



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. 2023¹, 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

- 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

- 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:
 - 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

- 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 Me	ntal Health Servi	ces
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 Me	ntal Health Servi	ces
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 Mer	ntal Health Servi	ices
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;
 - 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

- 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 wi3







Republic of the Philippines

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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. Medications¹

- 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. Laboratory²

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

VI. Radiology Diagnostic³

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. Medications¹

- 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
- 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

- 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. Laboratory²

- 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 Diagnostic3

- 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

Annex A.3: Health Facilities Standards

As of October 2023





Name of Health Facility (HF):

Non-mercury thermometer

2.10 Medical weighing scale

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

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

Directi	ion: Put a check (✔) under the HF column if the standa	rd is ava	nilable a	ınd (x) if	not.	
2. F p A	For outsourced services, put a (\checkmark) under the HF coolus the name of the outsourced service provider. Of Agreement (MOA) which reflects provisions for pay NBB) Policy.	lumn ar Jutsourc	nd write ed serv	under t	he rema t have a	Memorandum of
		Н	IF .	PF	IIC	
	REQUIREMENT	YES	NO	YES	NO	Remarks
1.	HF License and Accreditation					
1.1	The HF has updated PhilHealth Accreditation					
2.	Mandatory Ancillary Services					
2.1	Clean consultation and examination area					1
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					



	REQUIREMENT		HF		IC	
			NO	YES	NO	Remarks
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						
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)					

			HF		IIC	
REQUIREMENT		YES	NO	YES	NO	REMARKS
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

Designation	Signature
	Designation



Annex A.4: Health Facilities Standards

As of October 2023



Name of Health Facility (HF): _



Handwashing sink with water and soap available (liquid soap preferred) and with materials for drying hands (clean

Non-mercury sphygmomanometer

with pediatric and adult cuff Non-mercury thermometer

towels OR paper towels)

Alcohol hand rub

Adult Stethoscope

Pen light

Pediatric Stethoscope

Medical weighing scale

2.4

2.5

2.6

2.7

2.8

2.9

2.10

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

Date of Survey:Tin		Γime starte	me started:		Time ended:					
Directi	ion:									
1. P	Put a check (✓) under the HF column if the st	andard is ava	ilable a	nd (x) if	not.					
P	For outsourced services, put a (\checkmark) under the I- olus the name of the outsourced service provid Agreement (MOA) which reflects provisions fo NBB) Policy.	er. Outsourc	ed serv	ices mus	t have a	Memorandum o				
	DECLUDEMENT	Н	HF		HF		HF PHIC		пс	Damosla
	REQUIREMENT	YES	No	YES	NO	Remarks				
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									



	REQUIREMENT		F	PH	IC	REMARKS
			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					
0.10	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					

		Н	F	PH	IIC	
	REQUIREMENT	YES	NO	YES	NO	REMARKS
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						
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				-		
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						
4.5.a		1				
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						
5.5						
5.6						
5.7						
5.8						

	REQUIREMENT		HF		IIC	
			NO	YES	NO	REMARKS
5.9	Pregnancy Test		1211			
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						
5.20	Test for syphilis					
5.21	Test for hepatitis B and C					
6.	Radiology Diagnostic					
6.1						
	MRI) with or without contrast					
6.2	Chest X-ray (PA or AP)					
6.3	Electroencephalogram					
6.4	Electrocardiogram (ECG)					
7.	Psychotherapy					
7.1						
8.	Therapy (Optional)	-				
8.1						
8.2	Speech therapy					
9.	Available Forms/ Recordings					
9.1	Registry forms					
9.2						
9.3	Referral forms					



PhilHealth Survey Team

Surveyor's Name	Designation	Signature

HF Management Team

Names of Management Team	Designation	Signature



Annex B: Mental Health Benefits Package As of October 2023





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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 -



	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

DC: MASTER COPY Date: 10/11/83

Page 1 of 1 of Annex C





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Case No.		ITV (HE)			DA	TE OF ACCI	ESSMENT (mn	o /dd /sanar)
HEALIH I	ACIL	111 (111)			DA	TE OF ASSI	mii) inameea	i/dd/yyyy)
ADDRESS	OF H	F					AGE:	
A. PATIENT 1. Last Name, First Name,				Name, Sı				
		2. PhilHe	alth ID N	umber				
				ient is a dependent; otherwise, write, Middle Name, Suffix				
		2. PhilHe	alth ID N	umber			ППП-	
A. Follow	w – u	p Visits	MENT	AL HEA	LTH I	PASSPORT	r	
Follow- up visits	Dat	te of Visit	Date o Vis (mm/de	sit	Par Guar	ient/ rent/ rdian's	Attending Physician's signature	MH Coordinator's Signature
1					Digi	attare		
2								-1+
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
B. Medi	catio	ns						
Name o			Dosage	Prepar	ation	Date Given (mm/dd/yyyy)	Patient/ Parent/ Guardian's Signature	Attending Physician's signature

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

As of October 2023



Case No.



