Annex F.2: Checklist of Requirements for Reimbursement - 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 ☐ 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 Requirements for Reimbursement - Rehabilitation Services

(Place a ✓if attached or NA if not applicable)

REQUIREMENTS	Status
a. Transmittal Forms (Annex G)	
b. Properly accomplished Claim Form 2	
c. Accomplished Checklist of Requirements for Reimbursement-Rehabilitation Services (Annex F.2.)	
d. Accomplished Checklist of Essential Health Services for Physical Medicine, Rehabilitation Services, and Assistive Mobility Devices (Annex E)	
e. Photocopy of the Treatment Plan	
f. Original or Certified true copy (CTC) of the Statement of Account (SOA)	
g. Satisfaction Questionnaire (Annex H)	
Date Completed (mm/dd/yyyy)	
Date Filed (mm/dd/yyyy)	

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)	