TAMANG SAGOT (TS)

Gabay sa Tamang Pag-Unawa sa PhilHealth Circular

TITLE	**Z BENEFITS FOR CHILDREN WITH DEVELOPMENTAL IMPAIRMENTS AND DISABILITIES (REVISION 1)**
PC NUMBER	**2026-0014**

FOR PHILHEALTH MEMBERS

1 What is the Z Benefits Package for Children with Developmental Impairments and Disabilities?

It is a benefit package that provides services from assessment to rehabilitation therapy for children with developmental impairments and disabilities. It aims to increase their functional capacities and improve the quality of life for both children and their caregivers.

2 Who are eligible to avail of this benefit?

All Filipinos are automatically entitled to avail of this benefits package, provided that they fulfilled the selections criteria as listed in this policy.

3 What are the criteria for a child to be eligible for this benefit?

The selections criteria for this Z Benefits package are the following:

1. Chronological age must be zero (0) to 17 years and 364 days old; and
2. The child presents with functional problems secondary to delays, regressions, or deviations in any of the following developmental domains: mental, intellectual, learning, speech, language and communication, and physical.

4 How to know if the child is qualified to avail of this benefit?

The child may be brought to any PhilHealth-contracted health facility (HF) accredited for this benefit package. The child must be assessed by an appropriate health care provider. If the child is found eligible based on the assessment and established criteria, the child may already be enrolled in the program.

5 Where can we avail of this benefit?

The benefit may be availed of at any PhilHealth-contracted health facility.

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6 What is a contracted health facility (HF)?

It is any HF that enters into a contract with PhilHealth for the provision of specialized care such as the Z Benefits Package for Children with Developmental Impairments and Disabilities.

7 Who may conduct the initial and discharge assessment of the child?

The initial and discharge assessments can be done by any of the following Medical Specialist:

1. Physical Medicine and Rehabilitation Specialist/ Physiatrist;
2. Neurodevelopmental Pediatrician;
3. Developmental and Behavioral Pediatrician;
4. Pediatric Neurologist;
5. Child and Adolescent Psychiatrist

8 Who may conduct the child's assessment, discharge assessment, and rehabilitation therapy?

The initial assessment, discharge assessment, and rehabilitation therapy shall be provided by any of the following allied health professionals:

1. Physical Therapist;
2. Occupational Therapist;
3. Speech and Language Pathologist or Speech Therapist;
4. Child Psychologist.

9 What is Member Empowerment Form (ME Form)?

This is a document that certifies that the patient, parent, or guardian has been fully informed about the benefit package, treatment options, treatment schedule and follow-up visits, as well as their roles and responsibilities.

10 Is the ME Form required to be signed?

Yes. The beneficiary or their guardian or representative and the attending healthcare provider in charge jointly sign the ME form.

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11 How many times may a child avail of the initial and discharge assessments and rehabilitation therapy services?

A child may avail of this benefit for a maximum of three (3) cycles of initial and discharge assessments and rehabilitation therapy services, based on the recommendation of a medical specialist, provided that the patient continues to meet the selection criteria.

12 What is covered under one (1) cycle of this benefit?

One (1) cycle consists of an initial assessment, rehabilitation therapy sessions of up to 90 sessions, and a discharge assessment, all of which must be completed in accordance with the prescribed treatment plan.

13 Are medicines, laboratory tests, and diagnostic procedures covered under this benefit?

No. Medicines, laboratory tests, and diagnostic procedures are not covered by the Z Benefits package. Instead, these may be availed of under the YAKAP and GAMOT benefit packages.

14 May a contracted health facility (HF) charge additional fees for services covered under this benefit package?

No. The contracted HF shall not charge beyond the amount prescribed under this benefit for covered services. If there is an agreed copayment, the HF shall not charge more than the agreed amount at the point of service.

15 What if the patient is unable to sign or provide a thumb mark on documents requiring approval or consent?

An authorized representative, such as a parent, legal guardian, or patient representative, may sign or provide consent on behalf of the patient.

16 May members or beneficiaries directly file claims for this package?

No. Direct filing of claims by members or beneficiaries is not allowed under this

package. The contracted HF is responsible for submitting the required documents and claims to PhilHealth on behalf of the patient.

