receipt of the claim.

2. Five (5) days shall automatically be deducted from the required remaining 45-day annual benefit limit upon submission of the mental health registry matrix (Annex C) to the PhilHealth Regional Offices. In cases where the remaining annual benefit is at least one (1) day at the time of registration, the member shall remain eligible to avail of the benefits package for mental health. There shall be no more deductions from the 45 days for the succeeding tranches.

U. Monitoring

1. Utilization and Compliance

   a. Monitoring of the implementation of the outpatient benefits package for MH shall be conducted by PhilHealth.

   b. Conduct of field monitoring of service provision by accredited health facilities shall also be conducted as well as to gather patient feedback.

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

2. Policy Review

   PhilHealth shall conduct a regular policy review of this benefits 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, shall take the lead in the policy review process. The review results shall guide policy decisions regarding future benefits enhancements and rate adjustments.

V. Marketing and Promotion

In order to educate the general public and increase their awareness of this benefits package and to promote informed decision-making and participation among patients, healthcare professionals, and health facilities, and other stakeholders, marketing and promotional activities shall be undertaken following the integrated marketing and communication plan of PhilHealth.

W. List of Annexes (Posted on official website)

1. Annex A.1: Health Facilities Standards - Minimum Requirements for Accreditation of General Mental Health Services
2. Annex A.2: Health Facilities Standards - Minimum Requirements for Accreditation for Specialty Mental Health Services
3. Annex A.3: Health Facilities Standards - Self-Assessment Tool for the Outpatient Benefits Package for General Mental Health Services
4. Annex A.4: Health Facilities Standards - Self-Assessment Tool for the Outpatient Benefits Package for Specialty Mental Health Services
5. Annex B: Mental Health Benefits Package
6. Annex C: Mental Health Registry Matrix
7. Annex D: Mental Health Passport

8. Annex E: Letter of Intent for the Transfer of MH Care to a Referral MH Provider

9. Annex F: Checklist for Patient Transfer

10. Annex G: Patient Referral

11. Annex H: Transmittal Form

12. Annex I: Sample CF2
    a. Annex I.1: General Mental Health Services – Tranche 1
    b. Annex I.2: General Mental Health Services – Tranche 2
    c. Annex I.3: Specialty Mental Health Services – Tranche 1
    d. Annex I.4: Specialty Mental Health Services – Tranche 2

13. Annex J: Checklist of Mandatory and Other Services
    a. Annex J.1: General Mental Health Services – Tranche 1
    b. Annex J.2: General Mental Health Services – Tranche 2
    c. Annex J.3: Specialty Mental Health Services – Tranche 1
    d. Annex J.4: Specialty Mental Health Services – Tranche 2

14. Annex K: Mental Health Satisfaction Questionnaire

15. Annex L: Checklist of Requirements for Reimbursement
    a. Annex L.1: General Mental Health Services – Tranche 1
    b. Annex L.2: General Mental Health Services – Tranche 2
    c. Annex L.3: Specialty Mental Health Services – Tranche 1
    d. Annex L.4: Specialty Mental Health Services – Tranche 2

VI. PENALTY CLAUSE

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

VII. SEPARABILITY CLAUSE

Should any provision of this PhilHealth Circular be declared invalid, unconstitutional or unenforceable in whole or in part by any court of law or competent authority, those provisions not affected by such declaration shall remain valid and effective.

VIII. TRANSITORY CLAUSE

A. Upon publication of this Circular, PhilHealth shall disseminate the information to the health facilities and relevant stakeholders, and ensure the availability of the forms in the website; and

B. While the necessary system is being developed, health facilities shall submit the claims manually.

PhilHealth shall issue a corresponding advisory to inform the health facilities once the mental health package is fully integrated into the eclaims system.

IX. DATE OF EFFECTIVITY

This PhilHealth Circular shall take effect after fifteen (15) days following the completion of its publication in a newspaper of general circulation. Three (3) certified copies shall thereafter be filed with the Office of the National Administrative Register (ONAR) of the University of the Philippines Law Center.

EMMANUEL R. LEDESMA, JR.
President and Chief Executive Officer (PCEO)

Date signed: 10/10/2023

MASTER COPY
DC: Date: 10/11/23

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Minimum Requirements for Accreditation of Outpatient Benefits Package for Mental Health – General Mental Health Services

I. Health Facility License and Accreditation

The health facility shall have an updated PhilHealth accreditation

II. List of Mandatory Services

A. Clean consultation and examination area
B. Designated room or area for consultation with minimal sound transmission
C. Handwashing sink with water and soap available (liquid soap preferred) and with materials for drying hands (clean towels OR paper towels)
D. Alcohol hand rub
E. Adult Stethoscope
F. Pediatric Stethoscope
G. Pen Light
H. Non-mercury sphygmomanometer with pediatric and adult cuff
I. Non-mercury thermometer
J. Medical weighing scale
K. Emergency medicines and supplies kept in a secured area with the following:
   1. Epinephrine
   2. IV hydrocortisone
   3. Diphenhydramine
   4. Haloperidol (amp)
   5. Risperidone OR olanzapine
   6. Intravenous (IV) fluids
   7. 3cc or 5cc syringes
   8. Cotton balls
   9. Micropore tape
   10. IV line (adult and pediatric)
   11. IV cannula (gauges 22 and 26)
L. O2 tank/source with O2 mask/cannula for pediatric and adult

III. Medications[1]

A. Carbamazepine 200 mg tablet
B. Divalproex Sodium 500 mg tablet
C. Biperiden HCl 2 mg tablet
D. Chlorpromazine 200 mg tablet
E. Clozapine 100 mg tablet
F. Olanzapine 10 mg tablet
G. Risperidone 2 mg tablet
H. Escitalopram 10 mg tablet

[1] Provided by DOH

I. Setraline 50 mg tablet

IV. Human Resources

A. Primary Care Physician

1. Valid PRC license
2. Valid PhilHealth accreditation
3. Certification of Completion of Training on Mental Health Gap Action Programme (mhGAP)

B. Mental Health Nurse

1. Valid PRC License
2. Certification of Completion of Training on Primary healthcare nurse trained on mhGAP, basic mental health and psychosocial support (training package of the mental health program and HEMB)

C. Mental Health Navigator

1. Administrative Staff
2. With working knowledge on operation /process flow for Mental Health who will be in-charge of record keeping and accomplishment of PhilHealth documents/forms

V. Laboratory[2]

A. Complete Blood Count (CBC) w/ platelet
B. Urinalysis
C. Fasting Blood Glucose
D. Lipid Profile
E. Renal Function Test (Creatinine)

VI. Radiology Diagnostic[3]

Chest X-ray (PA or AP)

VII. Psychotherapy

Provisions for psychoeducation and psychosocial support

VIII. Primary care screening tool based on mhGAP

IX. Available Forms/ Recordings

A. Registry forms
B. Assessment form
C. Referral forms

[2] may be outsourced
[3] may be outsourced

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Minimum Requirements for Accreditation of Outpatient Benefits Package for Mental Health – Specialty Mental Health Services

I. Health Facility License and Accreditation

The health facility shall have an updated PhilHealth accreditation

II. List of Mandatory Services

A. Clean consultation and examination area
B. An enclosed room that respects the privacy of the patients
C. Handwashing sink with water and soap available (liquid soap preferred) and with materials for drying hands (clean towels OR paper towels)
D. Alcohol hand rub
E. Adult Stethoscope
F. Pediatric Stethoscope
G. Pen light
H. Non-mercury sphygmomanometer with pediatric and adult cuff
I. Non-mercury thermometer
J. Medical weighing scale
K. Emergency kit (e-kit), emergency cart (e-cart) or emergency cabinet (e-cabinet) with the following:
   1. Epinephrine
   2. IV hydrocortisone
   3. Diphenhydramine
   4. Haloperidol (amp)
   5. Risperidone OR olanzapine
   6. IV fluids
   7. 3cc or 5cc syringes
   8. Cotton balls
   9. Micropore tape
   10. IV line (adult and pediatric)
   11. IV cannula (gauge 22 and 26)

   Note: keys to e-cabinet should always be available to authorize personnel

L. O2 tank/source with O2 mask/cannula for pediatric and adult

III. Medications[1]

A. Carbamazepine 200 mg tablet
B. Divalproex Sodium 500 mg tablet
C. Biperiden HCl 2 mg tablet
D. Chlorpromazine 200 mg tablet
E. Clozapine 100 mg tablet

