

Annex A: Checklist of Eligibility Criteria for Physical Medicine and Rehabilitation Services



Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
 Citystate Centre, 709 Shaw Boulevard, Pasig City
 ☎ (02) 8662-2588 🌐 www.philhealth.gov.ph
 📱 PhilHealthOfficial 📧 teamphilhealth

Case No. _____

CONTRACTED HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	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"/>	
B. MEMBER <input type="checkbox"/> Same as patient (Answer only if the patient is a dependent)	1. Last Name, First Name, Suffix, Middle Name	
	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"/>	

Physical Medicine, Rehabilitation Services, and Assistive Mobility Devices

General Criteria	Place a (✓) if "Yes" YES
The patient must be at least 18 y/o and above at the time of enrollment to the PMRS Package	

History of PMRS Patient	Place a (✓) if "Yes" YES
<p>Currently Receiving Physical Medicine and Rehabilitation Services</p> <p>*If <i>yes</i>, indicate the date of assessment by a Physiatrist/Physical Medicine and Rehabilitation Specialist, and the date of last PMRS session</p> <hr style="border: 0; border-top: 1px solid black; margin: 10px 0;"/> <p style="text-align: center;">Date of Assessment by a Physiatrist/Physical Medicine and Rehabilitation Specialist (MM/DD/YYYY)</p> <hr style="border: 0; border-top: 1px solid black; margin: 10px 0;"/> <p style="text-align: center;">Date of Last PMRS Session (MM/DD/YYYY)</p>	
<p>Continued Physical Medicine and Rehabilitation Services are needed</p> <p>*If <i>yes</i>, indicate the date of last PMRS Session</p> <hr style="border: 0; border-top: 1px solid black; margin: 10px 0;"/> <p style="text-align: center;">Date of Last PMRS Session (MM/DD/YYYY)</p>	



Place a (✓) on the appropriate severity and functional domains based on assessment of the patient

Disability-Focused Assessment	Mild	Moderate	Severe
Mobility and Self-Care	<input type="checkbox"/> Independent with standby assistance	<input type="checkbox"/> Assisted in preparing initiating or completing activity	<input type="checkbox"/> Unable to perform & dependent on caregiver
Cognitive Behavioral	<input type="checkbox"/> Follows 3-step instructions +/- standby assist	<input type="checkbox"/> Has difficulty in following 2-3 step instructions and needs assistance in preparing, initiating, or completing an activity	<input type="checkbox"/> Unable to follow 1-2 step instructions and needs a caregiver to perform an activity
Communication	<input type="checkbox"/> Intact receptive and expressive communication but with difficulty in articulation and prosody	<input type="checkbox"/> Intact receptive, but expressive communication needs caregiver assistance and/or assistive technology	<input type="checkbox"/> Communication is limited to caregiver assistance and/or assistive technology

Certified correct by:															Conforme by:														
(Printed name and signature) Attending Physical Medicine and Rehabilitation Specialist/Physiatrist															(Printed name and signature) Patient/ Guardian														
PhilHealth Accreditation No.															Date signed (mm/dd/yyyy)														
Date signed (mm/dd/yyyy)																													