17 What is the proper order for deducting PhilHealth benefits, mandatory discounts, and other health insurance or HMO benefits from the total bill?

The PhilHealth benefits and all mandatory discounts required by law, such as the PWD (Persons with Disabilities) discount, shall be deducted first from the patient's total bill. Benefits from private health insurance, health maintenance organizations (HMO), or employee benefits shall be applied only after PhilHealth deductions and shall complement the PhilHealth benefits package.

18 Will PhilHealth provide additional services under this benefit package?

Yes. As announced by President Marcos during his State of the Nation Address (SONA) in July 2026, PhilHealth will expand its covered services. This includes an increase in the number of covered rehabilitation therapy sessions, among other benefit enhancements. These improvements are expected to be introduced during Phase 2 of the expansion of this benefit package.

19 When can we expect the expansion of services?

PhilHealth is currently focused on increasing the number of contracted health facilities to improve members' access to healthcare services. The expansion of covered services is expected to be implemented within the year.

20 Where can concerns or feedback regarding PhilHealth benefits be reported?

You may report or give feedback through the Corporate Action Center (CAC) via the PhilHealth hotline (02) 8662-2588 or email at actioncenter@philhealth.gov.ph

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FOR HEALTH FACILITIES

1 How to become a contracted HF for this Z Benefit Package?

PhilHealth will engage capable accredited HFs that can provide the specialized multi- and interdisciplinary health care delivery for this Z Benefits package. PhilHealth will issue updated HF standards for contracting, which shall be uploaded to the PhilHealth website.

For the supplemental rules for accrediting contracting HF, refer to the Supplemental Rules on Contracting Health Facilities for the Z Benefits Package for Children with Developmental Impairments and Disabilities (Annex A).

2 Can a patient be applied for pre-authorization during any treatment phase?

Yes. The contracted HF may apply the patient for pre-authorization at any of the treatment phase.

3 What documents must a contracted HF submit before a patient can avail of the Z Benefits package?

The contracted HF should submit the following documents to the Local Health Insurance Office (LHIO) or the Office of the Head of PhilHealth Benefits Administration Section (BAS), for approval:

1. Properly accomplished Pre-Authorization Checklist and Request Form (Annex B); and
2. Properly accomplished Member Empowerment (ME Form) (Annex C).

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4 When may a contracted health facility (HF) start providing services under this Z Benefits package?

Services under the Z Benefits package may only be provided after the pre-authorization request has been approved based on the selection criteria.

5 Is there a guide that may be followed when requesting approval for pre-authorization?

Yes. Contracted HFs should follow the prescribed process for seeking approval of pre-authorization as provided under Section V.D. of PhilHealth Circular No. 2021-0022, or the "Guiding Principles of the Z Benefits, Revision 1."

6 How long is an approved Pre-Authorization Checklist and Request valid?

It is valid for one (1) fiscal year from the date of PhilHealth's approval.

7 What to do once the Pre-Authorization Checklist and Request expires?

Inform PhilHealth and submit a new Pre-Authorization Checklist and Request, provided that the child is still below 18 years old.

8 Does 45-day annual benefit limit apply to this benefit package?

No. The 45-day annual benefit limit does not apply, as the rule has already been lifted.

9 What is the purpose of ME Form?

The primary purpose of the ME Form is to empower patients to actively participate in healthcare decision-making by providing them with essential information and education regarding their health condition and available treatment options.

10 When can we charge a copayment to a patient?

You may charge a copayment or out-of-pocket (OOP) expense only for amenities or services that are not covered by the Z Benefits package.

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11 Are drugs used to treat patients reimbursable by PhilHealth?

PhilHealth will only reimburse drugs listed in the latest edition of the Philippine National Drug Formulary (PNDF).

12 What are the mandatory services for Z Benefits for Children with Developmental Impairments and Disabilities?

The contracted HF for the Z Benefits for children with developmental impairments and disabilities shall provide the following mandatory services based on the patient's conditions:

1. The assessment (initial and discharge) and rehabilitation plan shall be conducted by any of the medical specialists using any of the standardized tests for developmental assessments and functional tests as recommended by their respective professional societies/organizations.
2. The assessment (initial and discharge) and rehabilitation plan by any of the allied health professional/s using any of the standardized tests as recommended by their respective professional societies/organizations.
3. Rehabilitation therapy rendered by a physical therapist or occupational therapist or speech and language pathologist/speech therapist or child psychologist.