[1] Provided by DOH

F. Olanzapine 10 mg tablet
G. Risperidone 2 mg tablet
H. Escitalopram 10 mg tablet
I. Setraline 50 mg tablet

IV. Human Resources

A. Psychiatrist

1. Valid PRC license
2. Valid PhilHealth accreditation
3. Psychiatrist certified by the Specialty Board of the Philippine Psychiatric Association OR, in areas where there is no board certified psychiatrist, a physician who has completed a residency program in psychiatry or neuropsychiatry in an institution accredited by the Philippine Psychiatric Association

B. Neurologist

1. Valid PRC license
2. Valid PhilHealth accreditation
3. Neurologist certified by the Specialty Board of the Philippine Neurological Association OR, in areas where there is no board certified neurologist, a physician who has completed a residency program in neurology or neuropsychiatry in institution accredited by the Philippine Neurological Association

C. Psychologist

1. Valid PRC License
2. Psychologist certified by the Psychological Association of the Philippines who is practicing psychological assessment and/or intervention

D. Mental Health Nurse

1. Valid PRC License
2. Certification of Completion of Training on Primary healthcare nurse trained on mhGAP, basic mental health and psychosocial support (training package of the mental health program and HEMB)

E. Mental Health Navigator

1. Administrative Staff
2. With working knowledge on operation /process flow for Mental Health who will be in-charge of record keeping and accomplishment of PhilHealth documents/forms

V. Laboratory[2]

A. Complete Blood Count (CBC) w/ platelet
B. Urinalysis
C. Fasting Blood Glucose
D. Lipid Profile
E. Liver Function Test (AST, ALT)
F. Renal Function Tests (BUN, Creatinine)

[2] may be outsourced

G. Thyroid Function Tests (TSH, FT4, FT3)
H. Electrolytes (Na, K)
I. Pregnancy Test
J. ESR
K. Anti-thyroid antibody
L. Lactate Dehydrogenase (LDH)
M. Alkaline phosphatase
N. Serum alcohol
O. Serum carbamazepine
P. Serum lithium
Q. Serum valproic acid
R. Urine drug test
S. HIV screening
T. Test for syphilis
U. Test for hepatitis B and C

VI. Radiology Diagnostic[3]

A. Neuroimaging study (CT Scan and/or MRI) with or without contrast
B. Chest X-ray (PA or AP)
C. Electroencephalogram
D. Electrocardiogram (ECG)

VII. Psychotherapy

Provisions for psychoeducation, psychosocial support and psychotherapy

VIII. Therapy (Optional)

A. Occupational therapy
B. Speech therapy

IX. Available Forms/ Recordings

A. Registry forms
B. Assessment form
C. Referral forms

[3] may be outsourced

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Self-assessment / Survey Tool for the Outpatient Benefits Package for General Mental Health Services Provider

Name of Health Facility (HF): _____

Date of Survey:_____Time started:_____Time ended:_____

Direction:

1. Put a check (✓) under the HF column if the standard is available and (x) if not.
2. For outsourced services, put a (✓) under the HF column and write under the remarks "outsourced:" plus the name of the outsourced service provider. Outsourced services must have a Memorandum of Agreement (MOA) which reflects provisions for payment such as compliance to the No Balance Billing (NBB) Policy.

REQUIREMENT		HF		PHIC		Remarks
		YES	NO	YES	NO	
1.	**HF License and Accreditation**					
1.1	The HF has updated PhilHealth Accreditation					
2.	**Mandatory Ancillary Services**					
2.1	Clean consultation and examination area					
2.2	Designated room or area for consultation with minimal sound transmission					
2.3	Handwashing sink with water and soap available (liquid soap preferred) and with materials for drying hands (clean towels OR paper towels)					
2.4	Alcohol hand rub					
2.5	Adult Stethoscope					
2.6	Pediatric Stethoscope					
2.7	Pen light					
2.8	Non-mercury sphygmomanometer with pediatric and adult cuff					
2.9	Non-mercury thermometer					
2.10	Medical weighing scale					

	REQUIREMENT	HF		PHIC		Remarks
		YES	NO	YES	NO	
2.11	Emergency medicines and supplies kept in a secured area with the following: a. Epinephrine b. IV hydrocortisone c. Diphenhydramine d. Haloperidol (amp) e. Risperidone OR olanzapine f. IV fluids g. 3cc or 5cc syringes h. Cotton balls i. Micropore tape j. IV line (adult and pediatric) k. IV cannula (gauges 22 and 26)					
2.12	O2 tank/source with O2 mask/cannula for pediatric and adult					
3.	**Medications**					
3.1	Carbamazepine 200 mg tablet					
3.2	Divalproex Sodium 500 mg tablet					
3.3	Biperiden HCl 2 mg tablet					
3.4	Chlorpromazine 200 mg tablet					
3.5	Clozapine 100 mg tablet					
3.6	Olanzapine 10 mg tablet					
3.7	Risperidone 2 mg tablet					
3.8	Escitalopram 10 mg tablet					
3.9	Sertraline 50 mg tablet					
4.	**Human Resources**					
4.1	**Primary Care Physician**					
4.1.a	Valid PRC license					
4.1.b	Valid PhilHealth accreditation					
4.1.c	Certification of Completion of Training on Mental Health Gap Action Programme (mhGAP)					
4.2	**Mental Health Nurse**					
4.2.a	Valid PRC License					
4.2.b	Certification of Completion of Training on Primary healthcare nurse trained on mhGAP, basic mental health and psychosocial support (training package of the mental health program and HEMB)					

REQUIREMENT		HF		PHIC		REMARKS
		YES	NO	YES	NO	
4.3	**Mental Health Navigator**					
4.3.a	Administrative Staff					
4.3.b	With working knowledge on operation /process flow for Mental Health who will be in-charge of record keeping and accomplishment of PhilHealth documents/forms					
5.	**Laboratory**					
5.1	Complete Blood Count (CBC) w/ platelet					
5.2	Urinalysis					
5.3	Fasting Blood Glucose					
5.4	Lipid Profile					
5.5	Renal Function Test (Creatinine)					
6.	**Radiology Diagnostic**					
6.1	Chest X-ray (PA or AP)					
7.	**Psychotherapy**					
7.1	Provisions for psychoeducation and psychosocial support					
8	Primary care screening tool based on mhGAP					
9.	**Available Forms/ Recordings**					
9.1	Registry forms					
9.2	Assessment form					
9.3	Referral forms					

PhilHealth Survey Team

Surveyor's Name	Designation	Signature

HF Management Team

Names of Management Team	Designation	Signature

MASTER COPY Date: 10/11/23 DC:

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Self-assessment / Survey Tool for the Outpatient Benefits Package for Specialty Mental Health Services Provider

Name of Health Facility (HF): _____

Date of Survey:_____Time started:_____Time ended: _____

Direction:

1. Put a check (✓) under the HF column if the standard is available and (x) if not.
2. For outsourced services, put a (✓) under the HF column and write under the remarks "outsourced:" plus the name of the outsourced service provider. Outsourced services must have a Memorandum of Agreement (MOA) which reflects provisions for payment such as compliance to the No Balance Billing (NBB) Policy.

REQUIREMENT		HF		PHIC		Remarks
		YES	No	YES	NO	
1.	**HF License and Accreditation**					
1.1	The HF has updated PhilHealth Accreditation					
2.	**Mandatory Ancillary Services**					
2.1	Clean consultation and examination area					
2.2	An enclosed room that respects the privacy of the patients					
2.3	Handwashing sink with water and soap available (liquid soap preferred) and with materials for drying hands (clean towels OR paper towels)					
2.4	Alcohol hand rub					
2.5	Adult Stethoscope					
2.6	Pediatric Stethoscope					
2.7	Pen light					
2.8	Non-mercury sphygmomanometer with pediatric and adult cuff					
2.9	Non-mercury thermometer					
2.10	Medical weighing scale					

