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PHILHEALTH CIRCULAR
No. 2025 - 0003

TO : **ALL CONTRACTED HEALTH FACILITIES FOR THE BENEFITS PACKAGE ON PHYSICAL MEDICINE, REHABILITATION SERVICES AND ASSISTIVE MOBILITY DEVICES, AND OTHERS CONCERNED**

SUBJECT : **Benefits Package for Physical Medicine, Rehabilitation Services, and Assistive Mobility Devices**

I. RATIONALE

According to the study on Global Burden of Disease in 2021, about 2·6 billion individuals had conditions that would benefit from rehabilitation[1], contributing to 340 million Years of Living with Disability (YLD). This number had increased by 79.4% in a span of 31 years from 190 million YLD in 1990. Regionally, it is estimated that 630 million people from Southeast Asia could benefit from rehabilitation services[2]. In the Philippines, around 12% of Filipinos aged 15 and older experienced severe disability based on the 2016 National Disability Prevalence survey of the Philippine Statistics Authority (PSA), 47% of which experienced moderate disability, while 23% faced mild disability.[3]

Republic Act (RA) No. 11223, or the Universal Health Care Act (UHC Act), Republic Act No. 7277, as amended by RA No. 11228, also known as the Magna Carta for Persons with Disability, and RA No. 11215, also known as the National Integrated Cancer Control Act (NICCA), collectively states that PhilHealth shall develop a benefits package for rehabilitation services.

In 2012, PhilHealth introduced Z Benefits packages covering rehabilitation, including inpatient case rates for cardiac and stroke rehabilitation, as well as outpatient care for children with disabilities. However, adult outpatient services are currently limited to specific mobility impairments.

Thus, the PhilHealth Board of Directors, through Board Resolution No. 2963 s. 2024 approved the benefits package for physical medicine, rehabilitation

[1] World Health Organization-Institute for Health Metrics and Evaluation, Rehabilitation is not a Service for the few, 2021
[2] The Lancet, Global incidence, prevalence, years lived with disability (YLDs), disability-adjusted life-years (DALYs), and healthy life expectancy (HALE) for 371 diseases and injuries in 204 countries and territories and 811 subnational locations,1990–2021: a systematic analysis for the Global Burden of Disease Study, 2021
[3] Philippine Statistics Authority, Disability Spares No One: A New Perspective, 2019 https://psa.gov.ph/statistics/national-disability-prevalence-survey

services, and assistive mobility devices to ensure continuity of access of care in line with the government's direction to provide health for all.

II. OBJECTIVES

This PhilHealth Circular aims to provide coverage for physical medicine, rehabilitation services, and assistive mobility devices, and ensure equitable access to quality healthcare services and financial risk protection.

III. SCOPE

This PhilHealth Circular shall apply to all contracted health facilities (HFs) and all others involved in the implementation of the benefits package for physical medicine, rehabilitation services, and assistive mobility devices.

IV. DEFINITION OF TERMS

A. Active Wheelchair – a customizable, self-propelled wheelchair designed for users with an active lifestyle, often used for enhanced mobility.

B. Assistive Mobility Device – any device prescribed and adapted to improve safe and functional mobility towards social participation.

C. Balance Billing[4] – the additional payments by insured patients on top of the amount paid by insurance when the provider's charges exceed the amount covered by health insurance. Due to financial and service coverage decisions, balance billing may result in increased financial burdens and limited access to health services by households.

D. Basic Wheelchair – a standard, manually operated wheelchair for permanent mobility issues, offering basic support and functionality.

E. Contracted Health Facility (HF)[5] – any health facility that enters into a contract with the Corporation for the provision of specialized care.

F. Copayment – a flat fee or predetermined rate paid at a point of service, as may be determined by PhilHealth. This amount will be charged to patients as their share for amenities or upgrades of services beyond the coverage of the benefits package. Co-payments shall have a fixed limit or cap not exceeding the corresponding package rate. These co-payment rates shall be subject to negotiation by PhilHealth and stipulated in the contract to determine the applicable rates and ensure financial risk protection for the beneficiaries.

G. Cost-sharing – the direct payment of a portion of health care costs by the members/dependents when receiving health services. This term generally includes deductibles, coinsurance, and copayments, or similar charges.

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[4] PC No. 2024-0023: Institutionalization of 156 Hemodialysis Sessions and Coverage Expansion (Revision 2)

[5] PC No. 2022-0012: Contracting of a Health Facility as a Z Benefit Provider (Revision 1)

H. **Crutch** – a height-adjustable medical device designed to aid in ambulation, by transferring body weight from the legs to the torso and arms. They are mainly used to assist individuals with musculoskeletal injury and/or neurological impairment.

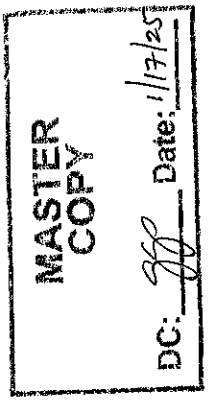
I. **Essential Health Services** – the minimum services that PhilHealth covers that HFs must provide based on clinical practice guidelines (CPG) and/or expert consensus as approved by the Corporation. These include assessment, drugs and medicines, staff time, laboratory tests, diagnostic procedures and monitoring procedures, consultations, rehabilitation sessions, and assistive mobility prescription with user training.

J. **Fee Schedule** – a predetermined list of fees or charges that outlines the prices or reimbursements for various medical procedures, services, or treatments. This list of items with equivalent rates is used to reimburse healthcare providers on a fee-for-service with a cap.

K. **Free-standing Rehabilitation Center** – organized health facility with access to a physical medicine and rehabilitation specialist that operates independently inside or outside the hospital and offers provision of care for physical medicine and rehabilitation

L. **Functional Goal** – a specific objective aimed at establishing, improving, maintaining, or preventing the deterioration of a person's functional abilities. Functional goals are often set in healthcare, rehabilitation, or fitness contexts to enhance individuals' quality of life and independence.

   1. **Maintenance** – Preservation of restored or optimized function
   2. **Prevention** – Avoidance of onset of new impairments and/or occurrence of secondary ability
   3. **Restoration** – Recovery from impairment or functional loss



M. **Lost to Follow-up** – a term used to characterize a patient who has not returned to or followed up at a contracted health facility after sixty (60) calendar days from the next rehabilitation visit, as advised.

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

O. **Motorized Wheelchair** – a battery-powered wheelchair suitable for users with mild to moderate disability in mobility and self-care related to strength, balance, and endurance.

P. **Multidisciplinary-Interdisciplinary Team (MDT) Approach** – an approach to patient care involving team members from different professional backgrounds or work disciplines, with each member providing specific services while working collaboratively together to provide the best care to the

patient. The rehabilitation team includes rehabilitation medicine specialists/physiatrists, physical therapists, occupational therapists, speech and language pathologists or speech therapists, psychologists, prosthetists and orthotists, and nursing staff.

Q. Quad Cane – a height-adjustable cane with a four-point base for increased stability, used by individuals with balance or mobility challenges.

R. Physical Medicine and Rehabilitation Services[6]– type of services that aim to enhance and restore functional ability and quality of life to those with the following physical impairments resulting from:

1. Connective tissue, Musculoskeletal or Orthopedic disorders
2. Neurological or neuromuscular disorders
3. Cardiopulmonary disorders
4. Congenital disorders
5. Immunologic, endocrine, and metabolic disorders

S. Rollator – a walker with wheels, brakes, and often a seat, providing mobility support while allowing the user to rest when needed.

T. Single Tip Cane – a height-adjustable cane with one tip, used for mild balance issues or light support during walking.

U. Supportive Wheelchair – a wheelchair with features like headrests, adjustable footrests, and extra cushioning for postural support or long-term use.

V. Walker – a height- adjustable, four-legged frame for users needing support while walking.

W. White Cane – a foldable cane used by individuals with visual impairments to navigate their surroundings and identify obstacles.

V. POLICY STATEMENTS

A. Benefits Availment

1. All Filipinos are automatically entitled to avail of this benefits package. PhilHealth beneficiaries shall comply with the existing membership eligibility rules.

2. All patients shall be assessed by the physical medicine and rehabilitation specialist/physiatrist.

3. The following rules shall apply to all eligible patients availing of these benefits packages, whether in an inpatient or outpatient setting:

[6] DOH Administrative Orders 2013-0095A and 2013-0095B: National Policy on the Unified Registry Systems of the Department of Health (Chronic Non- Communicable Diseases, Injury Related Cases, Persons with Disabilities and Violence Against Women and Children Registry System)

a. The designated liaison of the contracted HF shall submit the following documents for the physical medicine and rehabilitation services during the initial filing of claims reimbursement to the Local Health Insurance Office (LHIO) or the office of the Head of the PhilHealth Benefits Administration Section (BAS) who has jurisdiction over the contracted HFs:

a.1. Properly accomplished photocopy of the Checklist of Eligibility Criteria for Physical Medicine, Rehabilitation Services (Annex A)

a.2. Photocopy of the properly accomplished Member Empowerment (ME) Form (Annex B); and

a.3. Treatment Plan.

The health facilities may provide succeeding services including follow-up and discharge assessments, rehabilitation services, laboratory and diagnostics tests, and drugs/medicines to their patients.

b. Prior to the availment of assistive mobility devices, the contracted HFs shall submit the following documents to the PhilHealth Regional Office:

b.1. Properly accomplished Pre-authorization Checklist and Request Form for Assistive Mobility Devices (Annex C); and

b.2. Properly accomplished Member Empowerment (ME) Form (Annex B)

The pre-authorization checklist and request for assistive mobility devices shall be processed for approval within seven (7) working days upon submission to PhilHealth.

4. PhilHealth shall cover essential health services listed in Annex D, such as initial, follow-up and discharge assessments, drugs/medicines, laboratory and diagnostic tests, rehabilitation services, and assistive mobility devices including training for safe and functional use.

5. The patient may re-avail of the benefits packages for initial, follow-up and discharge assessments, drugs/medicines, laboratory and diagnostic tests, and rehabilitation services based on the following conditions and provided that the patient fulfills the selections criteria:

a. Continued physical medicine and rehabilitation services are needed; or

b. New or recurring health issues arise.

