Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8441-7442 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

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

CHECKLIST OF MANDATORY AND OTHER SERVICES
General Mental Health Services
Tranche 1

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

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

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