13 Is a Z Benefits Coordinator required under this package?

Yes. The contracted HF must appoint at least one (1) Z Benefits Coordinator.

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14 What are the package codes, rates, tranche payment, and claims filing schedule for Developmental and Functional Assessment?

Package Code	Description of services	Tranche	Rate (Php)	Maximum Availment*	Filing Period
Z017.1	Developmental and functional assessment by a medical specialist only	1	3,626	1 per cycle year for a maximum of three cycles	Within 60 calendar days after assessment by the medical specialist
Z017.2	Developmental and functional assessment by a medical specialist and one allied health professional or rehabilitation therapist	1	3,626	1 per cycle year for a maximum of three cycles	Within *60* calendar days after assessment by the medical specialist
		2	550		Within *60* calendar days after submission of rehabilitation plan of care by the rehabilitation therapist or allied health professional
Z017.3	Developmental and functional assessment by a medical specialist and two allied health professionals or rehabilitation therapists	1	3,626	1 per cycle year for a maximum of three cycles	Within *60* calendar days after assessment by the medical specialist
		2	1,100		Within 60 calendar days after submission of rehabilitation

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					plan of care by the rehabilitation therapist or allied health professional
Z017.4	Developmental and functional assessment by medical specialist and three allied health professionals or rehabilitation therapists	1	3,626	1 per cycle year for a maximum of three cycles	Within 60 calendar days after assessment by the medical specialist
		2	1,650		Within 60 calendar days after submission of rehabilitation plan of care by the rehabilitation therapist or allied health professional
*One cycle of care can be availed of for a second or third time during the duration of eligibility as specified in the recommendations of the Discharge Assessment.					

15 How many sets of rehabilitation therapy may a patient avail of under the package?

An eligible patient may avail of a maximum of nine (9) sets of rehabilitation therapies during the period of eligibility. Each set may consist of a maximum of ten (10) therapy sessions.

16 How will rehabilitation therapy with fewer than 10 sessions in the last set be paid?

If the last set of rehabilitation therapy has fewer than 10 sessions based on the approved plan, the rehabilitation therapy shall be paid on a pro-rated basis.

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17 What are the package codes, rates, tranche payment, and claims filing schedule for Rehabilitation Therapy?

Package Code	Description of services	Tranche	Rate (Php)	Maximum Availment [a]	Filing Period
Z017.5	Rehabilitation Therapy [b c]	Nine tranches (as needed)	5,000 per tranche *(500/ session)*	Nine sets of therapies per one year cycle starting from the first day of initial team assessment	Within *60 calendar* days after the last session for one set of therapies completed

[a] One cycle of care can be availed of for nine times during the duration of eligibility as specified in the recommendations of the Discharge Assessment.
[b] Eligible children with developmental *impairment and* disability can only avail of a maximum of nine sets of therapies. Each set of therapies has a maximum of 10 sessions.
[c] *Rehabilitation therapy with less than 10 sessions on the last set of the therapies based on the plan shall be paid on a pro-rated basis.*

18 What are the package codes, rates, tranche payment, and claims filing schedule for Discharge Assessment?

Package Code	Description of services	Tranche	Rate (Php)	Maximum Availment*	Filing Period
Z017.6	Discharge assessment by a medical specialist	1	3,626	1 per cycle year for a maximum of three cycles	1 per cycle year for a maximum of three cycles Within *60* calendar days after submission of discharge assessment and plan

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Z017.7	Discharge assessment by one rehabilitation therapist or allied health professional and a medical specialist	1	550	1 per cycle year for a maximum of three cycles	Within *60* calendar days after submission of discharge assessment and plan
	Discharge assessment by one rehabilitation therapist or allied health professional and a medical specialist	2	3,626	1 per cycle year for a maximum of three cycles	Within *60* calendar days after submission of discharge assessment and plan
Z017.8	Discharge assessment by two rehabilitation therapists or allied health professionals and a medical specialist	1	1,100	1 per cycle year for a maximum of three cycles	Within *60* calendar days after submission of discharge assessment and plan
		2	3,626		
Z017.9	Discharge assessment by three rehabilitation therapists or allied health professionals and a medical specialist	1	1,650	1 per cycle year for a maximum of three cycles	Within *60* calendar days after submission of discharge assessment and plan
		2	3,626		
*One cycle of care can be availed of for a second or third time during the duration of eligibility as specified in the recommendations of the discharge assessment.					