6. The patient may re-avail of the benefits package for assistive mobility devices based on the rules set in this policy (Table 9).

7. The forty-five (45) day annual benefit limit shall not apply when a patient avails of this benefits package.

8. The contracted HF shall discuss the ME Form with the patient and explain the cost-sharing aspect of the benefits package. The primary purpose of the ME Form is to empower patient to actively participate in healthcare decision-making by providing them with essential information and education regarding their health condition and available treatment options.

9. The contracted HF may charge copayment or out-of-pocket (OOP) expenses for amenities or services that are not covered by the benefits package. This copayment is mutually agreed upon by the patient and contracted HFs during the discussion of the ME Form for services beyond the scope of essential health services.

10. PhilHealth shall reimburse drugs listed in the latest edition of the Philippine National Formulary (PNF). PhilHealth reiterates the mandate of the Health Technology Assessment, which provides a positive recommendation for any proposal to cover drugs/medicines, biologicals not listed in the latest PNF, new technologies, diagnostic procedures, surgical interventions, and other treatment interventions.

B. Responsibilities of Contracted Health Facilities

1. The contracted HFs shall adhere to the selection criteria as specified in the Checklist of Eligibility Criteria for Physical Medicine, Rehabilitation Services (Annex A) and/or Pre-Authorization Checklist and Request Form (Annex C) to qualify for this benefits package.

2. The physical medicine and rehabilitation specialist/ physiatrist shall evaluate the patient's health conditions, requests for laboratory and diagnostic tests, prescribe assistive mobility devices, develop a treatment plan, and adopt a multidisciplinary team approach involving a physical therapist, occupational therapist, speech and language therapist, and psychologist, including device training for safe and functional use.

3. The following may compose the MDT, depending on their availability at the contracted HF:

   a. Physical Medicine and Rehabilitation Specialist/ Physiatrist; and

   b. Physical therapist; and,

   Any of the following allied health professionals:
   a. Occupational therapist
   b. Speech and language pathologist (SLPs) or speech therapist
   c. Psychologist
   d. Prosthetists and orthotists

4. The physical medicine and rehabilitation specialist/ physiatrist shall set the functional goals (restoration, prevention, and maintenance) of the patient that will be indicated in the patient's treatment plan. These goals aim to improve the patient's overall well-being and quality of life by addressing the physical, cognitive, and psychological aspects of rehabilitation. Services are provided based on the patient's health condition and functional goals.

5. Allied health professionals, such as physical therapist (PT), occupational therapist (OT), speech and language pathologist (SLPs) or speech therapist, and psychologist, shall collaborate and utilize their expertise to restore function, prevent loss of functions, reduce the impact of impairment, prevent further disability, and support patient in achieving their full potential for independence and optimal health.

6. The concerned health professional(s) shall discuss the patient's specific needs, as well as the schedule of laboratory and diagnostic tests, follow-up assessments, monitor the patient's progress, and adjust the treatment plan as needed for optimal recovery, and medication prescription and dispensing, as needed.

7. The contracted HF shall document in the patient's record the rehabilitation sessions, and their respective dates, including all services rendered.

8. The contracted HFs shall refer their patients for further medical evaluation to the appropriate medical specialist if needed.

9. The contracted HF shall ensure access to needed physical medicine and rehabilitation services and availability of assistive mobility devices and drugs/medicines.

10. The contracted HF shall follow standard protocols and guidelines to ensure good patient outcomes and minimize complications through proper monitoring, checking compliance with the treatment plan and medications, and follow-up appointments.

11. The contracted HFs shall not balance bill any patient beyond the amount prescribed in the benefits package for covered services. In cases of copayment, the contracted HF shall not charge the patient more than the agreed copayment at the point of service.

12. The contracted HFs must appoint at least one (1) Physical Medicine and Rehabilitation Services (PMRS) Coordinator for this benefits package. The following are the responsibilities of the PMRS coordinator, whose responsibilities may include, but are not limited to the following, as may be deemed necessary by the contracted HF:

    a. Guide and navigate patients by facilitating timely access to the services required for this benefits package. Guiding the patients enrolled in the program aims to overcome health care barriers and

avail of the said benefits to ensure patient adherence to agreed treatment plans to achieve good clinical outcomes and ultimate patient satisfaction.

b. Coordinate with PhilHealth on matters pertinent to the availment of the benefits package of candidate patients, such as filling out forms, assessing eligibility requirements, and providing feedback and other inputs required by PhilHealth.

c. Encode pertinent clinical information and other data (i.e., demographics, among others) of all patients availing of this benefits package, whether or not the patient fulfills the set eligibility criteria.

13. The contracted HFs shall maintain a digital or physical copy of all medical records for monitoring and post-audit purposes by PhilHealth.

14. As stipulated in the Universal Healthcare Act, Chapter IV, Sec. 18 (b), there shall be no differentiation between facility and professional fees (PF). PhilHealth shall credit all payments to the accounts of contracted private and public HFs.

C. Responsibilities of the Patient and their Representatives

1. All patients shall adhere to the treatment plan including follow-up appointments as agreed with their attending physiatrists and allied health professionals.

2. All patients shall sign or affix their signature or thumb mark on documents that require the patient's approval or consent. In case the patient cannot sign or affix a thumb mark, an authorized representative (legal guardian or patient relative) may act on behalf of the patient.

3. Assistive mobility devices, including parts of the devices, are intended solely for the personal use of the patient to support their mobility needs. These devices are prescribed based on the individual's specific health condition and functional requirements and are not to be shared, rented, or used by others.

4. Patients found liable for trading or selling assistive mobility devices, including their parts and attached components, shall forfeit all privileges of availing themselves of these benefits, without prejudice to the filing of appropriate charges for possible violations in accordance with the existing laws, rules, and regulations of the Corporation. This information must be clearly explained by the contracted HF and understood and agreed upon by the patient.

D. Package Codes, Descriptions, Package Rates, and, Filing Period

General Package Code	Description
PMR01	Initial Assessment
PMR02	Follow-up Assessment
PMR03	Discharge Assessment
PMR04	Rehabilitation Services
PMR05	Assistive Mobility Devices
PMR06	Laboratory and Diagnostic Tests
PMR07	Drugs and Medicines

Table 1: Summary of Package Codes and Description

1. Initial Assessment

Package Code	Description	Package Rate (PHP)	Filing Schedule
PMR01A	Initial Assessment by a Physical Medicine and Rehabilitation Specialist/ Physiatrist	1,200	Within 60 days after the date of initial assessment by the Physical Medicine and Rehabilitation Specialist/ Physiatrist
PMR01B	Initial Assessment by Physical Therapist	1,300	Within 60 days after the date of initial assessment by the Physical Therapist
PMR01C	Initial Assessment by Occupational Therapist	2,350	Within 60 days after the date of initial assessment by the Occupational Therapist
PMR01D	Initial Assessment by Speech and Language Pathologist (SLPs) or Speech Therapist	2,300	Within 60 days after the date of initial assessment by the Speech and Language

Package Code	Description	Package Rate (PHP)	Filing Schedule
			Pathologist (SLPs) or Speech Therapist
PMR01E	Initial Assessment by Psychologist	2,800	Within 60 days after the date of initial assessment by the Psychologist

Table 2: Package Codes, Descriptions, Rates, and Filing Schedules for Initial Assessment

2. Follow-up Assessment

Package Code	Description	Package Rate (PHP)	Filing Schedule
PMR02	Follow-up assessment (Physical Medicine and Rehabilitation Specialist/ Physiatrist)	1,200 per assessment (Maximum of 10 follow-up assessments)	Within 60 days after the date of the 10th or last follow-up assessment

Table 3: Package Codes, Descriptions, Rates, and Filing Schedules for Follow-up Assessment by Rehabilitation Specialist/Physiatrist

3. Discharge Assessment

Package Code	Description	Package Rate (PHP)	Filing Schedule
PMR03A	Discharge Assessment by Physical Medicine and Rehabilitation Specialists/ Physiatrist	1,200	Within 60 days after the date of discharge assessment by the Physical Medicine and Rehabilitation Specialist/ Physiatrist
PMR03B	Discharge Assessment by Physical Therapist	1,200	Within 60 days after the date of discharge assessment by the Physical Therapist

Package Code	Description	Package Rate (PHP)	Filing Schedule
PMR03C	Discharge Assessment by Occupational Therapist	2,000	Within 60 days after the date of discharge assessment by the Occupational Therapist
PMR03D	Discharge Assessment by Speech and Language Pathologist (SLPs) or Speech Therapist	2,000	Within 60 days after the date of discharge assessment by the Speech and Language Pathologist (SLPs) or Speech Therapist
PMR03E	Discharge Assessment by Psychologist	2,800	Within 60 days after the date of discharge assessment by the Psychologist

Table 4: Package Codes, Descriptions, Rates, and Filing Schedules for Discharge Assessment

4. Rehabilitation Services

a. Physical Therapy (PT)

Package Code	Functional Goals	Package Rate (PHP)	Filing Schedule
PMR04A	Physical Therapy	16,800 per set (1,400 per session) Note: One (1) set is equivalent to 12 sessions	
PMR04A1	Restoration	Maximum of 4 sets in a year	Within 60 days after the date of the last session per set
PMR04A2	Prevention	Maximum of 2 sets in a year	
PMR04A3	Maintenance	Maximum of 1 set in a year	

Table 5: Package Codes, Descriptions, Rates, and Filing Schedules for Rehabilitation Therapy Conducted by a Physical Therapist

b. Occupational Therapy (OT)

Package Code	Functional Goals	Package Rate (PHP)	Filing Schedule
PMR04B	Occupational Therapy	27,600 per set (2,300 per session) Note: One (1) set is equivalent to 12 sessions	
PMR04B1	Restoration	Maximum of 4 sets in a year	Within 60 days after the date of the last session per set
PMR04B2	Prevention	Maximum of 2 sets in a year	
PMR04B3	Maintenance	Maximum of 1 set in a year	

