



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

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Bawat Pilipino MIYEMBRO  
Bawat miyembro PROTEKTADO  
Kalusugan natin **SEGUARADO**

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

**Annex “K– Hearing impairment”**

**Z BENEFITS FOR CHILDREN WITH HEARING IMPAIRMENT**

PATIENT (Last name, First name, Middle name, Suffix)	BIRTHDAY (mm/dd/yyyy)
ADDRESS	
CONTACT NUMBER	

**CERTIFICATE OF COMPLETED SPEECH THERAPY SESSIONS**

This certifies that patient \_\_\_\_\_, has completed the speech therapy sessions on the specified dates

Remarks (if any): \_\_\_\_\_  
\_\_\_\_\_

Conforme by Patient/Parent/Guardian:

Certified by:

\_\_\_\_\_  
Printed name and signature

\_\_\_\_\_  
Printed name and signature  
Attending Speech Therapist/Pathologist