

Annex B.2: Checklist of Mandatory and Other Services (0 to less than 6 Months Old – Tranche 2



Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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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 □□ - □□□□□□□□□□ - □	
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 □□ - □□□□□□□□□□ - □	

Kindly indicate the date of the follow up visits in the space provided

MANDATORY AND OTHER SERVICES	
Follow-up Visit	
<input type="checkbox"/> Follow-up Visits (Assessment, IYCF Counseling and support for exclusive breastfeeding, Nutritional Counseling, Water, Sanitation, and Hygiene (WASH), Child development and nurturing care)	1. Date (mm/dd/yyyy): _____ 2. Date (mm/dd/yyyy): _____ 3. Date (mm/dd/yyyy): _____ 4. Date (mm/dd/yyyy): _____ 5. Date (mm/dd/yyyy): _____ 6. Date (mm/dd/yyyy): _____ 7. Date (mm/dd/yyyy): _____ 8. Date (mm/dd/yyyy): _____ 9. Date (mm/dd/yyyy): _____ 10. Date (mm/dd/yyyy): _____ 11. Date (mm/dd/yyyy): _____ 12. Date (mm/dd/yyyy): _____ 13. Date (mm/dd/yyyy): _____ 14. Date (mm/dd/yyyy): _____ 15. Date (mm/dd/yyyy): _____
OTHER SERVICES	
<input type="checkbox"/> Referral Outpatient Therapeutic Care (OTC) to Inpatient Therapeutic Care (ITC) ^a	Date (mm/dd/yyyy): _____
<input type="checkbox"/> Medical complications, maternal health, mental and social well-being check	Date (mm/dd/yyyy): _____

^a Required when a child fails the appetite test, worsening edema or development of a medical complications based on the PIMAM guidelines, or in case of failure to respond treatment



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B. MEMBER	(Answer only if the patient is a dependent; otherwise, write, "same as above")	
	1. Last Name, First Name, Middle Name, Suffix	
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Certified correct by:		Conforme by:	
(Printed name and signature) Attending Physician		(Printed name and signature) Patient/ Parent/ Guardian	
PhilHealth Accreditati on No.		Date signed (mm/dd/yyyy)	
Date signed (mm/dd/yyyy)			