Annex “C – Developmental Disability”

CHECKLIST OF MANDATORY SERVICES
Z BENEFITS FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES
REHABILITATION THERAPY

<table>
<thead>
<tr>
<th>HEALTH CARE INSTITUTION (HCI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS OF HCI</td>
</tr>
</tbody>
</table>

PATIENT (Last name, First name, Middle name, Suffix)

PHILHEALTH ID NUMBER OF PATIENT

MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)

PHILHEALTH ID NUMBER OF MEMBER

<table>
<thead>
<tr>
<th>Therapy received</th>
<th>Dates of Therapy Sessions*</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Occupational Therapy</td>
<td></td>
</tr>
<tr>
<td>☐ Physical Therapy</td>
<td></td>
</tr>
<tr>
<td>☐ Speech Therapy</td>
<td></td>
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</tbody>
</table>

* maximum of 10 sessions per tranche from appropriate rehabilitation therapist/s based on assessment

Certified correct by:

(Printed name and signature) Attending Rehabilitation Therapy Specialist

Certified correct by:

(Printed name and signature) Executive Director/Chief of Hospital/
Medical Director/ Medical Center Chief

PhinHealth Accreditation No. |
Date signed (mm/dd/yyyy)

PhinHealth Accreditation No. |
Date signed (mm/dd/yyyy)

Conforme by:

(Printed name and signature) Patient/Parent/Guardian

Date signed (mm/dd/yyyy)