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HEALTH FAC	CILITY (HF)		
ADDRESS OF	HF		
A. PATIENT	1. Last Name, First Name, Mid	dle Name, Suffix	SEX Male Female
	2. PhilHealth ID Number		
B. MEMBER	(Answer only if the patien "same as above") 1. Last Name, First Name, Mid		therwise, write,
	2. PhilHealth ID Number		
Γhis is to certif	y, that patient(Name of the Patie	nt) , bo	
Γhis is to certif	y, that patient (Name of the Patie	nt), bo	
This is to certif	y, that patient (Name of the Patie years old, residing at	nt) (Address)	orn on(Date of Birth)
Γhis is to certif	y, that patient (Name of the Patie years old, residing at	nt) (Address)	orn on(Date of Birth)
Γhis is to certifage	y, that patient (Name of the Patie years old, residing at with (Diagnosis)	(Address)	orn on(Date of Birth)
This is to certif	y, that patient (Name of the Patie years old, residing at with (Diagnosis)	(Address)	
This is to certif	y, that patient(Name of the Patie years old, residing atwith(Diagnosis) (Name of the Referring I as completed:	(Address) OI MH Provider)	orn on(Date of Birth) n(Date: mm/dd/yyyy)
This is to certif	(Name of the Patie years old, residing at with (Diagnosis) (Name of the Referring last completed: number of follow-to five the patients of	(Address) Of MH Provider) up visits and the next	(Date of Birth) (Date: mm/dd/yyyy) c scheduled visit is on
This is to certif	y, that patient(Name of the Patie years old, residing at with(Diagnosis) (Name of the Referring is as completed: number of follow-to f Visit) Attached is a photogyy)	(Address) Of MH Provider) up visits and the next socopy of the MH pas	(Date of Birth) (Date of Birth) (Date: mm/dd/yyyy)
This is to certifage	y, that patient(Name of the Patie years old, residing at with(Diagnosis) (Name of the Referring is as completed: number of follow-to f Visit) Attached is a photogyy) request for transfer of MH Care	(Address) (Address) Of MH Provider) ap visits and the next cocopy of the MH pase to	(Date of Birth) (Date: mm/dd/yyyy) c scheduled visit is on

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



HEALTH FAC	CILITY (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 pat "same as above") 1. Last Name, First Name,	ient is a dependent; otherwise, write, Middle Name, Suffix	
	2. PhilHealth ID Number		
Conforme by:		Certified correct by:	
Comornie by.		Certified correct by.	
	name and signature)	(Printed name and signature)	
		Physician, Referring MH Provider 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)	
Acknowledge	d by:	Acknowledged by:	
(Printed name and signature)		(Printed name and signature) Head or MH Coordinator, Referral M	
PhilHealth Re	Authorized Signatory, egional Officethe Referring MH Provider	Provider	
(To provide a o	copy to the referring MH provider g days upon receipt of the form;		
	eanned copy allowed) mm/dd/yyyy)	Date signed (mm/dd/yyyy)	

MASTER COPY C: M Date: 10/11/23





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Case No.							
HEALTH FAC	CILITY (HF)						
ADDRESS OF	HF						
A. PATIENT	1. Last Name, I	First Name, M	iddle Name, Su	ffix SEX Male Female			
	2. PhilHealth ID Number						
B. MEMBER	(Answer only "same as abo 1. Last Name, I	ve")		dent; otherwise, write,			
5.14	2. PhilHealth	ID Number	□-□				
	REFERRAL MH PI	H PROVIDER	OR NO	Signature of Responsible			
7777		(tick appropriate box)		Person			
Photocopy accomplis Passport		□ Yes	□ №	Name and Signature Attending Physician			
	requesting for a referral MH	□ Yes	□ №	Name and Signature Patient/Parent/Guardian			
Certified com	plete by:		Conforme b	y:			
	ed name and sig MH Coordinato		Pa	nted name and signature atient/Parent/Guardian			
Data cianad (mm/dd/yyyy)		Date signed	l (mm/dd/yyyy)			







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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 Bene	efits Package	Reimburse	ment	nent		
		Services	Code	Amount		
Referred by General Mental Health Service Provider		 Screening or assessment Diagnostics At least one (1) follow-up consultation 	RMHG1 2,	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 packag General Me Services - 7	ntal Health		

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 require	
_	number of sessions of follow	v- Specialty Mental Health
	up consultations for tranch	ne Services - Tranche 2
	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: Neurologist Psychologist Psychiatrist		ge rate of the Iental Health Tranche 1	
Referred to	General Mental Health Service Provider	Completed the required number of sessions of follow- up consultations for tranche 2		ge rate of the Iental Healtl Tranche 2	







Annex H: Transmittal Form for Claims Application

As of October 2023

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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	, 보다 중 하는 것은 하는 사람들은 마다가 되어 되어 되어 되어 가장 보다 되었다.	

