*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

**Case No. _____**

**Annex "E1 – Developmental Disability"**

| |
|---|
| HEALTH CARE INSTITUTION (HCI) |
| ADDRESS OF HCI |
| 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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐ |

**CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 1)**
**Z Benefits for Children with Developmental Disabilities**
**Developmental and Functional Assessment**

| **Requirements** | **Please Check** |
|---|---|
| 1. Checklist of Requirements for Reimbursement (Tranche 1) (Annex E1-Developmental Disability) | |
| 2. Photocopy of approved Pre–Authorization Checklist & Request (Annex A- Developmental Disability) | |
| 3. Photocopy of accomplished ME FORM (Annex B) | |
| 4. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2 | |
| 5. Checklist of Mandatory Service for Developmental Disabilities (Annex C1 – Developmental Disability) | |
| 6. Photocopy of completed Z Satisfaction Questionnaire (Annex D) | |
| 7. Photocopy of Certificate of Assessment and Recommendations from Medical Specialist (Annex J) | |
| DATE COMPLETED : | |
| DATE FILED : | |

| | |
|---|---|
| Certified correct by: | Certified correct by: |
| (Printed name and signature)<br>Attending Medical Specialist | (Printed name and signature)<br>Executive Director/Chief of Hospital/<br>Medical Director/ Medical Center Chief |
| PhilHealth Accreditation No. ☐☐☐☐–☐☐☐☐☐☐☐–☐ | PhilHealth Accreditation No. ☐☐☐☐–☐☐☐☐☐☐☐–☐ |
| Date signed (mm/dd/yyyy) | Date signed (mm/dd/yyyy) |

| |
|---|
| Conforme by: |
| (Printed name and signature)<br>Patient/Parent/Guardian |
| Date signed (mm/dd/yyyy) |