	REQUIREMENT	HF		PHIC		REMARKS
		YES	NO	YES	NO	
2.11	Emergency kit (e-kit), emergency cart (e-cart) or emergency cabinet (e-cabinet) with the following: a. Epinephrine b. IV hydrocortisone c. Diphenhydramine d. Haloperidol (amp) e. Risperidone OR olanzapine f. IV fluids g. 3cc or 5cc syringes h. Cotton balls i. Micropore tape j. IV line (adult and pediatric) k. IV cannula (gauge 22 and 26) Note: keys to e-cabinet should always be available to authorize personnel					
2.12	O2 tank/source with O2 mask/cannula for pediatric and adult					
3.	**Medications**					
3.1	Carbamazepine 200 mg tablet					
3.2	Divalproex sodium 500 mg tablet					
3.3	Biperiden HCl 2 mg tablet					
3.4	Chlorpromazine 200 mg tablet					
3.5	Clozapine 100 mg tablet					
3.6	Olanzapine 10 mg tablet					
3.7	Risperidone 2 mg tablet					
3.8	Escitalopram 10 mg tablet					
3.9	Setraline 50 mg tablet					
4.	**Human Resources**					
4.1	**Psychiatrist**					
4.1.a	Valid PRC license					
4.1.b	Valid PhilHealth accreditation					
4.1.c	Psychiatrist certified by the Specialty Board of the Philippine Psychiatric Association OR, in areas where there is no board certified psychiatrist, a physician who has completed a residency program in psychiatry or neuropsychiatry in an institution accredited by the Philippine Psychiatric Association					

	REQUIREMENT	HF		PHIC		REMARKS
		YES	NO	YES	NO	
4.2	**Neurologist**					
4.2.a	Valid PRC license					
4.2.b	Valid PhilHealth accreditation					
4.2.c	Neurologist certified by the Specialty Board of the Philippine Neurological Association OR, in areas where there is no board certified neurologist, a physician who has completed a residency program in neurology or neuropsychiatry in institution accredited by the Philippine Neurological Association					
4.3	**Psychologist**					
4.3.a	Valid PRC License					
4.3.b	Psychologist certified by the Psychological Association of the Philippines who is practicing psychological assessment and/or intervention					
4.4	**Mental Health Nurse**					
4.4.a	Valid PRC License					
4.4.b	Certification of Completion of Training on Primary healthcare nurse trained on mhGAP, basic mental health and psychosocial support (training package of the mental health program and HEMB)					
4.5	**Mental Health Navigator**					
4.5.a	Administrative Staff					
4.5.b	With working knowledge on operation /process flow for Mental Health who will be in-charge of record keeping and accomplishment of PhilHealth documents/forms					
5.	**Laboratory**					
5.1	Complete Blood Count (CBC) w/ platelet					
5.2	Urinalysis					
5.3	Fasting Blood Glucose					
5.4	Lipid Profile					
5.5	Liver Function Test (AST, ALT)					
5.6	Renal Function Tests (BUN, Creatinine)					
5.7	Thyroid Function Tests (TSH, FT4, FT3)					
5.8	Electrolytes (Na, K)					

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	REQUIREMENT	HF		PHIC		REMARKS
		YES	NO	YES	NO	
5.9	Pregnancy Test					
5.10	ESR					
5.11	Anti-thyroid antibody					
5.12	Lactate Dehydrogenase (LDH)					
5.13	Alkaline phosphatase					
5.14	Serum alcohol					
5.15	Serum carbamazepine					
5.16	Serum lithium					
5.17	Serum valproic acid					
5.18	Urine drug test (Specify): _____					
5.19	HIV screening					
5.20	Test for syphilis					
5.21	Test for hepatitis B and C					
6.	**Radiology Diagnostic**					
6.1	Neuroimaging study (CT Scan and/or MRI) with or without contrast					
6.2	Chest X-ray (PA or AP)					
6.3	Electroencephalogram					
6.4	Electrocardiogram (ECG)					
7.	**Psychotherapy**					
7.1	Provisions for psychoeducation, psychosocial support and psychotherapy					
8.	**Therapy (Optional)**					
8.1	Occupational therapy					
8.2	Speech therapy					
9.	**Available Forms/ Recordings**					
9.1	Registry forms					
9.2	Assessment form					
9.3	Referral forms					

PhilHealth Survey Team

Surveyor's Name	Designation	Signature

HF Management Team

Names of Management Team	Designation	Signature

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Mental Health Benefits Package

	Package Rate per patient per year (PHP)	Services Covered	Target facilities
I. General Mental Health Package	9,000.00	a. Screening b. Assessment based on mhGAP c. Diagnostics d. 12 follow-up visits (at most) e. Psychoeducation and psychosocial support f. Medicines that are currently provided under the medicine access program for mental health (MAP-MH)	• Rural health units • City/municipal health offices • Levels 1 and 2 hospitals • DOH Medicine Access Program - Mental Health Access Sites • Freestanding facilities • Other facilities with trained family medicine, internal medicine, general practitioners, pediatrician including

	Package Rate per patient per year (PHP)	Services Covered	Target facilities
			MHOs based on mhGAP
II. Specialty Mental Health Package	16,000.00	a. Assessment b. Diagnostics c. 12 follow-up visits (at most) d. Psychotherapy e. Medicines that are currently provided under the medicine access program for mental health (MAP-MH)	● Level 3 hospitals, ● Level 2 hospitals with psychiatrists, neurologists and psychologists ● Custodial care facilities ● DOH identified national specialty centers for mental health

Annex C: Mental Health Registry

As of October 2023

Health Facility _____

Address _____

PhilHealth Identification Number	Sex	Diagnosis	Diagnostics ordered	Medications Given	Attending Physician

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Case No. _____

HEALTH FACILITY (HF)		DATE OF ASSESSMENT (mm/dd/yyyy)
ADDRESS OF HF		AGE: _____
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

MENTAL HEALTH PASSPORT

A. Follow – up Visits

Follow-up visits	Date of Visit (mm/dd/yyyy)	Date of Next Visit (mm/dd/yyyy)	Patient/ Parent/ Guardian's Signature	Attending Physician's signature	MH Coordinator's Signature
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					

MASTER COPY Date: 10/11/23 DC: ___

B. Medications

Name of Medicine	Dosage	Preparation	Date Given (mm/dd/yyyy)	Patient/ Parent/ Guardian's Signature	Attending Physician's signature

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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 ☐☐-☐☐☐☐☐☐☐☐-☐	

LETTER OF INTENT FOR THE TRANSFER OF CARE TO A REFERRAL MH PROVIDER

This is to certify, that patient _____ (Name of the Patient), born on _____ (Date of Birth), age _____ years old, residing at _____ (Address), was diagnosed with _____ (Diagnosis) on _____ (Date: mm/dd/yyyy) at the _____ (Name of the Referring MH Provider)

The patient has completed:

_____ (Number of Visit) number of follow-up visits and the next scheduled visit is on _____ (mm/dd/yyyy). Attached is a photocopy of the MH passport for reference.

We would like request for transfer of MH Care to _____ (Name of Referral MH Provider) under the care of _____ (Name of Physician/Specialist).

We understand that upon transfer to a referral MH provider, we will have to waive all subsequent MH claims as the referring MH facility.

MASTER COPY
DC: ___ Date: 10/11/23

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:	Certified correct by:
(Printed name and signature) Patient/Parent/Guardian	(Printed name and signature) Physician, Referring MH Provider
Date signed (mm/dd/yyyy)	PhilHealth Accreditation No. ☐☐☐☐.☐☐☐☐☐☐.☐
	Date signed (mm/dd/yyyy)

Certified correct by:
(Printed name and signature) MH Coordinator, Referring MH Provider
Date signed (mm/dd/yyyy)

Acknowledged by:	Acknowledged by:
(Printed name and signature) BAS Head or Authorized Signatory, PhilHealth Regional Office _____ In-charge of the Referring MH Provider (To provide a copy to the referring MH provider five working days upon receipt of the form; scanned copy allowed)	(Printed name and signature) Head or MH Coordinator, Referral MH Provider
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

MASTER COPY
Date: 10/11/23
D.C.

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PhilHealthOfficial teamphilhealth

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 FOR PATIENT TRANSFER
Mental Health

For Mental Health patients who will be transferred to a referral MH provider, the following checklist shall be accomplished:

NAME OF REFERRAL MH PROVIDER
ADDRESS OF REFERRAL MH PROVIDER

Requirements	**YES OR NO** (tick appropriate box)	**Signature of Responsible Person**
1. Photocopy of accomplished MH Passport	☐ Yes ☐ No	_____ Name and Signature Attending Physician
2. Letter of Intent from patient requesting for transfer to a referral MH provider (Annex J)	☐ Yes ☐ No	_____ Name and Signature Patient/Parent/Guardian

Certified complete by:	Conforme by:
_____ Printed name and signature MH Coordinator	_____ Printed name and signature Patient/Parent/Guardian
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

MANAGER COPY Date: 10/11/23 DC:

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Patient Referral

1. The referring MH provider who has rendered all the mandatory services for tranche 1 which includes screening or assessment, diagnostics and required follow up visit, shall receive the full tranche amount of the benefits package applicable to the referring MH provider.
2. If the referring MH provider rendered screening or assessment, diagnostics and at least 1 follow-up consultation prior to referring the patient, 50% of the corresponding tranche amount of the package applicable to the referring MH provider shall be reimbursed.
3. The referral MH provider shall be reimbursed 50% of the amount of tranche 1 and the full amount of the succeeding tranche applicable to the referral MH provider, provided that the follow-up consultations of the patient is completed.