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



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	AND CHECK THE APPROPRIATE BOX			Tassporty
information, fields and trick boxes	required in this form are necessary	iin saty (66) calendardays from date of discharge. Claim forms with incomplete information shall not		
SE/INCORRECT INFORMATION	SHART WE SHEET WITH SHARE	BE SUBJECT TO CRIMINAL, CIVIL OR ADMINISTR CARE INSTITUTION (HCI) INFORMA	to the state of th	
PhilHealth Accreditation	white the same of the same of the same of	are Institution: H19131010 X1X		Date of the 6th
Name of Health Care Inst	ARC PLIDAL	HEALTH CENTER		follow up
Address:	SHAW BLVD	PASIG CITY		visits (Refer to Annex D:
80	ilding Number and Street Name	City/Municipality	Province	MH passport
	PART II - PA DELA CRUZ	TIENT CONFINEMENT INFORMATIO JUAN	N MAPAGPAI	A
Name of Patient:	Last Name	First Name Name	Extension Middle Name	
			P. SR/IBI BELACRUZ JUAN JA	
Was patient referred by a	an other Health Care Institu	ution (HCI)?		Write OUTPATIEN
	e of referring Health Garg Instituting	2 0 12 ing immber and Street Name Cit	y/Municipality Province	Zip code in lieu of time
	a. Date Admitted		AM D M	admitted &
	c. Date Discharge 127-29	J-LLL 1 O Time Discharge LL	ATIENT DAM DIM	discharged
Patient Disposition: (selec				
a. Improved b. Recovered	e Expited	red/Relerred	ES TAME THE TAME THE	Tick YES if
c. Home/Discharged Aga	_	Name of Perk	oral heast Care Institution	the patient
d. Absconded	Reason/	Storreferal/transfer	Haringales Posters	was referred
Type of Accomodation:		ate (Chanty/Service)		by another HF
Admission Diagnosis/es:				1 111
And the second s	Schizophrenia			
	Schizophrenia		anterior Annual Control of the Contr	This is not
Discharge Diagnosis/es @	Schizophrenia Jse additional CF2 if necessary):			This is not required as
	Schizophrenia Jse additional CF2 if necessary):	ure/s fil there's any RVS Code Da	te of Procedure Laterality (check appli	required as mental healt
Diagnos IC	Schizophrenia Jse additional CF2 if necessary):	ure/s fil there's any! RVS Code Da		required as mental healt services
Diagnos IC	Schizophrenia Jse additional CF2 if necessary); D-10 Code/s Related Proced ii	Additional and the second seco	lett right	required as mental healt services provided is a out-patient
Diagnos IC	Schizophrenia Jse additional CF2 if necessary); D-10 Code/s Related Proced ii. iii. iii.		lett right left right left right	required as mental healt services provided is a
Diagnos IC	Schizophrenia Jse additional CF2 if necessary); D-10 Code/s Related Proced ii. iii. iii.	Additional and the second seco	lett right left right left right	both both both both both services provided is a out-patient setting
Diagnos: IC Schizophrenia b Special Considerations:	Schizophrenia Jse edditional CF2 if necessary): D-10 Code/s Related Proced i. ii. iii. iii. iii. iii. iii. iii. i		lett right left right left right left right left right	required as mental healt services provided is a out-patient setting
Dispriors IC Schizophrenia b Special Considerations: a. For the following repetitive pro	Schizophrenia Jse edditional CF2 if necessary): D-10 Code/s Related Proced i. ii. iii. iii. iii. iii. iii. iii. i	d enumerate the procedure/sessions dates [mm-dd	lett right left right left right left right left right	required as mental healt services provided is a out-patient setting Indicate the
Disprose IC Schizophrenia b. Special Considerations: a. For the following repetitive pro	Schizophrenia Jse additional CF2 if necessary); D-10 Code/s Related Proced ii. iii. iii. iii. iii. iii. iii. iii	d enumerate the procedure/se stons dates [mm-dd	lett right left right left right left right left right	required as mental healt services provided is a out-patient setting
Dispriors IC Schizophrenia b Special Considerations: a. For the following repetitive pro	Schizophrenia Jse edditional CF2 if necessary): D-10 Code/s Related Proced i. ii. iii. iii. iii. iii. iii. iii. i	d enumerate the procedure/se stions dates from dd	lett right left right left right left right left right	required as mental healt services provided is a out-patient setting Indicate the
Disgross IC Schizophrenia b. Special Considerations: a. For the following repetitive pro Hemodialysis Perkoneal Dialysis	Schizophrenia Jse additional CF2 if necessary); D-10 Code/s Related Proced ii. iii. iii. iii. iii. iii. iii. iii	d enumerate the procedure/se stions dates [mm-dd	lett right left right left right left right left right	required as mental healt services provided is a out-patient setting Indicate the diagnosis Indicate the
Diagnose Schizophrenia b. Special Considerations: a. For the following repetitive pro Hemodialysis Peritoneal Dialysis Radiotherapy (LINAC) Radiotherapy (COBALT) b. For Z-Benefé Package	Schizophrenia Jse additional CF2 if necessary). D-10 Code/s Related Proced i. ii. iii. iii. iii. iii. iii. iii. i	d enumerate the procedure/sessions dates [mm-dd	lett right left right left right left right left right	required as mental healt services provided is a out-patient setting Indicate the appropriate
Diagnose Schizophrenia b. Special Considerations: a. For the following repetitive pro Hemodialysis Peritoneal Dialysis Radiotherapy (LINAC) Radiotherapy (COBALT) b. For Z-Benefé Package	Schizophrenia Jse additional CF2 if necessary): D-10 Code/s Related Proced i. ii. iii. iii. iii. iii. iii. iii. i	d enumerate the procedure/sessions dates [mm-dd	lett right left right left right left right left right	required as mental healt services provided is a out-patient setting Indicate the diagnosis Indicate the appropriate "benefit
Disprose IC Schizophrenia b. Special Considerations: a. For the following repetitive pro Hemodialysis Peritoneal Dialysis Radiotherapy (LINAC) Radiotherapy (COBALT) b. For Z-Benefé Package c. For MCP Package (enumerate) 1	Schizophrenia Jse additional CF2 if necessary). D-10 Code/s Related Proced ii. iii. iii. iii. iii. iii. iii. iii	d enumerate the procedure/se stions dates from dd Dispar franciscus Brachytherapy Chemotherapy Simple De bridement ge Code: MHG1 d checkups	lett right left right left right left right left right	required as mental healt services provided is to out-patient setting Indicate the diagnosis Indicate the appropriate "benefit
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war runner in tream.	Call Ce	enter (02) 441-7442 • Trunkline (02) 441-7444 www.philhealth.gov.ph	(Claim Form 2)	follow-up visits (Refer
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		PART IV - CERTIFI	CATION OF CONSUMPT	ION OF	HEALTH CAP	RE INSTITUTION		HF

