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 2

Kindly indicate the date of the follow-up visits in the space provided

SERVICES	
☐ 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)
	4. Date (mm/dd/yyyy)
	5. Date (mm/dd/yyyy)
	6. Date (mm/dd/yyyy)
	7. Date (mm/dd/yyyy)
	8. Date (mm/dd/yyyy)
	9. Date (mm/dd/yyyy)

SERVICES	
	☐ **Psychologist**
	1. Date (mm/dd/yyyy)
	2. Date (mm/dd/yyyy)
	3. Date (mm/dd/yyyy)
	4. Date (mm/dd/yyyy)
	5. Date (mm/dd/yyyy)
	6. Date (mm/dd/yyyy)
	7. Date (mm/dd/yyyy)
	8. Date (mm/dd/yyyy)
	9. Date (mm/dd/yyyy)

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