Scenario A

MH Benefits Package		Reimbursement		
		Services	Code	Amount
Referred by	General Mental Health Service Provider	● Screening or assessment ● Diagnostics ● At least one (1) follow-up consultation	RMHG1	2,700.00
Referred to	General Mental Health Service Provider	Follow-up consultations to complete six (6) sessions	RMHG1	2,700.00
		Completed the required number of sessions of follow-up consultations for tranche 2	Full package rate of the General Mental Health Services - Tranche 2	

Scenario B

MH Benefits Package		Reimbursement		
		Services	Code	Amount
Referred by	Specialty Mental Health Service Provider	● Assessment ● Diagnostics ● Follow-up consultations with any of the following: a. For neurologic cases: completed at least one (1) session of follow-up consultation b. For psychological cases: completed at least one (1) session of follow-up consultation	RMHS1	4,800.00

		c. For psychiatric cases: completed at least one (1) session of follow-up consultation		
Referred to	Specialty Mental Health Service Provider	● Follow-up consultations with any of the following: a. For neurologic cases: Consultations to complete three (3) sessions b. For psychological cases: Consultations to complete three (3) sessions c. For psychiatric cases: Consultations to complete six (6) sessions	RMHS1	4,800.00
		Completed the required number of sessions of follow-up consultations for tranche 2	Full package rate of the Specialty Mental Health Services - Tranche 2	

Scenario C

MH Benefits Package		**Reimbursement**		
		Services	**Code**	**Amount**
Referred by	General Mental Health Service Provider	● Screening or assessment ● Diagnostics ● At least one (1) follow-up consultation	RMHG1	2,700.00
Referred to	Specialty Mental Health Service Provider	● Assessment ● Diagnostics ● Follow-up consultations with any of the following: a. For neurologic cases: completed at least one (1) session of follow-up consultation b. For psychological cases: completed at least one (1) session of follow-up consultation c. For psychiatric cases: completed at least one (1) session of follow-up consultation	RMHS1	4,800.00

		Completed the required number of sessions of follow-up consultations for tranche 2	Full package rate of the Specialty Mental Health Services - Tranche 2

Scenario D

MH Benefits Package		**Reimbursement**		
		Services	**Code**	**Amount**
Referred by	Specialty Mental Health Service Provider	Completed the required services for tranche 1: ● Assessment ● Diagnostics ● Follow-up consultations any of the following specialist: o Neurologist o Psychologist o Psychiatrist	Full package rate of the Specialty Mental Health Services - Tranche 1	
Referred to	General Mental Health Service Provider	Completed the required number of sessions of follow-up consultations for tranche 2	Full package rate of the General Mental Health Services - Tranche 2	

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TRANSMITTAL FORM OF CLAIMS FOR THE MENTAL HEALTH BENEFITS PACKAGE

NAME OF HEALTH FACILITY	ADDRESS OF HF

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

a. Use CAPITAL letters or UPPER CASE letters in filling out the form.
b. Indicate the PhilHealth Identification Number (PIN) of the patient. If the patient is a dependent, indicate the dependent PIN.
c. For the period of availment, follow the format (mm/dd/yyyy).
d. For the Package Code, include the code for the order of tranche payment. Example: general mental health services – first tranche should be as "MHG1"
e. If the case number is available, include the case number in the first column
f. The Remarks column may include some relevant notes which pertain to the filed claim that need to be relayed to PhilHealth.

Case Number	PhilHealth Identification Number	Period of Availment		Package Code	Remarks
1.					
2.					
3.					
4.					
5.					

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)		

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SAMPLE CLAIM FORM 2 FOR GENERAL MH PACKAGE (TRANCHE 1)

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www.philhealth.gov.ph
email: actioncenter@philhealth.gov.ph

CF-2
(Claim Form 2)
Revised September 2018

Series #

Date of assessment (Refer to Annex D: MH Passport)

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

PART I - HEALTH CARE INSTITUTION (HCI) INFORMATION

1. PhilHealth Accreditation Number (PAN) of Health Care Institution: H 9 3 0 0 X X X X

2. Name of Health Care Institution: ABC RURAL HEALTH CENTER

3. Address: SHAW BLVD (Building Number and Street Name) | PASIG CITY (City/Municipality) | (Province)

Date of the 6th follow up visits (Refer to Annex D: MH passport)

PART II - PATIENT CONFINEMENT INFORMATION

1. Name of Patient: DELA CRUZ (Last Name) | JUAN (First Name) | III (Name Extension JR/SR/III) | MAPAGPALA (Middle Name (ex: DELACRUZ JUAN JR SPAG))

2. Was patient referred by another Health Care Institution (HCI)?
☑ NO ☐ YES — Name of referring Health Care Institution | Building Number and Street Name | City/Municipality | Province | Zip code

Write OUTPATIENT in lieu of time admitted & discharged

3. Confinement Period:
a. Date Admitted: 0 9 (month) 0 5 (day) 2 0 2 3 (year) — b. Time Admitted: (hour) (min) ☐ AM ☐ PM
c. Date Discharge: 1 2 (month) 2 9 (day) 2 0 2 3 (year) — d. Time Discharge: (hour) (min) ☐ AM ☐ PM
OUTPATIENT

4. Patient Disposition: (select only 1)
☑ a. Improved
☐ b. Recovered
☐ c. Home/Discharged Against Medical Advise
☐ d. Absconded
☐ e. Expired (month) (day) (year) Time: (hour) (min) ☐ AM ☐ PM
☐ f. Transferred/Referred — Name of Referral Health Care Institution | Building Number and Street Name | City/Municipality | Province | Zip code
Reason/s for referral/transfer:

Tick YES if the patient was referred by another HF

5. Type of Accomodation: ☐ Private ☐ Non-Private (Charity/Service)

6. Admission Diagnosis/es: Schizophrenia

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

Diagnosis	ICD-10 Code/s	Related Procedure/s (if there's any)	RVS Code	Date of Procedure	Laterality (check applicable box)
a. Schizophrenia		i.			☐ left ☐ right ☐ both
		ii.			☐ left ☐ right ☐ both
		iii.			☐ left ☐ right ☐ both
b.		i.			☐ left ☐ right ☐ both
		ii.			☐ left ☐ right ☐ both
		iii.			☐ left ☐ right ☐ both

This is not required as mental health services provided is an out-patient setting

8. Special Considerations:

a. For the following repetitive procedures, check box that applies and enumerate the procedure/sessions dates (mm-dd-yyyy). For chemotherapy, see guidelines.
☐ Hemodialysis ☐ Peritoneal Dialysis ☐ Radiotherapy (LINAC) ☐ Radiotherapy (COBALT)
☐ Bone Transplant ☐ Brachytherapy ☐ Chemotherapy ☐ Simple Debridement

Indicate the diagnosis

b. For Z Benefit Package — **Z-Benefit Package Code:** MHG1

Indicate the appropriate "benefit package code"

c. For MCP Package (enumerate four dates (mm-dd-year) of pre-natal check-ups)
1 ____ 2 ____ 3 ____ 4 ____

d. For TB DOTS Package ☐ Intensive Phase ☐ Maintenance Phase

e. For Animal Bite Package (write the dates (mm-dd-year) when the following doses of vaccine were given) — **Note: Anti Rabies Vaccine (ARV), Rabies Immunoglobulin (RIG)**
Day 0 ARV ____ **Day 3 ARV** ____ **Day 7 ARV** ____ **RIG** ____ **Others (Specify)** ____

f. For Newborn Care Package ☐ Essential Newborn Care ☐ Newborn Hearing Screening Test ☐ Newborn Screening Test — For Newborn Screening, *please attach NBS Filter Sticker here*

For Essential Newborn Care (check applicable boxes):
☐ Immediate drying of newborn ☐ Timely cord clamping ☐ Weighing of the newborn ☐ BCG vaccination ☐ Hepatitis B vaccination
☐ Early skin-to-skin contact ☐ Eye Prophylaxis ☐ Vitamin K administration ☐ Non-separation of mother/baby for early breastfeeding initiation