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19 When may a claim for reimbursement be filed under this package?

After receiving the approved Pre-Authorization Checklist and Request, the contracted HF may file a claim for reimbursement only after all mandatory services specified in this Circular have been provided to the patient.

20 When does a cycle of care begin, and when should it be completed?

A cycle of care begins when the designated health team of the contracted HF first sees the child. The cycle should be completed within the applicable fiscal year. All services covered under a given cycle are considered expended within that cycle and cannot be carried over to the next cycle.

21 What document is required when a patient will continue rehabilitation therapy for a second or third cycle?

A written recommendation from the attending medical specialist to continue the patient's rehabilitation therapy must be presented to PhilHealth when filing to avail of the package for the second or third cycle.

22 What documents should we submit when filing a claim for reimbursement under the Z Benefit package?

The contracted HF shall submit the following documents, as applicable:

1. Transmittal Form (Annex D) of claims for the Z Benefit Package to be used by the contracted HF per batch of claims;
2. Photocopy of the approved Pre-Authorization Checklist and Request (Annex B) signed by the patient, parent, legal guardian or patient representative, and the health care providers who are members of the multi- and interdisciplinary team (MDT) managing the patient, as applicable, for the first tranche;
3. PhilHealth Benefit Eligibility Form (PBEF) printout, or its equivalent, such as PhilHealth Claim Form 1 (CF1), as proof of eligibility during the pre-authorization process;
4. Photocopy of the properly accomplished ME Form (Annex C) for the first tranche. The contracted HF shall provide a copy to the patient, while the signed

original shall be attached to the patient's chart as a permanent record;

5. Properly accomplished PhilHealth Claim Form 2 (CF2) for all tranches;
6. Checklist of Mandatory Services (Annex E) for the corresponding tranche;
7. Corresponding Checklist of Requirements for Reimbursement (Annex F); and
8. Photocopy of the accomplished Z Satisfaction Questionnaire (Annex G) for services rendered for that particular tranche;
9. Photocopy of certificate from medical specialist and rehabilitation therapist (Annex H) for assessment and recommendations.

23 May a claim still be filed if the patient dies or is declared "lost to follow-up" while undergoing rehabilitation therapy?

Yes. You may still file a claim with PhilHealth for the services actually rendered to the patient.

For rehabilitation therapy, PhilHealth shall reimburse on a pro-rated basis, corresponding to the number of rehabilitation therapy sessions actually rendered to the patient during the last applicable set.

24 How to file claims for patient declared "lost to follow up"?

If the patient will be declared "lost to follow-up," the contracted HF shall submit to PhilHealth a notarized sworn declaration stating that the patient has been declared lost to follow-up.

Claims shall be filed within sixty (60) days from the date the patient is declared lost to follow-up.

25 When is a patient considered "lost to follow-up" under the package?

A patient is considered "lost to follow-up" if the patient does not return for the next scheduled rehabilitation visit or within four (4) weeks from the last attended clinic visit. Failure to return to the clinic for rehabilitation therapy more than four (4) weeks after the advised scheduled visit shall render the patient "lost to follow-up."

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26 How to file claims for a patient who died during the treatment phase?

If a patient dies at any time during the treatment phase, the contracted HF shall attach to the claim either a photocopy of the death certificate; or a notarized sworn declaration issued by the authorized government agency, as applicable. Claims must be filed within sixty (60) days from the receipt or issuance of the death certificate or notarized sworn declaration, whichever is applicable.

27 May a patient who was previously declared "lost to follow-up" be re-enrolled in the Z Benefits package?

Yes. A patient who was previously declared "lost to follow-up" by another contracted HF may re-enroll in the Z Benefits package at any contracted HF, provided that the patient continues to meet the applicable selections criteria.

28 May an appeal be filed for denied claims?

Yes. The contracted HF may file a Motion for Reconsideration (MR) or an appeal with the PhilHealth Regional Office (PRO) for claims denied by PhilHealth.