PhilHealth Your Perture In Health	Call Cente	Republic of the Philippines ALTH INSURANCE the Centre 709 Shaw Boulevard, P. or (02) 441-7442 • Trunkline (0 www.philhealth.gov.ph mail: actioncenter@philhealth.gov.	asig City 2) 441-7444	CF-2 (Claim Form 2) Revised September 2013	Date of assessment (Refer to Annex D: MH
3.Address:	ocuments should be filed with ired in this form are necessary. ISREPRESENTATION SHALL PART I - HEALTH mber (PAN) of Health C ABC Mental	in Soly (60) calendar days from d. Claim forms with incomplete info BE SUBJECT TO CRIMINAL, CIVI CARE INSTITUTION (H. are Institution: H. 9 and Wellness Hospital PASIG	mation shall not be processed. IL OR ADMINISTRATIVE LIABILITIE CI) INFORMATION 3 0 0 X X X X X	S. Province	Passport) Date of the follow-up visits with any of the following: Psychiatrist: On the 6th follow-up visit Neurologist:
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Eurlyskin-to-skit cented g. For Outpatient HIV/AIDS Treatment	Extrophylass Package Laborat	ory Number:	Non-separation of esobs	refleatly for early because earlies and instances	This is not required
9. PhilHealth Benefits: ICD 10 or RVS Code:	Pare .	MASTER COPY COPY	Second Case Rate		1 of 2 of Annex I.3

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men		PART IV - CERTIF	CATION OF CONSUMPT	ION OF	HEALTH CAR	REINSTITUTION	Affix
		NAME OF TAXABLE PARTY OF A PARTY.	CATION OF CONSUMPT		the section of the section is	RE INSTITUTION the herein information given are true and correct 1 2 0 6 2 0 2	signature

- N. W. W. S.	1 FORM 2 FOR SPECIALTY MH PACKAGE (TRANCHE 2) Annex 1.4: 5:	Date of the
6	Republic of the Philippines	succeeding follow-up visit
PhilHealt		with any of the following:
Your Partner in Health	Call Center (02) 441-7442 • Trunkline (02) 441-7444 (Claim Form 2)	a. Psychiatrist
	email: actioncenter@philhealth.gov.ph	b. Neurologist
Mean I have a series	Senes#	c. Psychologist
MPORTANT REMINDERS: LEASE WRITE IN CAPITAL LETTE	RS AND CHECK THE APPROXIMATE BOXES.	(D. C.)
	porting documents should befuled within sixty (69) calendar days from date of discharge.	(Refer to Annex D: MH
	KES required in this form are necessary. Claim forms with incomplete information shall not be processed. DN OR MISREPRESENTATION SHALL BE SUBJECT TO CRIMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.	passport)
建筑等对点等	PART I - HEALTH CARE INSTITUTION (HCI) INFORMATION	
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2.Name of Health Care In	ADC Mantal and Mallana Hamilton	follow-up visit
3.Address:	SHAW BLVD PASIG CITY	with any of the following:
	Building Number and Street Name City/Municipality Province	a. Psychiatrist
· 素 对 5 种	PART II - PATIENT CONFINEMENT INFORMATION	b. Neurologist
L.Name of Patient:	DELA CRUZ JUAN III MAPAGPALA	c. Psychologist
Litteric of Faticity	Last Name First Name Name Extension Middle Name	(Refer to Annex
	UR/SR/RU (ex DELACRUZ JUAN JR SFAC)	D: MH passport)
2. Was patient referred b	y another Health Care Institution (HCI)?	
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N Canting and Paris 1	amo of referring Health Care Institution Building Number and Street Name City/Munkipality Province Zip code a. Date Admitted	→ Write
3.Confinement Period:	a. Date Admitted	OUTPATIENT
d Dationt Diseaself	month day year CUTTATIENT	in lieu of time
4.Patient Disposition: (56	sections 2)	admitted &
b. Recovered	e Expend month day year Time tour dur. AM PM	discharged
C. Home/Discharged.	Name of Enforce Health Care Institution	Tick YES if
d. Absconded	Built of translation of the Company to Company to Company Topics	the patient
Type of Accomodation	Réason/s for referral/transfec Non-Projete (Chanty/Service)	was referred
6.Admission Diagnosis/e		by another
or company of the ground of the	Epilepsy	HF
	is test right both to the test right both test test right both test test test test test test test te	services provided is an out-patient setting
8. Special Consideration	s:	
a. For the following repetitive	procedures, the kibox that applies and enumerate the procedure/sessions dates [mm-dd-yyyy]. For chemotherapy, see guidelines.	Indicate the
Hemodialysis	Discouring Manager	diagnosis
Perkoneal Dialysis	Brachythelapy	diagnosis
Radiotherapy (UNAC)		
Radiotherapy (COBAL	Simple De bridement	Indicate the
b. For Z-Benefit Package	Z-Benefit Package Code: MHS2	appropriate "benefit
c. For MCP Package (enumera	te four dates [mm-did-year] of pre-natal check-ups)	package code"
I was a second or the second of the second o	The second state of the se	Package code
d For TB.DOTS Package	Intensive Phase Maintenance Phase	
Day 0 ARV	nte the dates [mm-dd-year] when the following doses of vectine were given: Note: Anti Rabies Vaccine (ARV), Rabies Immunoglobulin (RIG) Day 3 ARV Day 7 ARV RIG Others (Specify)	
f. For Newborn Care Package		
	are idealy applicable bases.	
Immediate drying of nev		
Early sian to aller contac	T Ge Prophyland Vanese K administration Non-separation of mother baby for early broadlesting in history	This is not
g. For Outpatient HIVAIDS To	otriket Package Laboratory Number:	required
9. PhilHealth Benefits:		
ICD 10 or RVS Code:	Second Cash Rate	
	i i	1)
	MASTE COPY COPY Lass	ge 1 of 2 of Annex I
	42	
	22	