This is not required

g. For Outpatient HIV/AIDS Treatment Package — **Laboratory Number:** ____

9. PhilHealth Benefits:
ICD 10 or RVS Code: — First Case Rate ____ Second Case Rate ____

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10. Accreditation Number/Name of Accredited Health Care Professional/Date Signed and Professional Fees/Charges
(Use additional CF2 if necessary)

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

Tick this box if patient paid no additional Professional fee

Tick this box if patient paid an additional Professional fee

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

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

A. CERTIFICATION OF CONSUMPTION OF BENEFITS:

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

	Total Actual Charges*
Total Health Care Institution Fees	5,400.00
Total Professional Fees	
Grand Total	5,400.00

Tick this box if patient has NO co-payment

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

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

	Total Actual Charges*	Amount after Application of Discount (i.e., personal discount, Senior Citizen/PWD)	PhilHealth Benefit	Amount after PhilHealth Deduction
Total Health Care Institution Fees	6,400.00		5,400.00	Amount: P 1,000.00 Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☑ Others (i.e., PCSO, Promissory note, etc.)
Total Professional Fees (for accredited and non-accredited professionals)				Amount: P Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☐ Others (i.e., PCSO, Promissory note, etc.)

Tick this box if patient has a co-payment

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

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

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

MASTER COPY Date: 10/11/23 DC:

B. CONSENT TO ACCESS PATIENT RECORD/S:

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

JUAN MAPAGPALA DELA CRUZ, III
Signature Over Printed Name of Member/Patient/Authorized Representative

Affix signature of the patient/parent /authorized representative

Date Signed: 1 2 - 2 9 - 2 0 2 3 (month - day - year)

Indicate date signed

If patient/representative is unable to write, put right thumbmark. Patient/Representative should be assisted by an HCI representative.

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

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

☐ Patient ☐ Representative

PART IV - CERTIFICATION OF CONSUMPTION OF HEALTH CARE INSTITUTION

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

CARDING DELOS REYES — Signature Over Printed Name of Authorized HCI Representative

RECORDS OFFICER — Official Capacity/Designation

Date Signed: 1 2 - 3 0 - 2 0 2 3 (month - day - year)

Affix signature of HF representative

PhilHealth
Your Partner In Health

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 • Trunkline (02) 441-7444
www.philhealth.gov.ph
email: actioncenter@philhealth.gov.ph

CF-2
(Claim Form 2)
Revised September 2015

Series #

Date of the 7th follow-up visits (Refer to Annex D: MH Passport)

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

PART I - HEALTH CARE INSTITUTION (HCI) INFORMATION

1. PhilHealth Accreditation Number (PAN) of Health Care Institution: H 9 3 0 0 X X X X

2. Name of Health Care Institution: ABC RURAL HEALTH CENTER

3. Address: SHAW BLVD (Building Number and Street Name) | PASIG CITY (City/Municipality) | (Province)

Date of the last follow-up visits (Refer to Annex D: MH passport)

PART II - PATIENT CONFINEMENT INFORMATION

1. Name of Patient: DELA CRUZ (Last Name) | JUAN (First Name) | III (Name Extension (JR/SR/III)) | MAPAGPALA (Middle Name (ex. DELACRUZ JUAN JR/SEPAG))

2. Was patient referred by another Health Care Institution (HCI)?
☑ NO ☐ YES
Name of referring Health Care Institution | Building Number and Street Name | City/Municipality | Province | Zip code

Write OUTPATIENT in lieu of time admitted & discharged

3. Confinement Period:
a. Date Admitted: 01 (month) 05 (day) 2023 (year) b. Time Admitted: ____ (hour) ____ (min) ☐ AM ☐ PM
c. Date Discharge: 06 (month) 05 (day) 2024 (year) d. Time Discharge: ____ (hour) ____ (min) ☐ AM ☐ PM
OUTPATIENT

4. Patient Disposition: (select only 1)
☑ a. Improved
☐ b. Recovered
☐ c. Home/Discharged Against Medical Advise
☐ d. Absconded
☐ e. Expired ____ (month) ____ (day) ____ (year) Time: ____ (hour) ____ (min) ☐ AM ☐ PM
☐ f. Transferred/Referred
Name of Referral Health Care Institution
Building Number and Street Name | City/Municipality | Province | Zip code
Reason/s for referral/transfer

Tick YES if the patient was referred by another HF

5. Type of Accomodation: ☐ Private ☐ Non-Private (Charity/Service)

6. Admission Diagnosis/es: Schizophrenia

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

	Diagnosis	ICD-10 Code/s	Related Procedure/s (if there's any)	RVS Code	Date of Procedure	Laterality (check applicable box)
a.	Schizophrenia		i.			☐ left ☐ right ☐ both
			ii.			☐ left ☐ right ☐ both
			iii.			☐ left ☐ right ☐ both
b.			i.			☐ left ☐ right ☐ both
			ii.			☐ left ☐ right ☐ both
			iii.			☐ left ☐ right ☐ both

This is not required as mental health services provided is an out-patient setting

8. Special Considerations:

a. For the following repetitive procedures, check box that applies and enumerate the procedure/sessions dates (mm-dd-yyyy). For chemotherapy, see guidelines.
☐ Hemodialysis ____ ☐ Blood Transfusion ____
☐ Peritoneal Dialysis ____ ☐ Brachytherapy ____
☐ Radiotherapy (LINAC) ____ ☐ Chemotherapy ____
☐ Radiotherapy (COBALT) ____ ☐ Simple Debridement ____

Indicate the diagnosis

b. For Z-Benefit Package **Z-Benefit Package Code:** MHG2

Indicate the appropriate "benefit package code"

c. For MCP Package (enumerate four dates (mm-dd-year) of pre-natal check-ups)
1 ____ 2 ____ 3 ____ 4 ____

d. For TB DOTS Package ☐ Intensive Phase ☐ Maintenance Phase

e. For Animal Bite Package (write the dates (mm-dd-year) when the following doses of vaccine were given) **Note: Anti Rabies Vaccine (ARV), Rabies Immunoglobulin (RIG)**
Day 0 ARV ____ **Day 3 ARV** ____ **Day 7 ARV** ____ **RIG** ____ **Others (Specify)** ____

f. For Newborn Care Package ☐ Essential Newborn Care ☐ Newborn Hearing Screening Test ☐ Newborn Screening Test
For Newborn Screening, please attach NBS Filer Sticker here
For Essential Newborn Care (check applicable boxes)
☐ Immediate drying of newborn ☐ Timely cord clamping ☐ Weighing of the newborn ☐ BCG vaccination ☐ Hepatitis B vaccination
☐ Early skin-to-skin contact ☐ Eye Prophylaxis ☐ Vitamin K administration ☐ Non-separation of mother/baby for early breastfeeding initiation

This is not required

g. For Outpatient HIV/AIDS Treatment Package **Laboratory Number:** ____

9. PhilHealth Benefits:
ICD 10 or RVS Code: ____ First Case Rate ____ Second Case Rate ____

MASTER COPY
Date: 10/1/23
DC: ____

10. Accreditation Number/Name of Accredited Health Care Professional/Date Signed and Professional Fees/Charges
(Use additional CF2 if necessary)

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

Tick this box if patient paid no additional Professional fee

Tick this box if patient paid an additional Professional fee

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

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

A. CERTIFICATION OF CONSUMPTION OF BENEFITS:

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

	Total Actual Charges*
Total Health Care Institution Fees	3,600.00
Total Professional Fees	
Grand Total	3,600.00

Tick this box if patient has NO co-payment

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

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

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

Tick this box if patient has a co-payment

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

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

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

MASTER COPY Date: 10/23 DC: JJ

B. CONSENT TO ACCESS PATIENT RECORD/S:

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

JUAN MAPAGPALA DELA CRUZ, III
Signature Over Printed Name of Member/Patient/Authorized Representative

Affix signature of the patient/parent /authorized representative

Date Signed: 0 6 0 5 2024 (month - day - year)

Indicate date signed

If patient/representative is unable to write, put right thumbmark. Patient/Representative should be assisted by an HCI representative.

