

Annex L.1: Checklist of Requirements for Reimbursement – Tranche 1

As of October 2023



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 <input type="checkbox"/> Male <input type="checkbox"/> Female
	2. PhilHealth ID Number <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>	
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 <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>	

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT GENERAL MENTAL HEALTH SERVICES – TRANCHE 1

Requirements	Please Check
1. Transmittal Form of Claims for Mental Health (Annex H)	
2. Checklist of Requirements for Reimbursement (Annex L.1)	
3. Properly accomplished Claim Form (CF) 2	
4. Checklist of Mandatory and Other Services (Annex J.1)	
5. Properly accomplished MH Satisfaction Questionnaire (Annex K)	
6. Photocopy of the Mental Health Passport (Annex D)	
7. Original or Certified True Copy (CTC) of the Statement of Account	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Physician	(Printed name and signature) Head of the Health Facility
PhilHealth Accreditation No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	PhilHealth Accreditation No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient/Parent/Guardian
Date signed (mm/dd/yyyy)