Table 6: Package Codes, Descriptions, Rates, and Filing Schedules for Rehabilitation Therapy Conducted by an Occupational Therapist

c. Speech and Language Pathology (SLPs) or Speech Therapy

Package Code	Functional Goals	Package Rate (PHP)	Filing Schedule
PMR04C	Speech and Language Pathology/ Speech Therapy	30,000.00 per set (2,500.00 per session) Note: One (1) set is equivalent to 12 sessions	
PMR04C1	Restoration	Maximum of 4 sets in a year	Within 60 days after the date of the last session per set
PMR04C2	Prevention	Maximum of 2 sets in a year	
PMR04C3	Maintenance	Maximum of 1 set in a year	

Table 7: Package Codes, Functional Goals, Rates, and Filing Schedules for Rehabilitation Therapy Conducted by a Speech and Language Pathologist (SLPs) or Speech Therapist

d. Psychological Services

Package Code	Package Rate (PHP)	Filing Schedule
PMR04D	2,800 per session (12 sessions per year; maximum of 3 per month, as needed)	Within 60 days after the date of the last session

Table 8: Package Codes, Descriptions, Rates, and Filing Schedules for Psychological Services

5. Assistive Mobility Devices

Package Code	Description	Package Rate (PHP) *per item price	Filing Schedule
PMR05A	Basic wheelchair	7,500 (Maximum of 2 in a lifetime) (Replacement after 1 year from the date of availment)	Within 60 days after the date of issuance of the basic wheelchair
PMR05B	Active wheelchair	15,000 (Maximum of 2 in a lifetime) (Replacement after 1 year from the date of availment)	Within 60 days after the date of issuance of the active wheelchair
PMR05C	Supportive wheelchair	25,000 (Maximum of 2 in a lifetime) (Replacement after 2 years from the date of availment)	Within 60 days after the date of issuance of the supportive wheelchair
PMR05D1	Motorized wheelchair	40,000 (Once in a lifetime)	Within 60 days after the date of issuance of the motorized wheelchair
PMR05D2	Battery replacement	5,000	Within 60 days after

Package Code	Description	Package Rate (PHP) *per item price	Filing Schedule
		(Availment after 1 year from the date of availment of the motorized wheelchair)	the date of issuance of the battery replacement
PMR05E	Walker	2,000 (Maximum of 2 in a lifetime) (Replacement after 1 year from the date of availment)	Within 60 days after the date of issuance of the device
PMR05F	Rollator	3,000 (Maximum of 2 in a lifetime) (Replacement after 1 year from the date of availment)	Within 60 days after the date of issuance of the mobility device
PMR05G	Quad cane	2,000 (Maximum of 2 in a lifetime) (Replacement after 1 year from the date of availment)	Within 60 days after the date of issuance of the mobility device
PMR05H	Single tip cane	1,000 (Maximum of 2 in a lifetime) (Replacement after 1 year from the date of availment)	Within 60 days after the date of issuance of the mobility device
PMR05I	Crutch axillary	1,500 (Maximum of 2 in a lifetime) (Replacement after 1 year from the date of availment)	Within 60 days after the date of the issuance of the mobility device
PMR05J	Crutch triceps	2,500 (Maximum of 2 in a lifetime)	Within 60 days after the date of

Package Code	Description	Package Rate (PHP) *per item price	Filing Schedule
		(Replacement after 1 year from the date of availment)	issuance of the mobility device
PMR05K	White cane	3,000 (Maximum of 2 in a lifetime) (Replacement after 1 year from the date of availment)	Within 60 days after the date of issuance of the mobility device

Table 9: Package Codes, Descriptions, Rates, and Filing Schedules for Assistive Mobility Devices

6. Laboratory and Diagnostic Tests

Package Code	Description	Package Rate (PHP)	Filing Schedule
PMR06A	Segmental X-Ray	320 per session (Maximum of 4 per year)	Within 60 days after the conduct of the services
PMR06B	Skeletal Survey	6,365 (Once per year)	Within 60 days after the conduct of the services
PMR06C	EMG-NCV (Initial segments)	5,000 per session (Maximum of 2 per year)	Within 60 days after the conduct of the services
PMR06D	EMG-NCV (Succeeding segments)	3,000 per session (Maximum of 6 per year)	Within 60 days after the conduct of the services
PMR06E	MSK Ultrasound	3,000 per session (Maximum of 4 per year)	Within 60 days after the conduct of the services
PMR06F	MRI	24,000 per session	Within 60 days after the conduct

Package Code	Description	Package Rate (PHP)	Filing Schedule
		(Maximum of 2 per year)	of the services
PMR06G	CT Scan	9,100 per site (Maximum of 2 per site per year)	Within 60 days after the conduct of the services
PMR06H	FEES or Barium swallow	10,500 (Once per year)	Within 60 days after the conduct of the services
PMR06I	ECG	620 (Once per year)	Within 60 days after the conduct of the services
PMR06J	2D echo	3,200 (Once per year)	Within 60 days after the conduct of the services
PMR06K	Exercise Stress Test	2,730 (Once per year)	Within 60 days after the conduct of the services
PMR06L	Pulmonary function test	2,300 (Once per year)	Within 60 days after the conduct of the services
PMR06M	Urinalysis	170 (Maximum of 6 per year)	Within 60 days after the conduct of the services
PMR06N	KUB Ultrasound	1,300 per session (Maximum of 4 per year)	Within 60 days after the conduct of the services
PMR06O	Urodynamic Studies	7,000 per session (Maximum of 2 per year)	Within 60 days after the conduct of the services
PMR06P	BUN	1,900.00 per set	Within 60 days

Package Code	Description	Package Rate (PHP)	Filing Schedule
	Creatinine Fasting Blood Sugar (FBS) Complete Blood Count (CBC) Serum electrolytes: Sodium (Na) Potassium (K) Chloride (Cl)	(Maximum of 4 sets every year)	after the conduct of the services

Table 10: Package Codes, Descriptions, Rates, and Filing Schedules for Laboratory and Diagnostics

7. Drugs and Medicine

Package Code	Description	Package Rate (PHP)	Filing Schedule
PMR07	Oral Medication: Gabapentin Diclofenac Tramadol Methylprednisolone acetate	Maximum of 2,000 per year	Within 60 days after dispensing of drugs/ medicine
	Intravenous Injection: Bupivacaine Hydrocortisone acetate Methylprednisolone acetate Tramadol		

Table 11: Package Codes, Descriptions, Rates, and Filing Schedules for Drugs and Medicine

E. Claims Filing and Reimbursement

1. The contracted HFs shall render the essential health services prescribed to patients under this benefits package. Services provided shall be documented in the Checklist of Essential Health Services (Annex E).

2. There shall be no direct filing of claims by members/beneficiaries. All claims shall be filed by contracted HFs.

3. The contracted HFs shall be responsible for the accuracy, adherence to rules and efficient handling of all claims filed on behalf of patients. All

required documents, forms, and attachments should be properly filled out before claims filing. The contracted HFs shall submit the complete requirements for claims submission, including supporting documents.

4. The contracted HFs shall follow the documentary requirements for filing claims, as listed in the Checklist of Requirements for Reimbursement (Annex F) including Transmittal Form (Annex G), which shall be attached per claim or per batch of claims.

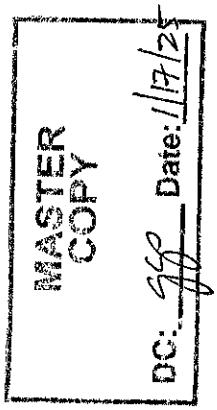
5. The contracted HFs shall accomplish one (1) Claim Form 2 per package availed of by the patient.

6. For patients availing more than one (1) benefits package, the contracted HF shall prepare one (1) CF2 per package availed of and attach respective statements of account (SOA) or consolidated SOA, whichever is applicable.

7. The Physiatrist/Physical Medicine and Rehabilitation Specialist, or both the Physiatrist and the concerned allied health professional(s), shall affix their signatures to confirm that the services were provided to patients

8. The contracted HFs shall properly indicate the OOP and/or copayment of the member/patient and other funding sources in PhilHealth Claim Form 2 (CF2) Part III, "Consumption Benefits," and in the Statement of Account (SOA).

9. Accredited HFs shall follow all relevant laws, such as RA No. 9994 or the "Expanded Senior Citizens Act of 2010" and RA No. 10754 or the "Act Expanding the Benefits and Privileges of Persons with Disability (PWD)," including prospective laws providing mandatory discounts, guidelines of the Bureau of Internal Revenue (BIR), and the order of charging based on DOH-DSWD-PCSO-PHIC Joint Administrative Order No. 2020-0001 [Operational Guidelines for the Implementation of the Medical and Financial Assistance to Indigent and Financially-Incapacitated Patients according to Republic Act No. 11463 also known as "Malasakit Centers Act of 2019"].



With this, PhilHealth benefits and all mandatory discounts provided by law, such as senior citizen and PWD discounts, shall be deducted first from the patient's total hospital bill. Benefits from private health insurance (PHI), health maintenance organizations (HMO), or employee benefits shall be applied after PhilHealth deductions and complement the PhilHealth benefits packages.

10. If the patient expires or is declared lost to follow-up, the contracted HF shall file claims based on the services provided.

11. The contracted HFs shall exhaust all efforts to contact or obtain information about the whereabouts or situation of their patients. In case of patients who are declared lost to follow-up or when the patient expires, the contracted HFs shall file claims based on the applicable scenarios:

a. The contracted HF shall submit to PhilHealth a notarized sworn declaration for patients declared lost to follow-up. The contracted HF shall submit their claims within sixty (60) days from such declaration.

b. If the patient expires at any time during the treatment phases, the contracted HF shall submit a photocopy of the death certificate or a notarized sworn declaration issued by the authorized government agencies as an attachment to the claims. The contracted HF shall submit their claims within sixty (60) days from the receipt of the death certificate or notarized sworn declaration issued by the authorized government agencies.

12. The Satisfaction Questionnaire (Annex H) shall be administered to all patients enrolled in this benefits package which shall be attached to each claim application. The results of the Satisfaction Questionnaire are validated during field monitoring by PhilHealth and shall be used as input for benefits enhancement, policy research, and quality improvement purposes.

13. Contracted HFs may file a motion for reconsideration (MR) or appeal for claims denied by PhilHealth following existing policies.