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

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

PART IV - CERTIFICATION OF CONSUMPTION OF HEALTH CARE INSTITUTION

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

CARDING DELOS REYES
Signature Over Printed Name of Authorized HCI Representative

RECORDS OFFICER
Official Capacity/Designation

Date Signed: 0 6 0 6 2024 (month - day - year)

Affix signature of HF representative

SAMPLE CLAIM FORM 2 FOR SPECIALTY MH PACKAGE (TRANCHE 1)

PhilHealth
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Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 • Trunkline (02) 441-7444
www.philhealth.gov.ph
email: actioncenter@philhealth.gov.ph

CF-2
(Claim Form 2)
Revised September 2018

Series #

Date of assessment (Refer to Annex D: MH Passport)

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

PART I - HEALTH CARE INSTITUTION (HCI) INFORMATION

1. PhilHealth Accreditation Number (PAN) of Health Care Institution: H 9 3 0 0 X X X X

2. Name of Health Care Institution: ABC Mental and Wellness Hospital

3. Address: SHAW BLVD (Building Number and Street Name) | PASIG CITY (City/Municipality) | (Province)

Date of the follow-up visits with any of the following:
Psychiatrist: On the 6th follow-up visit
Neurologist: On the 3rd follow-up visit
Psychologist:

PART II - PATIENT CONFINEMENT INFORMATION

1. Name of Patient: DELA CRUZ (Last Name) | JUAN (First Name) | III (Name Extension (JR/SR/III)) | MAPAGPALA (Middle Name (ex. DELACRUZ JUAN JR SRMG))

2. Was patient referred by another Health Care Institution (HCI)?
☑ NO ☐ YES
Name of referring Health Care Institution | Building Number and Street Name | City/Municipality | Province | Zip code

3. Confinement Period:
a. Date Admitted: 0 9 - 0 5 - 2 0 2 3 (month - day - year) b. Time Admitted: ____ : ____ ☐ AM ☐ PM
c. Date Discharge: 1 2 - 0 5 - 2 0 2 3 (month - day - year) d. Time Discharge: ____ : ____ ☐ AM ☐ PM
OUTPATIENT

Write OUTPATIENT in lieu of time admitted & discharged

4. Patient Disposition: (select only 1)
☑ a. Improved
☐ b. Recovered
☐ c. Home/Discharged Against Medical Advise
☐ d. Absconded
☐ e. Expired ____ - ____ - ____ (month - day - year) Time: ____ : ____ ☐ AM ☐ PM
☐ f. Transferred/Referred ____ (Name of Referral Health Care Institution)
(Building Number and Street Name) | (City/Municipality) | (Province) | (Zip code)
Reason/s for referral/transfer: ____

Tick YES if the patient was referred by another HF

5. Type of Accomodation: ☐ Private ☐ Non-Private (Charity/Service)

6. Admission Diagnosis/es: Epilepsy

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

Diagnosis	ICD-10 Code/s	Related Procedure/s (if there's any)	RVS Code	Date of Procedure	Laterality (check applicable box)
a. Epilepsy		i.			☐ left ☐ right ☐ both
		ii.			☐ left ☐ right ☐ both
		iii.			☐ left ☐ right ☐ both
b.		i.			☐ left ☐ right ☐ both
		ii.			☐ left ☐ right ☐ both
		iii.			☐ left ☐ right ☐ both

This is not required as mental health services provided is an out-patient setting

8. Special Considerations:

a. For the following repetitive procedures, check box that applies and enumerate the procedure/sessions dates (mm-dd-yyyy). For chemotherapy, see guidelines.
☐ Hemodialysis ____ ☐ Blood Transfusion ____
☐ Peritoneal Dialysis ____ ☐ Brachytherapy ____
☐ Radiotherapy (LINAC) ____ ☐ Chemotherapy ____
☐ Radiotherapy (COBALT) ____ ☐ Simple Debridement ____

Indicate the diagnosis

b. For Z Benefit Package **Z-Benefit Package Code:** MHS1

Indicate the appropriate "benefit package code"

c. For MCP Package (enumerate four dates (mm-dd-year) of pre-natal check-ups)
1 ____ 2 ____ 3 ____ 4 ____

d. For TB DOTS Package ☐ Intensive Phase ☐ Maintenance Phase

e. For Animal Bite Package (write the dates (mm-dd-year) when the following doses of vaccine were given) **Note: Anti Rabies Vaccine (ARV), Rabies Immunoglobulin (RIG)**
Day 0 ARV ____ **Day 3 ARV** ____ **Day 7 ARV** ____ **RIG** ____ **Others (Specify)** ____

f. For Newborn Care Package ☐ Essential Newborn Care ☐ Newborn Hearing Screening Test ☐ Newborn Screening Test
For Newborn Screening, please attach NBS Filter Sticker here

For Essential Newborn Care (check applicable boxes)
☐ Immediate drying of newborn ☐ Timely cord clamping ☐ Weighing of the newborn ☐ BCG vaccination ☐ Hepatitis B vaccination
☐ Early skin-to-skin contact ☐ Eye Prophylaxis ☐ Vitamin K administration ☐ Non-separation of mother/baby for early breastfeeding initiation

g. For Outpatient HIV/AIDS Treatment Package **Laboratory Number:** ____

This is not required

9. PhilHealth Benefits:
ICD 10 or RVS Code: a. First Case Rate ____ Second Case Rate ____

MASTER COPY
DC: Date: 10/1/23

10. Accreditation Number/Name of Accredited Health Care Professional/Date Signed and Professional Fees/Charges
(Use additional CF2 if necessary)

Accreditation number/Name of Accredited Health Care Professional/Date Signed	Details
Accreditation No.: 1234-5678-9012 JUANA DELA CRUZ, MD Signature Over Printed Name Date Signed: month-day-year	☑ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____
Accreditation No.: _____ Signature Over Printed Name Date Signed: month-day-year	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____
Accreditation No.: _____ Signature Over Printed Name Date Signed: month-day-year	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____

Tick this box if patient paid no additional Professional fee

Tick this box if patient paid an additional Professional fee

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

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

A. CERTIFICATION OF CONSUMPTION OF BENEFITS:

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

	Total Actual Charges*
Total Health Care Institution Fees	9,600.00
Total Professional Fees	
Grand Total	9,600.00

Tick this box if patient has NO co-payment

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

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

	Total Actual Charges*	Amount after Application of Discount (i.e., personal discount, Senior Citizen/PWD)	PhilHealth Benefit	Amount after PhilHealth Deduction
Total Health Care Institution Fees	12,000.00		9,600.00	Amount P 2,400.00 Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☑ Others (i.e., PCSO, Promisory note, etc.)
Total Professional Fees (for accredited and non-accredited professionals)				Amount P _____ Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☐ Others (i.e., PCSO, Promisory note, etc.)

Tick this box if patient has a co-payment

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

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

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

MASTER COPY Date: 10/11/23 DC:

B. CONSENT TO ACCESS PATIENT RECORD/S:

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

JUAN MAPAGPALA DELA CRUZ, III
Signature Over Printed Name of Member/Patient/Authorized Representative

Affix signature of the patient/parent /authorized representative

Date Signed: 12-05-2023 (month-day-year)

Indicate date signed

If patient/representative is unable to write, put right thumbmark. Patient/ Representative should be assisted by an HCI representative.

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

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

☐ Patient ☐ Representative

PART IV - CERTIFICATION OF CONSUMPTION OF HEALTH CARE INSTITUTION

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

CARDING DELOS REYES — Signature Over Printed Name of Authorized HCI Representative
RECORDS OFFICER — Official Capacity/Designation
Date Signed: 12-06-2023 (month-day-year)

Affix signature of HF representative

SAMPLE CLAIM FORM 2 FOR SPECIALTY MH PACKAGE (TRANCHE 2)

PhilHealth
Your Partner in Health

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 • Trunkline (02) 441-7444
www.philhealth.gov.ph
email: actioncenter@philhealth.gov.ph

CF-2
(Claim Form 2)
Revised September 2019

Series #

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

PART I - HEALTH CARE INSTITUTION (HCI) INFORMATION

1. PhilHealth Accreditation Number (PAN) of Health Care Institution: H 9 3 0 0 X X X X

2. Name of Health Care Institution: ABC Mental and Wellness Hospital

3. Address: SHAW BLVD (Building Number and Street Name) | PASIG CITY (City/Municipality) | (Province)

PART II - PATIENT CONFINEMENT INFORMATION

1. Name of Patient: DELA CRUZ (Last Name) | JUAN (First Name) | III (Name Extension (JR/SR/III)) | MAPAGPALA (Middle Name (ex. DELACRUZ JUAN JR SIPAC))

