



*Republic of the Philippines*  
**PHILIPPINE HEALTH INSURANCE CORPORATION**

Citystate Centre, 709 Shaw Boulevard, Pasig City  
Call Center (02) 441-7442 Trunkline (02) 441-7444  
[www.philhealth.gov.ph](http://www.philhealth.gov.ph)



Case No. \_\_\_\_\_

**Annex "E – Developmental Disability"**

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT <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"/> <input type="text"/> - <input type="text"/>
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER <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"/> <input type="text"/> <input type="text"/> - <input type="text"/>

**CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT**  
**Z Benefits for Children with Developmental Disabilities**  
**Rehabilitation Therapy**

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E-Developmental Disability)	<input type="checkbox"/>
2. Completed PhilHealth Claim Form 2	<input type="checkbox"/>
3. Checklist of Mandatory Service for Developmental Disabilities (Annex C – Developmental Disability)	<input type="checkbox"/>
4. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	<input type="checkbox"/>
DATE COMPLETED :	
DATE FILED :	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Rehabilitation Therapy Specialist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. <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"/> <input type="text"/> - <input type="text"/>	PhilHealth Accreditation No. <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"/> <input type="text"/> - <input type="text"/>
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient/Parent/Guardian
Date signed (mm/dd/yyyy)