	re ditation Number additional CF2 if necessa		Health Care Professional	Date Signed and Pr	ofessional Fees/Charges		
Acure	si Kation number/Name o	of Accredited Health Care Pr	olessional/Date Signed		Details	more the property of	
Accre	sdiallun No. [1,2]	3,4,-15,6,7,8,9	0 1 - 2		(/- t +		Tick this box
	JUANA	DELA CRUZ, MD		No co-saventon o	f PhilHealth Beneir	-	if patient paid
		Signature Over Printed Nam	t:		of Phareach Beself P		no additional
	Date Signed:	north day ye		This ex hely much	DS. 1911-03-91-04-04-0		Professional fee
Actro	editationNo.: []]	11-1111	L-L-				ree
		Signature Over Printed Nam	10		if PhilHealth Benefit		
		torsh day ye		With co-pay on top	of Philhealth Benefi P	-	
Ann		ronsh day ye.		N			Tick this box
MUCH	edistrictivas [] [□ No concession to a	of PhilHealth Benefit		if patient paid an additional
		Sgnature Over Printed Nam	e		of Philhealth Benefit P		Professional
	Date Signed: L	month day ye			is desirable to the property of the control of the		fee
A.CER		TIFICATION OF COM	Rationt should sign only after the a	'S AND CONSENT T policable charges have bee	O ACCESS PATIENT RECORD/S		
	PhilHealth benefit is en	ough to cover HCI and PF CI	narges.				Tick this box
-	no purenase of drugs/n	neuranes, suppnes, diagnos	tics, and co-pay for professional fee		otal Actual Charges'		if patient has
	Total Health Care Insti	fution Fees.			,400.00		NO co-
	Total Professional Fee				, 100100		payment
	Grand Total	The Mary Country of the Country of t		6	,400.00		
	The hone is of the more	i jaržąstiant was asmalatoli,	ransomed poorts to any 19 the b		nt is not completely consumed BJT with		
Ш		drugs/medicines, supplies	, diagnostics and others.				
	a) The total co-pay for	the following are:			1		Tick this box
123	1	Total Actual Charges*	Amount after Application of Discount (i.e., personal discount, Senior Citizen/PWD)	Philinealth Benefit	Amount after PhilHealth Deduction		if patient has a co-payment
1/2					Amount P		
ate: 10/11/23	Total Health Care Institution Fees				Paid by (check-all that applies): Member/Patient HMO Others (i.e. PCSO, Promisory note, etc.)		
Ö	Total Professional				Amount P		
	Fees (for accredited				Paid by (check all that applies):		
2.	and non-accredited professionals)				Member/Patient HMO Others (i.e., PCSO, Promisory note, etc.)		
8	b.) Purchases/Expense	L S NOT included in the Hea	Ith Care Institution Charges			- 1	
	Total cost of purchase		I/or medical supplies bought by the	None	Total Amount P		
9		in/outside the HCl during o	onlinement paid by the patient/member done				
-	within/outside the HE		paso by the patient/member done	☐ None	Total Amount P		
	• NOTE: Total Actual	Charges should be based o	n Statement of Account (SOA)			1	
B.CON	SENT TO ACCESS	PATIENT RECORD/S:				- 11	Affix signatur
			the potient's pertinent medical rea	ords for the purpose of ve	rifying the veracity of this claim to effect		of the
	ent processing of benefit by hold Phil Health or at		and/or representatives free from	any and all legal liabilities	relative to the herein-mentioned consent		patient/paren
			on with this claim for reimburseme				/authorized
-	AN MAPAGPALA		termination and American and American				representative
Signa		of Member/Patient/Authori	The state of the s	If patient/repres			
	Date Signed 1	0 4 0 5 2 0	2 4	is unable to kint right thumbmar			Indicate date
Dalot		tive to Spouse S		Representative s		-	signed
then	nember/patient	Shing [Others, Specify				
	on for signing on behalf o ber/patient:	of the Patient is Ini Other Reaso	Capacitated Vis	Patient Represent	Mive		
3		PART IV - CERTIFI	CATION OF CONSUMPTI	ON OF HEALTH CA	REINSTITUTION		Affix
The Real Property lies	SIE SIE SIE			CHEN THE RESERVE		-	signature of
150	rtifu that candless and	orad warn raranded in the	notiont's chart and bealth in	etitution ramede dat -	the herein information given are true and corn	ract	HF