2. Was patient referred by another Health Care Institution (HCI)?
☑ NO ☐ YES
Name of referring Health Care Institution | Building Number and Street Name | City/Municipality | Province | Zip code

3. Confinement Period:
a. Date Admitted: 01 (month) - 05 (day) - 2024 (year) b. Time Admitted: (hour) : (min) ☐ AM ☐ PM
c. Date Discharge: 04 (month) - 05 (day) - 2024 (year) d. Time Discharge: (hour) : (min) ☐ AM ☐ PM

OUTPATIENT

4. Patient Disposition: (select only 1)
☑ a. Improved
☐ b. Recovered
☐ c. Home/Discharged Against Medical Advise
☐ d. Absconded
☐ e. Expired (month - day - year) Time: (hour : min) ☐ AM ☐ PM
☐ f. Transferred/Referred
Name of Referral Health Care Institution
Building Number and Street Name | City/Municipality | Province | Zip code
Reason/s for referral/transfer:

5. Type of Accomodation: ☐ Private ☐ Non-Private (Charity/Service)

6. Admission Diagnosis/es:
Epilepsy

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

	Diagnosis	ICD-10 Code/s	Related Procedure/s (if there's any)	RVS Code	Date of Procedure	Laterality (check applicable box)
a.	Epilepsy		i.			☐ left ☐ right ☐ both
			ii.			☐ left ☐ right ☐ both
			iii.			☐ left ☐ right ☐ both
b.			i.			☐ left ☐ right ☐ both
			ii.			☐ left ☐ right ☐ both
			iii.			☐ left ☐ right ☐ both

8. Special Considerations:

a. For the following repetitive procedures, check box that applies and enumerate the procedure/sessions dates [mm-dd-yyyy]. For chemotherapy, see guidelines.
☐ Hemodialysis
☐ Peritoneal Dialysis
☐ Radiotherapy (LINAC)
☐ Radiotherapy (COBALT)
☐ Blood Transfusion
☐ Brachytherapy
☐ Chemotherapy
☐ Simple Debridement

b. For Z-Benefit Package **Z-Benefit Package Code:** MHS2

c. For MCP Package (enumerate four dates [mm-dd-year] of pre-natal check-ups)
1 2 3 4

d. For TB DOTS Package ☐ Intensive Phase ☐ Maintenance Phase

e. For Animal Bite Package (write the dates [mm-dd-year] when the following doses of vaccine were given) **Note: Anti Rabies Vaccine (ARV), Rabies Immunoglobulin (RIG)**
Day 0 ARV **Day 3 ARV** **Day 7 ARV** **RIG** **Others (Specify)**

f. For Newborn Care Package ☐ Essential Newborn Care ☐ Newborn Hearing Screening Test ☐ Newborn Screening Test
For Newborn Screening, please attach NBS Filter Sticker here

For Essential Newborn Care (check applicable boxes)
☐ Immediate drying of newborn ☐ Timely cord clamping ☐ Weighing of the newborn ☐ BCG vaccination ☐ Hepatitis B vaccination
☐ Early skin-to-skin contact ☐ Eye Prophylaxis ☐ Vitamin K administration ☐ Non-separation of mother/baby for early breastfeeding initiation

g. For Outpatient HIV/AIDS Treatment Package **Laboratory Number:**

9. PhilHealth Benefits:
ICD 10 or RVS Code: First Case Rate Second Case Rate

MASTER COPY Date: 10/1/23

Date of the succeeding follow-up visit with any of the following:
a. Psychiatrist
b. Neurologist
c. Psychologist

(Refer to Annex D: MH passport)

Date of the last follow-up visit with any of the following:
a. Psychiatrist
b. Neurologist
c. Psychologist

(Refer to Annex D: MH passport)

Write OUTPATIENT in lieu of time admitted & discharged

Tick YES if the patient was referred by another HF

This is not required as mental health services provided is an out-patient setting

Indicate the diagnosis

Indicate the appropriate "benefit package code"

This is not required

10. Accreditation Number/Name of Accredited Health Care Professional/Date Signed and Professional Fees/Charges
(Use additional CF2 if necessary):

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

Tick this box if patient paid no additional Professional fee

Tick this box if patient paid an additional Professional fee

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

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

A. CERTIFICATION OF CONSUMPTION OF BENEFITS:

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

	Total Actual Charges*
Total Health Care Institution Fees	6,400.00
Total Professional Fees	
Grand Total	6,400.00

Tick this box if patient has NO co-payment

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

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

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

Tick this box if patient has a co-payment

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

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

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

MASTER COPY Date: 10/11/23 DC: ___

B. CONSENT TO ACCESS PATIENT RECORD/S:

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

JUAN MAPAGPALA DELA CRUZ, III
Signature Over Printed Name of Member/Patient/Authorized Representative

Affix signature of the patient/parent /authorized representative

Date Signed: 0 4 - 0 5 - 2 0 2 4 (month - day - year)

Indicate date signed

If patient/representative is unable to write, put right thumbmark. Patient/ Representative should be assisted by an HCI representative.

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

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

☐ Patient ☐ Representative

PART IV - CERTIFICATION OF CONSUMPTION OF HEALTH CARE INSTITUTION

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

CARDING DELOS REYES — Signature Over Printed Name of Authorized HCI Representative
RECORDS OFFICER — Official Capacity/Designation
Date Signed: 0 4 - 0 6 - 2 0 2 4 (month - day - year)

Affix signature of HF representative

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(02) 8441-7442 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

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 MANDATORY AND OTHER SERVICES
General Mental Health Services
Tranche 1

Place a (✓) in the appropriate tick box if the services is done

SERVICES	
☐ Screening	
☐ Assessment	
☐ Diagnostics	☐ Complete Blood Count (CBC) w/ platelet
	☐ Urinalysis
	☐ Fasting Blood Glucose
	☐ Lipid Profile
	☐ Renal Function Test
	☐ Creatinine
	☐ Radiology: Chest X-ray (PA or AP)
☐ Follow – up visits for psychoeducation and psychosocial support	1. Date (mm/dd/yyyy)
	2. Date (mm/dd/yyyy)
	3. Date (mm/dd/yyyy)
	4. Date (mm/dd/yyyy)
	5. Date (mm/dd/yyyy)
	6. Date (mm/dd/yyyy)
☐ Medicines provided	

MASTER COPY Date: 10/11/23 DC:

Conforme by:	**Certified correct by:**
(Printed name and signature) Parent/Guardian/Patient	(Printed name and signature) Attending Physician
	PhilHealth Accreditation No. ☐☐☐☐.☐☐☐☐☐☐☐.
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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PhilHealthOfficial teamphilhealth

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 MANDATORY AND OTHER SERVICES
General Mental Health Services
Tranche 2

Kindly indicate the date of the follow-up visits in the space provided

Services	
☐ Follow – up visits for psychoeducation and psychosocial support	1. Date (mm/dd/yyyy)
	2. Date (mm/dd/yyyy)
	3. Date (mm/dd/yyyy)
	4. Date (mm/dd/yyyy)
	5. Date (mm/dd/yyyy)
	6. Date (mm/dd/yyyy)

Conforme by:	**Certified correct by:**
(Printed name and signature) Parent/Guardian/Patient	(Printed name and signature) Attending Physician
Date signed (mm/dd/yyyy)	PhilHealth Accreditation No. ☐☐☐☐☐.☐☐☐☐☐☐☐☐☐.
	Date signed (mm/dd/yyyy)

MASTER COPY
Date 10/11/23
DC: TP

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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 MANDATORY AND OTHER SERVICES
Specialty Mental Health Services
Tranche 1

Place a (✓) in the appropriate tick box if the services is done or given

SERVICES	
☐ Assessment	
☐ Diagnostics	☐ Complete Blood Count (CBC) w/ platelet
	☐ Urinalysis
	☐ Fasting Blood Glucose
	☐ Lipid Profile
	Liver Function Test
	☐ AST
	☐ ALT
	Renal Function Tests
	☐ BUN
	☐ Creatinine
	Thyroid Function Tests
	☐ TSH
	☐ FT4
	☐ FT3
	Electrolytes
	☐ Sodium (Na)
	☐ Potassium (K)
	☐ Pregnancy Test (For Female)
	☐ ESR
	☐ Anti-thyroid antibody