14. Existing rules on late filing shall apply. If the delay in claims filing is due to natural calamities or other fortuitous events, the existing policy of the Corporation on the provision of special privileges to those affected by fortuitous events shall apply.

F. Claims Payment and Evaluation

1. PhilHealth shall reimburse covered services under the following applicable provider payment mechanism:

Benefits Package	Provider Payment Mechanism
Initial Assessment	Case-based payment
Follow-up Assessment	Case-based payment
Discharge Assessment	Case-based payment
Rehabilitation Services	Case-based payment per set or session
Assistive Mobility Devices	Fee for Service (based on SOA)
Laboratory and Diagnostic Tests	Fee for Service (based on SOA)
Drugs and Medicines	Fee for Service (based on SOA)

Table 12: Benefits Package and Provider Payment Mechanism for Physical Medicine, Rehabilitation Services, and Assistive Mobility Devices

2. PhilHealth shall review the completeness of all forms submitted by the contracted HFs. The PROs and LHIOs shall have the prerogative not to accept incomplete documents. However, they should directly coordinate with the contracted HFs regarding the deficiencies in the documents submitted. Once the documents are complete, the contracted HF shall submit these to PhilHealth for payment of claims within the required filing schedule.

3. PhilHealth shall apply the "return to sender (RTS)" policy only for claims documents with incomplete data or documentary requirements. However, inconsistencies in data or information contained in the documents or non-provision of a mandatory service are grounds for automatic denial of the claim.

   Upon receipt of the notice of RTS, the contracted HFs shall comply with the deficiency requirements within the prescribed period based on the existing rules and regulations set by PhilHealth.

4. PhilHealth shall have the right to subject any or all claims to medical review before and/or after payment or reimbursement of the contracted HFs, following the existing guidelines.

5. Any change of member/patient category upon enrollment shall not affect the claims filed by the contracted HF.

6. PhilHealth shall process claims without reference to any prior service. Claims for each service within the same date or period shall not be considered overlapping claims.

7. Any amount declared in the SOA that is below or above the package rates shall not be interpreted as overpayment or underpayment. PhilHealth can adjust payment rates in consideration of updates in standards of care and the cost of standard health services validated with content experts.

8. PhilHealth shall process all claims submitted by the contracted HFs within sixty (60) days upon receipt of claims applications, provided that the required documents and attachments are complied with.

9. Claims filed by the contracted HF shall be denied based on the following instances:

   a. If essential health services were not provided by the contracted HF;
   b. Late filing;
   c. Inconsistency of data and information contained in the claims application.

G. Monitoring

1. PhilHealth shall enforce current policies and guidelines on monitoring the performance of accredited HFs in implementing the Benefits Package for Physical Medicine, Rehabilitation Services, and Assistive Mobility

Devices and establish strict control mechanisms to ensure quality healthcare delivery and prevent adverse provider behaviors and non-compliance with existing rules.

2. PhilHealth encourages content experts to review and conduct appropriate studies on healthcare providers' actual practices during the implementation of this benefits package, especially documenting adverse provider behaviors resulting in cost-push inflation, such as unwarranted increases in health facility charges.

3. PhilHealth beneficiaries are strongly encouraged to provide feedback or report concerns about the implementation of this policy or their experience with benefit availment to the Corporate Action Center (CAC) via the hotline (02) 8862-2588 or email actioncenter@philhealth.gov.ph

4. PhilHealth shall conduct field monitoring activities.

5. The Corporation shall establish the performance indicators and outcome measures to monitor compliance with the policies of this Circular and the general treatment algorithm in collaboration with relevant stakeholders and experts and incorporate the indicators in the relevant monitoring policies.

H. Policy Review

PhilHealth shall conduct regular policy reviews of the benefits package in consultation and collaboration with relevant stakeholders, experts, and technical staff representatives from the Corporation.

This PhilHealth Circular shall be enhanced as necessary based on the results of the policy review.

I. Marketing and Promotion

PhilHealth shall conduct communication and social marketing activities to educate the general public and increase their awareness of the benefits package and to promote informed decision-making and participation among patients, healthcare professionals, healthcare providers, and other stakeholders, including marketing and promotional activities shall be undertaken following the Integrated Marketing and Communication Plan of PhilHealth.

J. Annexes (Posted on the Official Website of PhilHealth)

Annex A: Checklist of Eligibility Criteria for Physical Medicine, Rehabilitation Services

Annex B: Member Empowerment Form

Annex C: Pre-authorization Checklist and Request Form for Assistive Mobility Devices
- Annex C.1: Pre-authorization Checklist and Request Form for Wheelchairs
- Annex C.2: Pre-authorization Checklist and Request Form for Other Assistive Mobility Devices

Annex D: List of Essential Health Services

Annex E: Checklist of Essential Health Services

Annex F: Checklist of Requirements for Reimbursement
- Annex F.1: Checklist of Requirements for Reimbursement - Assessment
- Annex F.2: Checklist of Requirements for Reimbursement - Rehabilitation Services
- Annex F.3: Checklist of Requirements for Reimbursement - Laboratory and Diagnostic Tests and Drugs/ Medicines
- Annex F.4: Checklist of Requirements for Reimbursement - Assistive Mobility Devices

Annex G: Transmittal Form

Annex H: Satisfaction Questionnaire

Annex I: Pilot Testing of the PhilHealth Benefits Package on Physical Medicine, Rehabilitation Services, and Assistive Mobility Devices

VI. PENALTY CLAUSE

Any violation of this PhilHealth Circular shall be dealt with and penalized in accordance with pertinent provisions of RA No. 7875, as amended by RA Nos. 9241 and 10606 (National Health Insurance Act of 2013), RA No. 11223 (Universal Health Care Act), and their respective Implementing Rules and Regulations, including the PhilHealth Rules on Administrative Cases (PROAC).

VII. TRANSITORY CLAUSE

A. Upon publication of this PhilHealth Circular, PhilHealth shall disseminate information to contracted HFs, ensure the availability of forms specified in this policy on the PhilHealth website, and implement the necessary enhancements in the claims system.

B. While the necessary system is being developed, the contracted HFs shall submit the claims manually. PhilHealth shall issue a corresponding advisory

to inform the health facilities once the benefits package is fully integrated into the system.

C. The Health Finance Policy Sector shall conduct pilot testing of the benefits package in free-standing rehabilitation health facilities within one year from the effective date of this policy (Annex I). PhilHealth shall disseminate the guidelines for the conduct of the pilot test through an Advisory or issuance.

VIII. SEPARABILITY CLAUSE

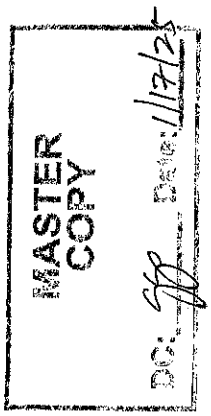
In the event that any part or provision of this PhilHealth Circular is declared unauthorized or invalid by any Court of Law or competent authority, those provisions not affected by such declaration shall remain valid and effective.

IX. DATE OF EFFECTIVITY

This PhilHealth Circular shall take effect on February 14, 2025 after its publication in the Official Gazette or any newspaper of general circulation. Three (3) certified copies shall 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

Date signed: 1/17/25



Annex A: Checklist of Eligibility Criteria for Physical Medicine and Rehabilitation Services

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No._____

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

Physical Medicine, Rehabilitation Services, and Assistive Mobility Devices

Place a (✓) if "Yes"

General Criteria	YES
The patient must be at least 18 y/o and above at the time of enrollment to the PMRS Package	

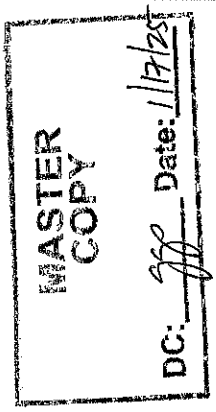
Place a (✓) if "Yes"

History of PMRS Patient	YES
Currently Receiving Physical Medicine and Rehabilitation Services *If *yes,* indicate the date of assessment by a Physiatrist/Physical Medicine and Rehabilitation Specialist, and the date of last PMRS session Date of Assessment by a Physiatrist/Physical Medicine and Rehabilitation Specialist (MM/DD/YYYY) Date of Last PMRS Session (MM/DD/YYYY)	
Continued Physical Medicine and Rehabilitation Services are needed *If *yes,* indicate the date of last PMRS Session Date of Last PMRS Session (MM/DD/YYYY)	

Place a (✓) on the appropriate severity and functional domains based on assessment of the patient

Disability-Focused Assessment	Mild	Moderate	Severe
Mobility and Self-Care	☐ Independent with standby assistance	☐ Assisted in preparing initiating or completing activity	☐ Unable to perform & dependent on caregiver
Cognitive Behavioral	☐ Follows 3-step instructions +/- standby assist	☐ Has difficulty in following 2-3 step instructions and needs assistance in preparing, initiating, or completing an activity	☐ Unable to follow 1-2 step instructions and needs a caregiver to perform an activity
Communication	☐ Intact receptive and expressive communication but with difficulty in articulation and prosody	☐ Intact receptive, but expressive communication needs caregiver assistance and/or assistive technology	☐ Communication is limited to caregiver assistance and/or assistive technology

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physical Medicine and Rehabilitation Specialist/Physiatrist	(Printed name and signature) Patient/ Guardian
PhilHealth Accreditation No.	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	



PhilHealth
Your Partner in Health
BAGONG PILIPINAS

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial X teamphilhealth

Numero ng kaso: _____
Case No.