Annex J.1: Checklist of Mandatory and Other Services - Tranche 1

As of October 2023





Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

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

Case No						
HEALTH FAC	CILITY (HF))				
ADDRESS OF	HF					
A. PATIENT	1. Last Na	me, First Name, I	Middle Name, Suffix	SEX Male Female		
	2. PhilHe	alth ID Number				
B. MEMBER	"same as	s above")	ent is a dependent; Middle Name, Suffix	otherwise, write,		
	2. PhilHe	alth ID Number	П-ПП	-		
	the appropr	General Men Tr	TORY AND OTHER tal Health Services ranche 1 e services is done			
SERV	ICES					
Screening						
Assessmen	nt					
Diagnosti	es	Complete Bl	lood Count (CBC) w/ p	olatelet		
		☐ Urinalysis				
		Fasting Bloc				
		Lipid Profile				
		Renal Funct	tion Test			
2		Creatinine				
			Chest X-ray (PA or AP)		
Follow – 1		1. Date (mm/c				
	education	2. Date (mm/c				
and psych	osocial	3. Date (mm/c				
support		4. Date (mm/dd/yyyy)				
		5. Date (mm/c	dd/yyyy)			
		6. Date (mm/c	dd/yyyy)			
☐ Medicines	provided					
Conforme l	ov:		Certified correc	et by:		
	ed name an ent/Guardia	d signature)		name and signature) nding Physician		
T CIT	Jan Guarana		PhilHealth			
			Accreditation No.			

Annex J.2: Checklist of Mandatory and Other Services - Tranche 2

As of October 2023

Page 1 of 1 of Annex J.2





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Ocitystate Centre, 709 Shaw Boulevard, Pasig City

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R PhilHealthOfficial teamphilhealth

ADDRESS OF	HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix SEX Male Fem		
	2. PhilHea	alth ID Number	
B. MEMBER	above")		ient is a dependent; otherwise, write, "san Middle Name, Suffix
	2. PhilHea	alth ID Number	
Serv	ices		ranche 2 sits in the space provided
Servi	ices up visits for	the follow-up vi	sits in the space provided
Servi	ices p visits for ion and	1. Date (mm 2. Date (mm	sits in the space provided /dd/yyyy) /dd/yyyy)
Servi	ices p visits for ion and	1. Date (mm 2. Date (mm 3. Date (mm	sits in the space provided /dd/yyyy) /dd/yyyy) /dd/yyyy)
Servi	ices p visits for ion and	1. Date (mm 2. Date (mm 3. Date (mm 4. Date (mm	sits in the space provided /dd/yyyy) /dd/yyyy) /dd/yyyy) /dd/yyyy)
Servi	ices p visits for ion and	1. Date (mm 2. Date (mm 3. Date (mm 4. Date (mm 5. Date (mm	sits in the space provided /dd/yyyy) /dd/yyyy) /dd/yyyy) /dd/yyyy) /dd/yyyy)
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Follow – upsychoeducat psychosocial s	ices up visits for ion and support	1. Date (mm 2. Date (mm 3. Date (mm 4. Date (mm 5. Date (mm 6. Date (mm	sits in the space provided /dd/yyyy) /dd/yyyy) /dd/yyyy) /dd/yyyy) /dd/yyyy) /dd/yyyy)
Follow – upsychoeducat psychosocial s Conforme be (Printer Pare)	ices up visits for ion and support ed name and ent/Guardiar	1. Date (mm 2. Date (mm 3. Date (mm 4. Date (mm 5. Date (mm 6. Date (mm	/dd/yyyy) /dd/yyyy) /dd/yyyy) /dd/yyyy) /dd/yyyy) /dd/yyyy) /dd/yyyy) /dd/yyyy) /dd/yyyy) Add/yyyy) /dd/yyyyi
Follow – upsychoeducate psychosocial seconforme be (Printer	ices up visits for ion and support ed name and ent/Guardiar	1. Date (mm 2. Date (mm 3. Date (mm 4. Date (mm 5. Date (mm 6. Date (mm	/dd/yyyy) /dd/yyyy) /dd/yyyy) /dd/yyyy) /dd/yyyy) /dd/yyyy) /dd/yyyy) /dd/yyyy) /dd/yyyy)





