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 ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐-☐☐☐☐☐☐☐☐-☐	
B. MEMBER ☐ *Same as patient (Answer only if the patient is a dependent)*	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐-☐☐☐☐☐☐☐☐-☐	

CHECKLIST OF ESSENTIAL HEALTH SERVICES

Assessment	
☐ Initial Assessment ☐ Discharge Assessment	**Date of Assessment (mm/dd/yyyy):**
	Assessed by: ☐ Physical Medicine and Rehabilitation Specialist/Physiatrist ☐ Physical Therapist ☐ Occupational Therapist ☐ Speech and Language Pathologist (SLPs) or Speech Therapist ☐ Psychologist
☐ Follow-up assessment by Physical Medicine and Rehabilitation Specialist/Physiatrist	**Dates (mm/dd/yyyy):** 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____

Rehabilitation Services	
☐ Physical Therapy ☐ Occupational Therapy ☐ Speech and Language Pathology (SLPs) or Speech Therapy	Functional Goal: ☐ Restoration ☐ Prevention ☐ Maintenance Dates of Session/s (mm/dd/yyyy): 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____ 11. _____ 12. _____ Note: 1 set is equivalent to 12 sessions
☐ Psychological Services	Dates of Session/s (mm/dd/yyyy): 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____ 11. _____ 12. _____ Note: 12 sessions per year; maximum of 3 per month

Laboratory/ Diagnostic Tests (as needed)	
Laboratory/ Diagnostic Test	**Date done (mm/dd/yyyy)**
☐ Segmental X-Ray	
☐ Skeletal Survey	
☐ EMG-NCV (Initial segments)	
☐ EMG-NCV (Succeeding segments)	
☐ MSK Ultrasound	
☐ MRI	
☐ CT Scan	

Laboratory/ Diagnostic Tests (as needed)	
Laboratory/ Diagnostic Test	**Date done (mm/dd/yyyy)**
☐ FEES or Barium swallow	
☐ ECG	
☐ 2D echo	
☐ Exercise Stress Test	
☐ Pulmonary function test	
☐ Urinalysis	
☐ KUB Ultrasound	
☐ Urodynamic Studies	
☐ BUN Creatinine Fasting Blood Sugar (FBS) Complete Blood Count (CBC) Serum electrolytes: Sodium (Na) Potassium (K) Chloride (Cl)	

Assistive Mobility Devices (as needed)	
Type of Assistive Mobility Devices	**Date of issuance (mm/dd/yyyy)**
☐ Basic wheelchair	
☐ Active wheelchair	
☐ Supportive wheelchair	
Motorized wheelchair: ☐ Motorized wheelchair ☐ Battery (After 1 year from the date of availment of the motorized wheelchair)	
☐ Walker	
☐ Rollator	
☐ Quad cane	
☐ Single tip cane	
☐Crutch axillary	
☐ Walker	

Drugs/ Medicines (as indicated)	
Drugs/ Medicines	**Date dispensed (mm/dd/yyyy)**
Oral Medication: ☐ Gabapentin ☐ Diclofenac ☐ Tramadol ☐ Methylprednisolone acetate	
Intravenous Injection: ☐ Bupivacaine ☐ Hydrocortisone acetate ☐ Methylprednisolone acetate ☐ Tramadol	

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)	