29 What should be done if the documents submitted for a claim are incomplete?

Claims with incomplete supporting documents may not be accepted by the PhilHealth Regional Offices (PROs) and Local Health Insurance Offices (LHIOs). Therefore, the contracted HF should coordinate with the appropriate PhilHealth office regarding any deficiencies in the submitted documents.

The required documents must be completed and re-submitted to PhilHealth for claim payment, ensuring that the re-submission is made within the prescribed filing period.

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30 How does PhilHealth apply the "Return to Sender" (RTS) policy to claims?

PhilHealth applies the Return to Sender (RTS) policy to claims with incomplete data or missing documentary requirements. Upon receipt of an RTS notice, the contracted health facility (HF) must address the identified deficiencies and comply with the stated requirements within the prescribed period, in accordance with existing PhilHealth policies.

However, inconsistencies in the data or information contained in the submitted documents, or failure to provide a mandatory service shall be grounds for automatic denial of the claim.

31 Will claims for the same treatment phase submitted for the same date or period be considered overlapping claims?

No. PhilHealth will process claims even if they are not based on any previously rendered service. Claims for each treatment phase that are rendered on the same date or within the same period shall not be considered overlapping claims.

32 Will a change in the member or patient category after enrollment affect the claims already filed?

No. Any change in the member or patient category after enrollment shall not affect the claims filed.

33 How long will PhilHealth process claims after submission?

PhilHealth will process claims submitted within thirty (30) working days from receipt of the claim application, provided that all mandatory documents and attachments have been properly submitted.

34 Under what circumstances may PhilHealth deny a claim?

Claims submitted by a contracted HF may be denied under any of the following circumstances:

- A mandatory service was not provided;
- The claim was filed late; or
- There is an inconsistency in the data or information contained in the claim application.

35 What should contracted health facilities do if they wish to make changes to their contract for this package?

All contracted HFs with an existing contract under the Z Benefits for Children with Developmental Disability shall remain eligible to provide services in accordance with this policy while awaiting the amendment or revision of their contracts.

36 When will the expansion of covered services, as announced by President Marcos during his SONA, take effect?

The expansion of covered services, including the increase in the number of covered rehabilitation therapy sessions, is targeted for implementation within the year.

PhilHealth is currently working to expand its network of contracted HFs to help ensure better access to these enhanced benefits upon implementation.

37 What is the difference between the application of this Circular and PhilHealth Circular No. 2017-0029, titled "Z Benefits for Children with Developmental Disabilities," with regard to healthcare professionals?

Under the revised Circular, contracted health facilities are no longer required to have all of the previously specified specialists on staff to provide services under the Z Benefits Package for Children with Developmental Disabilities, as follows:

a. Physiatrist (Rehabilitation Medicine Specialist);
b. Neurodevelopmental Pediatrician or Developmental and Behavioral Pediatrician;
c. Physical Therapist;
d. Occupational Therapist;
e. Speech Therapist

Instead, ANY of the following medical specialists may perform the initial and discharge assessments:

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a. Physical Medicine and Rehabilitation Specialist/ Physiatrist;
b. Neurodevelopmental Pediatrician;
c. Developmental and Behavioral Pediatrician;
d. Pediatric Neurologist;
e. Child and Adolescent Psychiatrist

While the initial assessment, discharge assessment, and rehabilitation therapy shall be provided by ANY of the following allied health professionals:

a. Physical Therapist;
b. Occupational Therapist;
c. Speech and Language Pathologist or Speech Therapist;
d. Child Psychologist

In simple terms, the requirements for healthcare professionals have been made more flexible, allowing more health facilities to provide these services while continuing to ensure appropriate and high-quality care for children.

38 When will this Circular take effect?

This Circular took effect on September 8, 2026, upon its publication in a newspaper of general circulation.

The Circular was published in Malaya Business Insight on September 8, 2026.

CONTACT INFORMATION

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This FAQ is based on PhilHealth Circular No. 2026-0014 on Z Benefits for Children with Developmental Impairments and Disabilities (Revision 1). For the latest updates, please visit the PhilHealth website or contact the nearest PhilHealth Regional Office or Local Health Insurance Office.