MEMBER EMPOWERMENT FORM
(Physical Medicine, Rehabilitation Services And Assistive Mobility Devices)

Magpaalám, tumulong, at magbigay kapangyarihan
Inform, Support & Empower

Mga Panuto:
Instructions:

Ipaliliwanag at tutulungan ng kinatawan ng ospital ang pasyente sa pagsasagot ng ME form.
The health care provider shall explain and assist the patient in filling-up the ME form.
Isulat nang maayos at malinaw ang mga impormasyon na kinakailangan.
Legibly print all information provided.
Para sa mga katanungang nangangailangan ng sagot na "oo" o "hindi", lagyan ng marka () ang angkop na kahon.
For items requiring a "yes" or "no" response, tick appropriately with a check mark ().
Gumamit ng karagdagang papel kung kinakailangan. Lagyan ito ng kaukulang marka at ilakip ito sa ME form.
Use additional blank sheets if necessary, label properly and attach securely to this ME form.
Ang kinontratang ospital na magkakaloob ng dalubhasang pangangalaga sa pagpaparami ng kopya ng ME Form.
The ME form shall be reproduced by the contracted health facility (HF) providing specialized care.
Dalawang kopya ng ME form ang kailangang ibigay ng kinontratang ospital. Ang mga kopyang nabanggit ay ilalaan para sa pasyente at sa ospital.
Duplicate copies of the ME form shall be made available by the contracted HF—one for the patient and one as file copy of the contracted HF providing the specialized care.

MASTER COPY
DC: Date: 11/4/25

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

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

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

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

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

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

PERMANENTENG TIRAHAN
PERMANENT ADDRESS

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

Kategorya bilang Miyembro:
Membership Category:

Direct contributor
Direct contributor

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

Indirect contributor
Indirect contributor

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

Iba pa
Others
- O Point of Service (POS) Financially Incapable

MASTER COPY Date: 11/25 DC:

B. Impormasyong Klinikal ***B. Clinical Information***	
1. Paglalarawan ng kondisyon ng pasyente *Description of condition*	
2. Napagkasunduang angkop na plano ng gamutan sa ospital *Applicable Treatment Plan agreed upon with healthcare provider*	
3. Napagkasunduang angkop na alternatibong plano ng gamutan sa ospital *Applicable alternative Treatment Plan agreed upon with health care provider*	
C. Talatakdaan ng Gamutan at Kasunod na Konsultasyon ***C. Treatment Schedule and Follow-up Visit/s***	
1. Petsa ng unang pagkakaospital o konsultasyon [a] (buwan/araw/taon) *Date of initial admission to HF or consult [a] (mm/dd/yyyy)*	
2. Pansamantalang Petsa ng susunod na pagpapa-ospital o konsultasyon (buwan/araw/taon) *Tentative Date/s of succeeding admission to HF or consult (mm/dd/yyyy)*	
3. Pansamantalang Petsa ng kasunod na pagbisita (buwan/araw/taon) *Tentative Date/s of follow-up visit/s (mm/dd/yyyy)*	

D. Edukasyon ng Miyembro ***D. Member Education***		
Lagyan ng tsek (√) ang angkop na sagot o NA kung hindi naaukol *Put a check mark (√) opposite appropriate answer or NA if not applicable.*	OO *YES*	HINDI *NO*
1. Ipinaliwanag ng kinatawan ng ospital ang uri ng aking karamdaman. *My health care provider explained the nature of my condition/disability.*		
2. Ipinaliwanag ng kinatawan ng ospital ang mga pagpipiliang paraan ng gamutan/interbensyon *My health care provider explained the treatment options/intervention.*		
3. Ipinaliwanag ng kinatawan ng ospital ang mga posibleng mga epekto/ masamang epekto ng gamutan/ interbensyon. *The possible side effects/adverse effects of treatment/intervention were explained to me.*		
4. Ipinaliwanag ng kinatawan ng ospital ang kailangang serbisyo para sa gamutan ng aking karamdaman/ interbensyon.		

My health care provider explained the mandatory services and other services required for the treatment of my condition/intervention.		
5. Lubos akong nasiyahan sa paliwanag na ibinigay ng ospital. *I am satisfied with the explanation given to me by my health care provider*		
6. Naibigay sa akin nang buo ang impormasyon na ako ay mahusay na aalagaan ng mga dalubhasang doktor sa aking piniling kinontratang ospital ng PhilHealth at kung gustuhin ko mang lumipat ng ospital ay hindi ito maka-aapekto sa aking pagpapagamot. *I have been fully informed that I will be cared for by all the pertinent medical and allied specialties, as needed, present in the PhilHealth contracted HF of my choice and that preferring another contracted HF for the said specialized care will not affect my treatment in any way.*		
7. Ipinaliwanag ng kinatawan ng ospital ang kahalagahan ng pagsunod sa panukalang gamutan/interbensyon. Kasama rito ang pagkompleto ng gamutan/interbensyon sa unang ospital kung saan nasimulan ang aking gamutan/interbensyon. *My health care provider explained the importance of adhering to my treatment plan/intervention. This includes completing the course of treatment/intervention in the contracted HF where my treatment/intervention was initiated.* Paalala: Ang hindi pagsunod ng pasyente sa napagkasunduang gamutan/interbensyon sa ospital ay maaaring magresulta sa hindi pagbabayad ng mga kasunod na claims at hindi dapat itong ipasa bilang case rates. *Note: Non-adherence of the patient to the agreed treatment plan/intervention in the HF may result to denial of filed claims for the succeeding tranches and which should not be filed as case rates.*		
Lagyan ng tsek (√) ang angkop na sagot o NA kung hindi nauukol Put a check mark(√) opposite appropriate answer or NA if not applicable.	**OO YES**	**HINDI NO**
8. Binigyan ako ng ospital ng talaan ng mga susunod kong pagbisita. *My health care provider gave me the schedule/s of my follow-up visit/s.*		
9. Ipinaalam sa akin ng ospital ang impormasyon tungkol sa maaari kong hingan ng tulong pinansiyal o ibang pang suporta, kung kinakailangan. a. Sangay ng pamahalaan (Hal.: PCSO, PMS, LGU, etc.) b. Civil society o non-government organization c. Patient Support Group d. Corporate Foundation e. Iba pa (Hal. Media, Religious Group, Politician, etc.) *My health care provider gave me information where to go for financial and other means of support, when needed.* *a. Government agency (ex. PCSO, PMS, LGU, etc.)* *b. Civil society or non-government organization* *c. Patient Support Group* *d. Corporate Foundation* *e. Others (ex. Media, Religious Group, Politician, etc.)*		
10. Nabigyan ako ng kopya ng listahan ng mga kinontratang ospital para sa karampatang paggagamot ng aking kondisyon o karamdaman. *I have been furnished by my health care provider with a list of other contracted HFs for the specialized care of my condition.*		

11. Nabigyan ako ng sapat na kaalaman hinggil sa benepisyo at tuntunin ng PhilHealth sa pagpapa-miyembro at paggamit ng benepisyong naaayon sa benefits: *I have been fully informed by my health care provider of the PhilHealth membership policies and benefit availment on the Benefits:* a. Kaalipikado ako sa mga itinakdang batayan para sa aking kondisyon/kapansanan. *I fulfill all selections criteria for my condition/disability.*		
b. Ipinaliwanag sa akin ang polisiya hinggil sa "No Balance Billing" (NBB) *The "no balance billing" (NBB) policy was explained to me.* Paalala: Ang polisiya ng NBB ay maaaring makamit ng mga sumusunod na miyembro at kanilang kalipikadong makikinabang kapag na-admit sa ward ng ospital: inisponsuran, maralita, kasambahay, senior citizens at miyembro ng iGroup na may kaukulang Group Policy Contract (GPC). *Note: NBB policy is applicable to the following members when admitted in ward accommodation: sponsored, indigent, household help, senior citizens and iGroup members with valid Group Policy Contract (GPC) and their qualified dependents.*		
Para sa inisponsuran, maralita, kasambahay, senior citizens at miyembro ng iGroup na may kaukulang Group Policy Contract (GPC) at kanilang kwalipikadong makikinabang, sagutan ang c, d at e. *For sponsored, indigent, household help, senior citizens and iGroup members with valid GPC and their qualified dependents, answer c, d and e.* c. Nauunawaan ko na sakaling hindi ako gumamit ng NBB ay maaari akong magkaroon ng kaukulang gastos na aking babayaran. *I understand that I may choose not to avail of the NBB and may be charged out of pocket expenses*		
d. Sakaling ako ay nagpalipat sa mas magandang kuwarto ayon sa aking kagustuhan o tumanggap ng karagdagang serbisyo na hindi kasama sa benepisyo, nauunawaan ko na hindi na ako maaaring humiling sa pagamutan para makagamit ng pribilehiyong ibinibigay sa mga pasyente na NBB (kapag NBB, wala nang babayaran pa pagkalabas ng pagamutan) *In case I choose to upgrade my room accommodation or avail of additional services that are not included in the benefit package, I understand that I can no longer demand the hospital to grant me the privilege given to NBB patients (that is, no out of pocket payment upon discharge from the hospital)*		
e. Ninanais ko na lumabas sa polisiyang NBB ang PhilHealth at dahil dito, babayaran ko ang anumang halaga na hindi sakop ng benepisyo sa PhilHealth *I opt out of the NBB policy of PhilHealth and I am willing to pay on top of my PhilHealth benefits*		

f. Pumapayag akong magbayad ng hanggang sa halagang PHP _____* para sa: *I agree to pay as much as PHP _____* for the following:* × Paglipat ko sa mas magandang kuwarto, o *I choose to upgrade my room accommodation, or* × anumang karagdagang serbisyo, tukuyin _____ *additional services, specify* _____ * Ito ay tinantiyang halaga lamang na gagabay sa pasyente kung magkano ang kanyang babayaran at hindi dapat gawing batayan para sa pagtutuos ng kuwenta ng nagugol na gastusin sa pagkakaospital na babayaran ng PhilHealth. *This is an estimated amount that guides the patient on how much the out of pocket may be and should not be a basis for auditing claims reimbursement.*		
Ang mga sumusunod na katanungan ay para sa mga miyembro ng formal at informal economy at kanilang mga kalipikadong makikinabang ***The following are applicable to formal and informal economy and their qualified dependents*** g. Naiintindihan ko na maaari akong magkaroon ng babayaran para sa halagang hindi sakop ng benepisyo sa PhilHealth. *I understand that there may be an additional payment on top of my PhilHealth benefits.* h. Pumapayag akong magbayad ng hanggang sa halagang PHP _____* para sa aking gamutan na hindi sakop ng benepisyo ng PhilHealth. *I agree to pay as much as PHP _____* as additional payment on top of my PhilHealth benefits.* * Ito ay tinantiyang halaga lamang na gagabay sa pasyente kung magkano ang kanyang babayaran at hindi dapat gawing batayan para sa pagtutuos ng kuwenta ng nagugol na gastusin sa pagkakaospital na babayaran ng PhilHealth. *This is an estimated amount that guides the patient on how much the out of pocket may be and should not be a basis for auditing claims reimbursement.*		
12. Walang babawasan mula sa 45 araw na palugit sa benepisyo sa isang taon para sa buong gamutan sa ilalim ng benefits na ito. *No deduction from the 45 confinement days benefit limit per year for the duration of my treatment/intervention under this Benefits.*		