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- PhilHealthOfficial y teamphilhealth

Case No	
HEALTH FAC	CILITY (HF)
ADDRESS OF	THF
A. PATIENT	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 (\checkmark) 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

Lactate Dehydrogenase (LDH) Alkaline Phosphatase Serum Alcohol Serum Carbamazepine Serum Lithium Serum Valproic Acid Urine Drug Test (Specify):
Serum Alcohol Serum Carbamazepine Serum Lithium Serum Valproic Acid Urine Drug Test (Specify):
Serum Carbamazepine Serum Lithium Serum Valproic Acid Urine Drug Test (Specify):
Serum Lithium Serum Valproic Acid Urine Drug Test (Specify):
Serum Valproic Acid Urine Drug Test (Specify):
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)
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)

COPY COPY COPY Date: 10/11/23



Case No.



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ADDRESS OF	HF	
A. PATIENT	1. Last Name, Firs	t Name, Middle Name, Suffix SEX Male Female
	2. PhilHealth ID 1	Number
B. MEMBER	as above")	the patient is a dependent; otherwise, write, "same t Name, Middle Name, Suffix
	2. PhilHealth ID l	Number
psychoeducat	ion, psychosocial	1. Date (mm/dd/yyyy)
	ip visits for	Psychiatrist Date (mm/dd/yana)
	sychotherapy	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)
الما		4. Date (mm/dd/yyyy)
2		5. Date (mm/dd/yyyy)
Da.je.		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.

Fo	r 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
Fo	or items 3 to 7, please select the one best response by ticking the appropriate ox.
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
	Page 1 of 2 of Annex K

of PhilHealth benefits package f ☐ Less than half ☐ By half	has your health facility expenses been lessened by availing for mental health?
☐ More than half ☐ Don't know	
 7. Overall patient satisfaction (PS : Excellent Satisfactory Unsatisfactory Don't know 	mark) is:
8. If you have other comments, ple	ease share them below:
Thank you. Y	Your feedback is important to us! Signature over Printed Name
Thank you. Y	

Annex L.1: Checklist of Requirements for Reimbursement – Tranche 1

As of October 2023





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HEALIH FAC	ILITY (HF)		
ADDRESS OF	HF		
A. PATIENT	1. Last Name, First Name, M	SEX Male Female	
A	2. PhilHealth ID Number		
B. MEMBER	(Answer only if the patie "same as above") 1. Last Name, First Name, M		therwise, write,
	2. PhilHealth ID Number	— -	
	HECKLIST OF REQUIREM GENERAL MENTAL HEA		
Requiremer			Please Check
	al Form of Claims for Mental		0.4
	of Requirements for Reimburg		
	ccomplished Claim Form (CF of Mandatory and Other Servi		
	ccompusued win Sansiachon	Unestionnaire (Annex	K)
	ccomplished MH Satisfaction of the Mental Health Passpo		K)
6. Photocopy	of the Mental Health Passpor Certified True Copy (CTC) o	rt (Annex D)	
 Photocopy Original or 	of the Mental Health Passpo r Certified True Copy (CTC) o	rt (Annex D)	
6. Photocopy 7. Original or Certified corre	of the Mental Health Passpor r Certified True Copy (CTC) o ect by:	rt (Annex D) f the Statement of Accor Certified correct by:	unt
6. Photocopy 7. Original or Certified corre (Printe	of the Mental Health Passpo r Certified True Copy (CTC) o	rt (Annex D) f the Statement of Accord Certified correct by: (Printed name	
6. Photocopy 7. Original or Certified corre (Printe At PhilHealth Accreditation No.	of the Mental Health Passpor Certified True Copy (CTC) of the Mental Health Passpor Certified True Copy (CTC) of the certified True	rt (Annex D) f the Statement of Accord Certified correct by: (Printed name Head of the H	and signature) Iealth Facility
6. Photocopy 7. Original or Certified corre (Printe At PhilHealth Accreditation No.	of the Mental Health Passpo r Certified True Copy (CTC) o ect by: d name and signature)	rt (Annex D) f the Statement of Accord Certified correct by: (Printed name Head of the	and signature) Iealth Facility
6. Photocopy 7. Original of Certified corre (Printe At PhilHealth Accreditation No. Date signed (1)	of the Mental Health Passpor Certified True Copy (CTC) of the Mental Health Passpor Certified True Copy (CTC) of the certified True	rt (Annex D) f the Statement of Accord Certified correct by: (Printed name Head of the H	and signature) Iealth Facility
6. Photocopy 7. Original of Certified corre (Printe At PhilHealth Accreditation No.	of the Mental Health Passpor Certified True Copy (CTC) of the Mental Health Passpor Certified True Copy (CTC) of the certified True	rt (Annex D) f the Statement of Accord Certified correct by: (Printed name Head of the	and signature) Iealth Facility

Annex L.2: Checklist of Requirements for Reimbursement – Tranche 2 As of October 2023