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DIC: _____ Date: 9/11/23

SERVICES	
	☐ Lactate Dehydrogenase (LDH)
	☐ Alkaline Phosphatase
	☐ Serum Alcohol
	☐ Serum Carbamazepine
	☐ Serum Lithium
	☐ Serum Valproic Acid
	☐ Urine Drug Test (Specify): _____
	☐ HIV Screening
	☐ Test for syphilis
	☐ Test for hepatitis B and C
	☐ Neuroimaging study (CT Scan and/or MRI) with or without contrast
	☐ Chest X-ray (PA or AP)
	☐ Electroencephalogram
	☐ Electrocardiogram (ECG)
☐ Follow – up visits for psychoeducation, psychosocial support and psychotherapy	☐ **Psychiatrist**
	1. Date (mm/dd/yyyy)
	2. Date (mm/dd/yyyy)
	3. Date (mm/dd/yyyy)
	4. Date (mm/dd/yyyy)
	5. Date (mm/dd/yyyy)
	6. Date (mm/dd/yyyy)
	☐ **Neurologist**
	1. Date (mm/dd/yyyy)
	2. Date (mm/dd/yyyy)
	3. Date (mm/dd/yyyy)
	☐ **Psychologist**
	1. Date (mm/dd/yyyy)
	2. Date (mm/dd/yyyy)
	3. Date (mm/dd/yyyy)

Conforme by:	**Certified correct by:**
(Printed name and signature) Parent/Guardian/Patient	(Printed name and signature) Attending Physician
	PhilHealth Accreditation No. |||||.|||||||||.|
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

MASTER COPY
DC: Date: 10/11/23

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Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8441-7442 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

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 MANDATORY AND OTHER SERVICES
Specialty Mental Health Services
Tranche 2

Kindly indicate the date of the follow-up visits in the space provided

SERVICES	
☐ Follow – up visits for psychoeducation, psychosocial support and psychotherapy	☐ **Psychiatrist**
	1. Date (mm/dd/yyyy)
	2. Date (mm/dd/yyyy)
	3. Date (mm/dd/yyyy)
	4. Date (mm/dd/yyyy)
	5. Date (mm/dd/yyyy)
	6. Date (mm/dd/yyyy)
	☐ **Neurologist**
	1. Date (mm/dd/yyyy)
	2. Date (mm/dd/yyyy)
	3. Date (mm/dd/yyyy)
	4. Date (mm/dd/yyyy)
	5. Date (mm/dd/yyyy)
	6. Date (mm/dd/yyyy)
	7. Date (mm/dd/yyyy)
	8. Date (mm/dd/yyyy)
	9. Date (mm/dd/yyyy)

SERVICES	
	☐ **Psychologist**
	1. Date (mm/dd/yyyy)
	2. Date (mm/dd/yyyy)
	3. Date (mm/dd/yyyy)
	4. Date (mm/dd/yyyy)
	5. Date (mm/dd/yyyy)
	6. Date (mm/dd/yyyy)
	7. Date (mm/dd/yyyy)
	8. Date (mm/dd/yyyy)
	9. Date (mm/dd/yyyy)

Conforme by:	**Certified correct by:**
(Printed name and signature) Parent/Guardian/Patient	(Printed name and signature) Attending Physician
	PhilHealth Accreditation No. | | | | | . | | | | | | | | . | |
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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MENTAL HEALTH SATISFACTION QUESTIONNAIRE

We would like to know how you feel about the services that pertain to the Outpatient Benefits Package for Mental Health 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 2, please tick on the appropriate box.

1. Respondent's age is:
   - ☐ 19 years old and below
   - ☐ Between 20 to 35
   - ☐ Between 36 to 45
   - ☐ Between 46 to 55
   - ☐ Between 56 to 65
   - ☐ Above 65 years old

2. Sex of respondent
   - ☐ Male
   - ☐ Female

For items 3 to 7, please select the one best response by ticking the appropriate box.

3. How would you rate the services received from the health facility in terms of availability of medicines or supplies needed for the treatment of your condition?
   - ☐ Adequate
   - ☐ Inadequate
   - ☐ Don't Know

4. How would you rate the patient's or family's involvement in the care in terms of patient empowerment?
   - ☐ Excellent
   - ☐ Satisfactory
   - ☐ Unsatisfactory
   - ☐ Don't Know

5. In general, how would you rate the health care professionals that provided the services for this benefit package in terms of doctor-patient relationship?
   - ☐ Excellent
   - ☐ Satisfactory
   - ☐ Unsatisfactory
   - ☐ Don't Know

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6. In your opinion, by how much has your health facility expenses been lessened by availing of PhilHealth benefits package for mental health?
   - ☐ Less than half
   - ☐ By half
   - ☐ More than half
   - ☐ Don't know

7. Overall patient satisfaction (PS mark) is:
   Excellent
   - ☐ Satisfactory
   - ☐ Unsatisfactory
   - ☐ Don't know

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

   _____
   _____
   _____
   _____
   _____

Thank you. Your feedback is important to us!

_____
Signature over Printed Name
(Patient/Parent/Guardian)

Date accomplished: _____

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PhilHealthOfficial teamphilhealth

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 GENERAL MENTAL HEALTH SERVICES – TRANCHE 1

Requirements	Please Check
1. Transmittal Form of Claims for Mental Health (Annex H)	
2. Checklist of Requirements for Reimbursement (Annex L.1)	
3. Properly accomplished Claim Form (CF) 2	
4. Checklist of Mandatory and Other Services (Annex J.1)	
5. Properly accomplished MH Satisfaction Questionnaire (Annex K)	
6. Photocopy of the Mental Health Passport (Annex D)	
7. Original or Certified True Copy (CTC) of the Statement of Account	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Physician	(Printed name and signature) Head of the Health Facility
PhilHealth Accreditation No. ☐☐☐☐.☐☐☐☐☐☐.☐	PhilHealth Accreditation No. ☐☐☐☐.☐☐☐☐☐☐.☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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Date: 10/11/23
DC: JJF

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

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PhilHealthOfficial teamphilhealth

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 GENERAL MENTAL HEALTH SERVICES – TRANCHE 2

Requirements	Please Check
1. Transmittal Form of Claims for Mental Health (Annex H)	
2. Checklist of Requirements for Reimbursement (Annex L.2)	
3. Properly accomplished Claim Form (CF) 2	
4. Checklist of Mandatory and Other Services (Annex J.2)	
5. Properly accomplished MH Satisfaction Questionnaire (Annex K)	
6. Photocopy of the Mental Health Passport (Annex D)	
7. Original or Certified True Copy (CTC) of the Statement of Account	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Physician	(Printed name and signature) Head of the Health Facility
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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Date: 10/11/23
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Annex L.3: Checklist of Requirements for Reimbursement – Tranche 1
As of October 2023

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PhilHealthOfficial teamphilhealth

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 SPECIALTY MENTAL HEALTH SERVICES – TRANCHE 1

Requirements	Please Check
1. Transmittal Form of Claims for Mental Health (Annex H)	
2. Checklist of Requirements for Reimbursement (Annex L.3)	
3. Properly accomplished Claim Form (CF) 2	
4. Checklist of Mandatory and Other Services (Annex J.3)	
5. Properly accomplished MH Satisfaction Questionnaire (Annex K)	
6. Photocopy of the Mental Health Passport (Annex D)	
7. Original or Certified True Copy (CTC) of the Statement of Account	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Physician	(Printed name and signature) Head of the Health Facility
PhilHealth Accreditation No. ☐☐☐☐☐-☐☐☐☐☐☐☐-☐	PhilHealth Accreditation No. ☐☐☐☐☐-☐☐☐☐☐☐☐-☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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

MASTER COPY
DC: ___ Date: 10/11/23

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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 SPECIALTY MENTAL HEALTH SERVICES – TRANCHE 2

Requirements	Please Check
1. Transmittal Form of Claims for Mental Health (Annex H)	
2. Checklist of Requirements for Reimbursement (Annex L.4)	
3. Properly accomplished Claim Form (CF) 2	
4. Checklist of Mandatory and Other Services (Annex J.4)	
5. Properly accomplished MH Satisfaction Questionnaire (Annex K)	
6. Photocopy of the Mental Health Passport (Annex D)	
7. Original or Certified True Copy (CTC) of the Statement of Account	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Physician	(Printed name and signature) Head of the Health Facility
PhilHealth Accreditation No. ☐☐☐☐.☐☐☐☐☐☐.☐	PhilHealth Accreditation No. ☐☐☐☐.☐☐☐☐☐☐.☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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

MASTER COPY
DC: ___ Date: 10/11/23