E. Tungkulin at Responsabilidad ng Miyembro ***E. Member Roles and Responsibilities***		
Lagyan ng (√) ang angkop na sagot o NA kung hindi naaukol *Put a (√) opposite appropriate answer or NA if not applicable*	OO *YES*	HINDI *NO*
1. Nauunawaan ko ang aking tungkulin upang masunod ang nararapat at nakatakda kong gamutan. *I understand that I am responsible for adhering to my treatment schedule.*		
2. Nauunawaan ko na ang pagsunod sa itinakdang gamutan ay mahalaga tungo sa aking paggaling at pangunahing kailangan upang magamit ko nang buo ang benefits na ito. *I understand that adherence to my treatment schedule is important in terms of clinical outcomes and a pre-requisite to the full entitlement of this benefits.*		
3. Nauunawaan ko na tungkulin kong sumunod sa mga polisiya at patakaran ng PhilHealth at ospital upang magamit ang buong benefits package. Kung sakali na hindi ako makasunod sa mga polisiya at patakaran ng PhilHealth at ospital, tinatalikuran ko ang aking pribilehiyong makagamit ng benepissyong ito. *I understand that it is my responsibility to follow and comply with all the policies and procedures of PhilHealth and the health care provider in order to avail of the full benefits package. In the event that I fail to comply with policies and procedures of PhilHealth and the health care provider, I waive the privilege of availing this benefits.*		

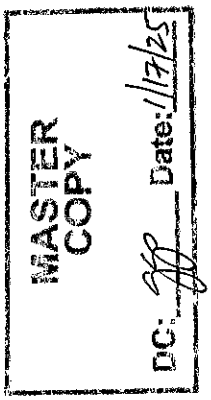
F. Pangalan, Lagda, Thumb Print at Petsa ***F. Printed Name, Signature, Thumb Print and Date***		
Pangalan at Lagda ng pasyente:* *Printed name and signature of patient** *Para sa mga menor de edad, ang magulang o tagapag-alaga ang pipirma o maglalagay ng thumb print sa ngalan ng pasyente. * *For minors, the parent or guardian affixes their signature or thumb print here on behalf of the patient.*	Thumb Print (kung hindi makakasulat ang pasyente) *(if patient is unable to write)*	Petsa (buwan/ araw/ taon)
Pangalan at lagda ng nangangalagang Doktor: *Printed name and signature of Attending Doctor*		Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*
Mga Saksi: *Witnesses:*		
Pangalan at lagda ng kinatawan ng ospital: *Printed name and signature of HF staff member*		Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*
Pangalan at lagda ng asawa/ magulang / pinakamalapit na kamag-anak/awtorisadong kinatawan *Printed name and signature of spouse/ parent/ next of kin /authorized guardian or representative* * walang kasama/ *no companion*		Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*

MASTER COPY
DC: ___ Date: 1/17/25

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

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

I. Pahintulot sa pagsusuri sa talaan ng pasyente ***I. Consent to access patient record***		
Ako ay pumapayag na suriin ng PhilHealth ang aking talaang medikal upang mapatunayan ang katotohanan ng claim *I consent to the examination by PhilHealth of my medical records for the sole purpose of verifying the veracity of the claim*		
Ako ay nagpapatunay na walang pananagutan ang PhilHealth o sinumang opisyal, empleyado o kinatawan mula sa pahintulot na nakasaad sa itaas sapagkat kusang-loob ko itong ibinigay upang makagamit ng benepisyo ng PhilHealth. *I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with the claim for reimbursement before PhilHealth.*		
Buong pangalan at lagda ng pasyente* *Printed name and signature of patient** * Para sa mga menor de edad, ang magulang o tagapag-alaga ang pipirma o maglalagay ng thumb print sa ngalan ng pasyente. * *For minors, the parent or guardian affixes their signature or thumb print here on behalf of the patient.*	Thumb print (Kung hindi na makasusulat) *(if patient is unable to write)*	Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*
Buong pangalan at lagda ng kumakatawan sa pasyente *Printed name and signature of patient's representative* × walang kasama/ *no companion*		Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*
Relasyon ng kumakatawan sa pasyente (Lagyan ng tsek ang angkop na kahon) *Relationship of representative to patient (tick appropriate box)* ☐ asawa *spouse* ☐ magulang *parent* ☐ anak *child* ☐ kapatid *next of kin* ☐ tagapag-alaga *guardian* ☐ walang kasama *no companion*		



Annex C.1: Pre-authorization Checklist and Request Form for Wheelchairs

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PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

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

Place a (✓) if "Yes"

General Criteria	YES
The patient must be at least 18 y/o and above at the time of enrollment to the Benefit Package on Assistive Mobility Device (Wheelchair)	

Place a (✓) if "Yes"

History of Previous Availment ☐ Not Applicable	YES
*If *yes,* indicate the date of last availment Date of last availment of Assistive Mobility Device: Wheelchair (mm/ yyyy) : _____ Name of HF where the wheelchair was previously availed from: _____	

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Eligibility Criteria for Assistive Mobility Device: Wheelchair

Place a (✓) if "Yes"

Inability to walk ≤400 meters or endure 10 minutes of continuous walking	☐ Yes
No masses, pressure sores on areas of contact, deformities, or contractures that deter safe & functional use of a wheelchair	☐ Yes

Place a checkmark (✓) on the appropriate type of Assistive Mobility Device based on the descriptive criteria for mobility and self-care, behavioral and communication disabilities, standing balance, sitting static and dynamic balance, and the ability to self-propel.

☐ **Basic Wheelchair**	1. Mild to moderate disability in mobility and self-care 2. Mild to moderate cognitive/ behavioral & communication disability 3. Absent to poor standing balance 4. Fair to good sitting static and dynamic balance 5. Cannot self-propel wheelchair
☐ **Active Wheelchair**	1. Mild to moderate disability in mobility and self-care 2. No cognitive/ behavioral & communication disability 3. Normal to good sitting balance 4. Good sitting dynamic and static balance & endurance 5. Able to self-propel wheelchair
☐ **Supportive Wheelchair**	1. Moderate to severe disability in mobility and self-care 2. Moderate to severe cognitive/ behavioral & communication disability 3. Absent to poor standing balance 4. Absent to poor sitting balance 5. Cannot self-propel wheelchair
☐ **Motorized Wheelchair**	1. Mild to moderate disability in mobility and self-care 2. Mild behavior/cognitive & communication disability 3. Normal to good sitting balance 4. Good sitting dynamic and static balance 5. Cannot self-propel wheelchair

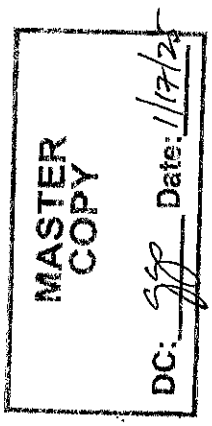
MASTER COPY

DC: Date: 1/17/25

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physical Medicine and Rehabilitation Specialist/Physiatrist	(Printed name and signature) Patient
PhilHealth Accreditation No.	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

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

There is no need to attach laboratory results. However, these should be included in the patient's chart and may be checked during the field monitoring of the **Physical Medicine, Rehabilitation Services, and Assistive Mobility Devices.** Please do not leave any item blank.



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(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

PRE-AUTHORIZATION REQUEST

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the **Physical Medicine, Rehabilitation Services, and Assistive Mobility Devices** benefit package for _____ (Patient's last, first, suffix, middle name) in _____ (Name of HF) under the terms and conditions as agreed for availment of the Benefit Package.

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

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

_____

Certified correct by:

(Printed name and signature)
Attending Physical Medicine and Rehabilitation Specialist

PhilHealth Accreditation No.

Conforme by:

(Printed name and signature)

☐ Patient ☐ Parent ☐ Guardian

Certified correct by:

(Printed name and signature)
Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief

PhilHealth Accreditation No.

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☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

INITIAL APPLICATION			**COMPLIANCE TO REQUIREMENTS**		
Activity	**Initial**	**Date**	☐ APPROVED ☐ DISAPPROVED (State reason/s) _____ (Printed name and signature) Head or authorized BAS representative		
Received by LHIO/BAS:					
Endorsed to BAS (if received by LHIO):					
☐ Approved ☐ Disapproved			**Activity**	**Initial**	**Date**
Released to HF:			Received by BAS:		
The pre-authorization shall be valid for sixty (60) calendar days			☐ Approved ☐ Disapproved		
			Released to HF:		

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DC: _____ Date: 1/17/22

Annex C.2: Pre-authorization Checklist and Request Form for other Assistive Mobility Devices

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No._____

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

Place a (✓) if "Yes"

General Criteria	YES
The patient must be at least 18 y/o and above at the time of enrollment to the Benefits Package on Other Assistive Mobility Devices	

Place a (✓) if "Yes"

History of Previous Availment ☐ Not Applicable	YES
*If *yes,* indicate the date of last availment (mm/ yyyy): _____ Specify the type of assistive mobility device: _____ Name of HF where the assistive device was previously availed from: _____	

A. Crutch/ Cane

Place a (✓) if "Yes"

1. Mild disability in mobility and self-care	☐ Yes
2. No cognitive/ behavioral & communication disability	☐ Yes
3. Inability to do weight-bearing on 1 or 2 lower limbs because of lower limb loss or dysfunction of ≥ 3 months	☐ Yes
4. Good to Fair Standing Static & Dynamic Balance	☐ Yes
5. Good Sitting Dynamic and Static Balance	☐ Yes
6. Self-propels with the use of crutches	☐ Yes

MASTER COPY
Date: 1/17/25
PG:

