Annex L.3: 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 ☐ 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 REQUIREMENTS FOR REIMBURSEMENT SPECIALTY 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.3)	
3. Properly accomplished Claim Form (CF) 2	
4. Checklist of Mandatory and Other Services (Annex J.3)	
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. ☐☐☐☐-☐☐☐☐☐☐-☐	PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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