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
Specialty Mental Health Services
Tranche 1

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

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

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

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