7. Upper extremity function intact, Fair proprioception & sensory awareness, or functional vision for mobility	☐ Yes
8. No masses, pressure sores on areas of contact, deformities or contractures that deter safe & functional use of crutches , canes, walker, rollator	☐ Yes

B. Walker/ Rollator

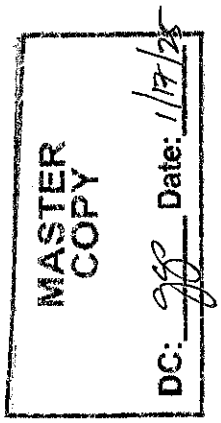
	Place a (✓) if "Yes"
1. Mild disability in mobility and self-care	☐ Yes
2. No cognitive/ behavioral & communication disability	☐ Yes
3. Inability to do weight-bearing on 1 or 2 lower limbs because of lower limb loss or dysfunction of ≥ 3 months and inability to endure continuous walking for ≥ 10 minutes	☐ Yes
4. Good to fair standing static and dynamic balance	☐ Yes
5. Good sitting dynamic and static balance	☐ Yes
6. Self-propels with the use of walker or rollator	☐ Yes
7. Upper extremity function intact, Fair proprioception and sensory awareness, or functional vision for mobility	☐ Yes
8. No masses, pressure sores on areas of contact, deformities or contractures that deter safe & functional use of crutches , canes, walker, rollator	☐ Yes

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physical Medicine and Rehabilitation Specialist/Physiatrist	(Printed name and signature) Patient
PhilHealth Accreditation No.	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

MASTER COPY
DC: Date: 1/17/25

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

There is no need to attach laboratory results. However, these should be included in the patient's chart and may be checked during the field monitoring of the **Physical Medicine, Rehabilitation Services, and Assistive Mobility Devices.** Please do not leave any item blank.



PRE-AUTHORIZATION REQUEST

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the **Physical Medicine, Rehabilitation Services, and Assistive Mobility Devices** benefit package for _____ in _____

(Patient's last, first, suffix, middle name) (Name of HF)

under the terms and conditions as agreed for availment of the Benefit Package.

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

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

_____

Certified correct by:

(Printed name and signature)
Attending Physical Medicine and Rehabilitation Specialist

PhilHealth Accreditation No.

MASTER COPY Date: 11/7/25 DC:

Conforme by:

(Printed name and signature)
☐ Patient ☐ Parent ☐ Guardian

Certified correct by:

(Printed name and signature)
Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief

PhilHealth Accreditation No.

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

_____

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

INITIAL APPLICATION		
Activity	**Initial**	**Date**
Received by LHIO/BAS:		
Endorsed to BAS (if received by LHIO):		
☐ Approved ☐ Disapproved		
Released to HF:		
The pre-authorization shall be valid for sixty (60) calendar days		

COMPLIANCE TO REQUIREMENTS

☐ APPROVED
☐ DISAPPROVED (State reason/s)

_____

(Printed name and signature)
Head or authorized BAS representative

Activity	**Initial**	**Date**
Received by BAS:		
☐ Approved ☐ Disapproved		
Released to HF:		

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List of Essential Health Services for Physical Medicine, Rehabilitation Services, and Assistive Mobility Devices

Essential Health Services	
A. Assessment	
1. Initial Assessment	a. Physical Medicine and Rehabilitation Specialist/ Physiatrist b. Physical Therapist c. Occupational Therapist d. Speech and Language Pathologist (SLPs) or Speech Therapist e. Psychologist
2. Follow-up Assessment	a. Physical Medicine and Rehabilitation Specialist/ Physiatrist
3. Discharge Assessment	a. Physical Medicine and Rehabilitation Specialist/ Physiatrist b. Physical Therapist c. Occupational Therapist d. Speech and Language Pathologist (SLPs) or Speech Therapist e. Psychologist
B. Rehabilitation Services Sessions	
1. Based on functional goals: Restoration, Prevention, Maintenance	a. Physical Therapist b. Occupational Therapist c. Speech and Language Pathologist (SLPs) or Speech Therapist d. Psychologist

C. Laboratory and Diagnostic Tests (as needed)	
1. Laboratory, Diagnostics and Imaging	a. Segmental X-Ray b. Skeletal Survey c. EMG-NCV c.1 Initial 2 segments c.2 Succeeding Segments d. MSK Ultrasound e. MRI f. CT Scan g. FEES or Barium Swallow h. ECG i. 2D Echo j. Exercise Stress Test k. Pulmonary Function Test l. Urinalysis m. KUB Ultrasound n. Urodynamic Studies o. Blood Test: o.2 BUN o.2 Creatinine o.3 Sodium (Na) o.4 Potassium (K) o.5 Chloride (Cl) o.6 Fasting Blood Sugar (FBS) o.7 Complete Blood Count (CBC)
D. Drugs/Medicine (as indicated)	
1. Tab/cap	a. Gabapentin b. Diclofenac c. Tramadol d. Methylprednisolone acetate
2. Intravenous Injection	a. Bupivacaine b. Hydrocortisone acetate c. Methylprednisolone acetate d. Tramadol
E. Assistive Mobility Devices (as needed)	
1. Wheelchair	a. Basic wheelchair b. Active wheelchair c. Supportive wheelchair d. Motorized wheelchair
2. Crutches/Canes	a. Quad cane b. Single tip cane c. Crutch axillary d. Crutch triceps e. White cane
3. Walker/Rollator	a. Walker b. Rollator

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Case No. _____

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

CHECKLIST OF ESSENTIAL HEALTH SERVICES

Assessment	
☐ Initial Assessment ☐ Discharge Assessment	**Date of Assessment (mm/dd/yyyy):** **Assessed by:** ☐ Physical Medicine and Rehabilitation Specialist/Physiatrist ☐ Physical Therapist ☐ Occupational Therapist ☐ Speech and Language Pathologist (SLPs) or Speech Therapist ☐ Psychologist
☐ Follow-up assessment by Physical Medicine and Rehabilitation Specialist/Physiatrist	**Dates (mm/dd/yyyy):** 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____

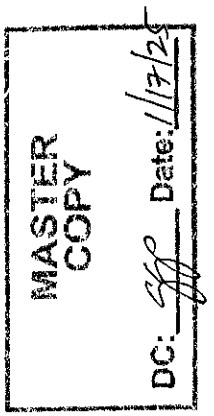
MASTER COPY Date: 1/17/25 DC: [signature]

Rehabilitation Services	
☐ Physical Therapy ☐ Occupational Therapy ☐ Speech and Language Pathology (SLPs) or Speech Therapy	Functional Goal: ☐ Restoration ☐ Prevention ☐ Maintenance Dates of Session/s (mm/dd/yyyy): 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____ 11. _____ 12. _____ Note: 1 set is equivalent to 12 sessions
☐ Psychological Services MASTER COPY DC: _____ Date: 1/12/23	Dates of Session/s (mm/dd/yyyy): 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____ 11. _____ 12. _____ Note: 12 sessions per year; maximum of 3 per month

Laboratory/ Diagnostic Tests (as needed)	
Laboratory/ Diagnostic Test	**Date done (mm/dd/yyyy)**
☐ Segmental X-Ray	
☐ Skeletal Survey	
☐ EMG-NCV (Initial segments)	
☐ EMG-NCV (Succeeding segments)	
☐ MSK Ultrasound	
☐ MRI	
☐ CT Scan	

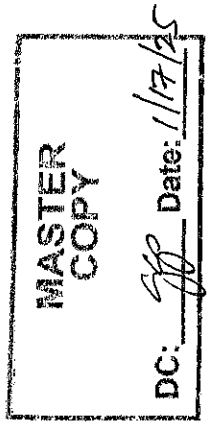
Laboratory/ Diagnostic Tests (as needed)	
Laboratory/ Diagnostic Test	**Date done (mm/dd/yyyy)**
☐ FEES or Barium swallow	
☐ ECG	
☐ 2D echo	
☐ Exercise Stress Test	
☐ Pulmonary function test	
☐ Urinalysis	
☐ KUB Ultrasound	
☐ Urodynamic Studies	
☐ BUN Creatinine Fasting Blood Sugar (FBS) Complete Blood Count (CBC) Serum electrolytes: Sodium (Na) Potassium (K) Chloride (Cl)	

Assistive Mobility Devices (as needed)	
Type of Assistive Mobility Devices	**Date of issuance (mm/dd/yyyy)**
☐ Basic wheelchair	
☐ Active wheelchair	
☐ Supportive wheelchair	
Motorized wheelchair: ☐ Motorized wheelchair ☐ Battery (After 1 year from the date of availment of the motorized wheelchair)	
☐ Walker	
☐ Rollator	
☐ Quad cane	
☐ Single tip cane	
☐Crutch axillary	
☐ Walker	



Drugs/ Medicines (as indicated)	
Drugs/ Medicines	**Date dispensed (mm/dd/yyyy)**
Oral Medication: ☐ Gabapentin ☐ Diclofenac ☐ Tramadol ☐ Methylprednisolone acetate	
Intravenous Injection: ☐ Bupivacaine ☐ Hydrocortisone acetate ☐ Methylprednisolone acetate ☐ Tramadol	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physical Medicine and Rehabilitation Specialist/Physiatrist	(Printed name and signature) Patient/ Guardian
PhilHealth Accreditation No.	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	



Annex F.1: Checklist of Requirements for Reimbursement - Assessment

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Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial X teamphilhealth

Case No. _____

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

Checklist of Requirements for Reimbursement - Assessment

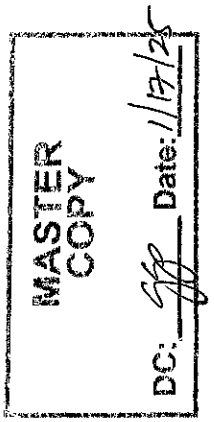
(Place a ✓ if attached or NA if not applicable)