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HEALTH FAC	CILITY (HF)			
ADDRESS OF	HF			
A. PATIENT	1. Last Name, First Name, M	EX Male		
	2. PhilHealth ID Number	п-ппп	П-П	
B. MEMBER	(Answer only if the pations "same as above") 1. Last Name, First Name, N		wise, write,	
	2. PhilHealth ID Number		□-□	
	HECKLIST OF REQUIRENGENERAL MENTAL HEA			
	al Form of Claims for Mental	Health (Annex H)		
2. Checklist of	of Requirements for Reimbur	sement (Annex L.2)		
3. Properly a	ccomplished Claim Form (CF	7) 2		
	of Mandatory and Other Servi			
	ccomplished MH Satisfaction			
	of the Mental Health Passpo			
7. Original of	r Certified True Copy (CTC) o	of the Statement of Account		
Certified corr	ect by:	Certified correct by:		
	d name and signature)	(Printed name and		
	tending Physician	Head of the Healt	h Facility	
PhilHealth Accreditation		Accreditation		
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy	<i>y</i>)	
		Conforme by:		
101		comornie by		
ate: 10/11/23		(Printed name and Patient/Parent/G Date signed (mm/dd/yyyy	luardian	

Annex L.3: Checklist of Requirements for Reimbursement – Tranche 1

As of October 2023





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	ILITY ()	HF)																
ADDRESS OF	HF																	
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix SEX Male Female																	
	2. Ph	2. PhilHealth ID Number																
B. MEMBER	as ab	ove	e")					ent is a depen Middle Name, S			th	erv	wise	e, w	rit	e, '	"sa	me
	2. Ph	ilH	ealtl	n I)	DN	[um]	er	□-□	1	II	I]-					
Requiremen		of C	lain	ne f	for	Mon	tol let	Health (Anney H	0				Pl	eas	e C	he	eck	
		of C	lain	ns f	or '	Mer	tal l	Health (Annex H	()	_	-		PI	eas	ec	116	CK	-
2. Checklist o	f Requi	rem	ents	fo	rR	eim	ours	ement (Annex L	_									
3. Properly a																		
- 1								ces (Annex J.3)			-	_						_
Ser .				_	_	_		Questionnaire (An	nex K	.)		-	-	_	_		_
PhotocopyOriginal or								the Statement	of A	CCOII	nt		10	_			-	_
/. Original of	CCITIIC	Ju I	ruc	CO	ру	CI) O	the Statement)1 F	iccou	111	-	1					
Certified corre	ect by:							Certified cor	rec	t by:								
Cortifica corre	ed name	and	l sig	na	tur	e)		(Pt	int	ed na	m	e aı	nd si	igna	tur	e)		
										d of tl								
(Printe	tending	2					1	PhilHealth Accreditation				1						
(Printe A		-								3 614					40			
(Printe	tending	1	y)					No. Date signed	(m	m/dd	/у	ууу)					
PhilHealth Accreditation No. Date signed (1	tending	1	y)					No. Date signed		m/dd	l/y,	ууу	•)					
(Printe A ² PhilHealth Accreditation No. Date signed (1	tending	1	<u> </u>					No. Date signed Conforme by	y:					•				
(Printe A ² PhilHealth Accreditation No. Date signed (1	tending	1	y) —					No. Date signed Conforme by	y: rin	ted na	am Pai	e a	nd s					
(Printe At PhilHealth Accreditation No.	tending	1	y) —					No. Date signed Conforme by	y: rin	ted na	am Pai	e a	nd s					

Annex L.4: Checklist of Requirements for Reimbursement – Tranche 2

As of October 2023





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PHILIPPINE HEALTH INSURANCE CORPORATION

Q Citystate Centre, 709 Shaw Boulevard, Pasig City

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HEALIH FACI	LITY (HF)								
ADDRESS OF	HF								
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix SEX Male Fema								
	2. PhilHealth ID Number								
B. MEMBER	(Answer only if the patie as above") 1. Last Name, First Name, M		erwise, write, "same						
	2. PhilHealth ID Number								
	CHECKLIST OF REQUIREM								
Requirement	SPECIALTY MENTAL HEA	ALTH SERVICES – TRA	NCHE 2 Please Check						
	Form of Claims for Mental He	alth (Annex H)	Tiease circex						
	Requirements for Reimbursen								
	complished Claim Form (CF) 2								
	Mandatory and Other Services								
	complished MH Satisfaction Q								
	of the Mental Health Passport (
7. Original or	Certified True Copy (CTC) of the	ne Statement of Account							
Certified correc	t by:	Certified correct by:							
(Print	et by: ed name and signature) attending Physician	(Printed nan Head of the	ne and signature) e Health Facility						
(Print A PhilHealth Accreditation	ed name and signature)	(Printed nan Head of the PhilHealth Accreditation							
(Print A PhilHealth Accreditation No.	ed name and signature) ttending Physician	(Printed nan Head of the	e Health Facility						
(Print A PhilHealth Accreditation No.	ed name and signature) ttending Physician	(Printed name Head of the PhilHealth Accreditation No.	e Health Facility						
	ed name and signature) ttending Physician	(Printed name Head of the PhilHealth Accreditation No. Date signed (mm/dd Conforme by:	e Health Facility						