REQUIREMENTS	Status
I. Upon filing of claims for the Initial Assessment	
a. Transmittal Form (Annex G)	
b. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF2	
c. Photocopy of the completely accomplished Checklist of Eligibility Criteria (Annex A)	
d. Photocopy of completely accomplished Member Empowerment (ME) Form (Annex B)	
e. Photocopy of the Treatment Plan	
f. Accomplished Checklist of Requirements for Reimbursement-Assessment (Annex F.1.)	
g. Original or Certified true copy (CTC) of the Statement of Account (SOA)	
h. Accomplished Checklist of Essential Health Services for Physical Medicine, Rehabilitation Services, and Assistive Mobility Devices (Annex E)	
i. Satisfaction Questionnaire (Annex H)	
II. To be submitted when filing claims for follow-up and discharge assessment	
a. Transmittal Form (Annex G)	
b. Accomplished Checklist of Requirements for Reimbursement-Assessment (Annex F.1.)	
c. Accomplished Checklist of Essential Health Services for Physical Medicine, Rehabilitation Services, and Assistive Mobility Devices (Annex E)	
d. Original or Certified true copy (CTC) of the Statement of Account (SOA)	
Date Completed (mm/dd/yyyy)	
Date Filed (mm/dd/yyyy)	

MASTER COPY
DC: Date: 11/12/25

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

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physical Medicine and Rehabilitation Specialist/Physiatrist	(Printed name and signature) Patient/ Guardian
PhilHealth Accreditation No. ☐☐☐☐☐.☐☐☐☐☐☐☐☐.☐☐	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	



Annex F.2: Checklist of Requirements for Reimbursement - Rehabilitation Services

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial X teamphilhealth

Case No. _____

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

Checklist of Requirements for Reimbursement - Rehabilitation Services

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

REQUIREMENTS	Status
a. Transmittal Forms (Annex G)	
b. Properly accomplished Claim Form 2	
c. Accomplished Checklist of Requirements for Reimbursement-Rehabilitation Services (Annex F.2.)	
d. Accomplished Checklist of Essential Health Services for Physical Medicine, Rehabilitation Services, and Assistive Mobility Devices (Annex E)	
e. Photocopy of the Treatment Plan	
f. Original or Certified true copy (CTC) of the Statement of Account (SOA)	
g. Satisfaction Questionnaire (Annex H)	
Date Completed (mm/dd/yyyy)	
Date Filed (mm/dd/yyyy)	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physical Medicine and Rehabilitation Specialist/Physiatrist	(Printed name and signature) Patient/ Guardian
PhilHealth Accreditation No. ☐☐☐☐☐.☐☐☐☐☐☐☐☐.☐☐	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

MASTER COPY Date: 1/14/25 DC: _____

Annex F.3: Checklist of Requirements for Reimbursement - Laboratory and Diagnostic Test and Drugs/ Medicines

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

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

Checklist of Requirements for Reimbursement - Laboratory and Diagnostic Test and Drugs/ Medicines

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

REQUIREMENTS	Status
a. Transmittal Form (Annex G)	
b. Properly accomplished Claim Form 2	
c. Accomplished Checklist of Requirements for Reimbursement of Laboratory and Diagnostic Tests and Drugs/ Medicines (Annex F.3)	
d. Accomplished Checklist of Essential Health Services for Physical Medicine, Rehabilitation Services, and Assistive Mobility Devices (Annex E)	
e. Photocopy of the Treatment Plan	
f. Original or Certified true copy (CTC) of the Statement of Account (SOA)	
g. Satisfaction Questionnaire (Annex H)	
Date Completed (mm/dd/yyyy)	
Date Filed (mm/dd/yyyy)	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physical Medicine and Rehabilitation Specialist/Physiatrist	(Printed name and signature) Patient/ Guardian
PhilHealth Accreditation No. ☐☐☐☐.☐☐☐☐☐☐☐.☐	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

MASTER COPY Date: 11/7/25 D.C.

Page 1 of 1 of Annex F.3

Annex F.4: Checklist of Requirements for Reimbursement - Assistive Mobility Devices

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
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Case No. _____

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

Checklist of Requirements for Reimbursement - Assistive Mobility Devices

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

REQUIREMENTS	Status
a. Transmittal Forms (Annex G)	
b. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF2	
c. Photocopy of completely accomplished Pre-authorization Checklist and Request Form for Assistive Mobility Devices (Annex C.1 or C.2)	
d. Photocopy of completely accomplished Member Empowerment (ME) Form (Annex B)	
e. Accomplished Checklist of Requirements for Reimbursement of Assistive Mobility Devices (Annex F.4)	
f. Accomplished Checklist of Essential Health Services for Physical Medicine, Rehabilitation Services, and Assistive Mobility Devices (Annex E)	
g. Photocopy of the prescription for the assistive mobility device	
h. Original or Certified true copy (CTC) of the Statement of Account (SOA)	
i. Satisfaction Questionnaire (Annex H)	
Date Completed (mm/dd/yyyy)	
Date Filed (mm/dd/yyyy)	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physical Medicine and Rehabilitation Specialist/Physiatrist	(Printed name and signature) Patient/ Guardian
PhilHealth Accreditation No.	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

MASTER COPY Date: 11/4/25 DC:

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Share your opinion with us!

We would like to know how you feel about the services that pertain to the Benefit Package in order that we can improve and meet your needs. This survey will only take a few minutes. Please read the items carefully. If you need to clarify items or ask questions, you may approach your friendly health facility or you may contact PhilHealth call center at 8662-2588. Your responses will be kept confidential and anonymous.

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

1. Z Benefits package availed is for:
   - ☐ Acute lymphoblastic leukemia
   - ☐ Breast cancer
   - ☐ Prostate cancer
   - ☐ Kidney transplantation
   - ☐ Post kidney transplantation services
   - ☐ Cervical cancer
   - ☐ Coronary artery bypass surgery
   - ☐ Surgery for Tetralogy of Fallot
   - ☐ Surgery for ventricular septal defect
   - ☐ ZMORPH/Expanded ZMORPH
   - ☐ Orthopedic implants
   - ☐ Peritoneal dialysis
   - ☐ Colorectal cancer
   - ☐ Prevention of preterm delivery
   - ☐ Preterm and small baby
   - ☐ Children with developmental disability
   - ☐ Children with mobility impairment
   - ☐ Children with visual disability
   - ☐ Children with hearing impairment

   Other Stand-alone Benefits
   - ☐ Physical Medicine, Rehabilitation Services and Assistive Mobility Devices

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

3. Sex of respondent
   - ☐ male
   - ☐ female

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

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

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

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

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

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

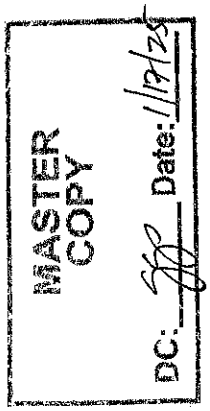
9. If you have other comments, please share them below:

_____

_____

_____

Thank you. Your feedback is important to us!



_____

Signature of Patient/ Parent/ Guardian

Date accomplished: _____

Republic of the Philippines
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TRANSMITTAL FORM OF CLAIMS FOR THE PHYSICAL MEDICINE, REHABILITATION SERVICES AND ASSISTIVE MOBILITY DEVICES

NAME OF CONTRACTED HEALTH FACILITY	ADDRESS OF HF

Instructions for filling out this Transmittal Form. Use additional sheets if necessary.
1. Use CAPITAL letters or UPPER CASE letters in filling out the form.
2. For the period of confinement, follow the format (mm/dd/yyyy).
3. For the Benefits Package Code, indicate the code based on the services provided. Example: PMR05A
4. For the Case Number, copy the case number that is provided in the approved pre-authorization checklist and request.
5. The Remarks column may include some relevant notes which pertain to the filed claim that need to be relayed to PhilHealth.

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

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)		

MASTER COPY Date: 1/19/25

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BAGONG PILIPINAS

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PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
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Pilot Testing of the PhilHealth Benefits Package on Physical Medicine, Rehabilitation Services, and Assistive Mobility Devices

HEALTH FACILITY (HF):
ADDRESS OF HF:

This pilot test aims to evaluate the feasibility, effectiveness, and efficiency of different models for delivering rehabilitation services through the PhilHealth Benefits Package on Physical Medicine, Rehabilitation Services, and Assistive Mobility Devices, enabling data-driven refinements and ensuring a harmonized nationwide rollout.

Pilot Testing Period (Start and End Date):	**Rehabilitation Services Offered**
START DATE:_____ **(MM/DD/YYYY)** **END DATE:**_____ **(MM/DD/YYYY)**	_____ _____ _____ _____ _____ _____
Assistive Mobility Devices Included: Place (✔) if applicable	**Recommendations for Improvement**
___Wheelchair **___ Walker** **___ Crutches** **___ Rollator** **___ Canes**	_____ _____ _____ _____ _____

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DC: Date: 1/17/25

For each of the following indicators, please indicate your level of agreement with the statements by **encircling** the corresponding number, where:

1 - Strongly Disagree, 2 - Disagree, 3 - Neutral, 4 - Agree, 5 - Strongly Agree.

Service Reach and Utilization	Patient Satisfaction and Outcomes
1. The services reached the intended beneficiaries effectively. - Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree	6. Patients reported satisfaction with the services provided. - Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree
2. The services were accessible to all eligible patients. - Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree	7. Patients experienced significant improvements in their conditions. - Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree
3. The services were equitably distributed across various demographics. - Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree	8. The services provided were appropriate and effective - Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree
4. There was an increase in service utilization during the pilot period. - Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree	9. Patients' expectations of care and outcomes were met. - Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree
5. Patients faced minimal barriers to accessing services. - Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree	10. The services provided help enhance the overall quality of life for patients. - Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

Healthcare Provider Experience and Feedback	Cost-effectiveness and Financial Impact
11. Healthcare providers had access to adequate resources and support. - Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree	16. The services were delivered within the allocated budget. - Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree
12. Providers were satisfied with the pilot's operational structure. - Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree	17. Patients' out-of-pocket expenses were significantly reduced. - Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree
13. Training and capacity-building initiatives were sufficient. - Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree	18. The cost of delivering services was reasonable compared to the benefits. - Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

14. Collaboration and communication among providers were effective. - Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree 15. Feedback mechanisms for providers were robust and responsive. - Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree	19. Resources were allocated efficiently during the pilot. - Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree 20. The pilot test demonstrated potential for long-term financial sustainability. - Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

Name of PMRS Coordinator:	
Contact Number:	
E-mail Address