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

Bawat Pilipino MIYEMBRO
Bawat miyembro PROTEKTADO
Kalusugan natin SEGURADO

Case No. _____

Annex "E1 – Hearing Impairment"

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (answer only if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 1) ASSESSMENT

Requirements	**Please Check**
1. Checklist of Requirements for Reimbursement (Annex E1)	
2. Photocopy of approved Pre–Authorization Checklist & Request (Annex A)	
3. Photocopy of completely accomplished ME FORM (Annex B)	
4. Completed PhilHealth Claim Form (CF1) or PhilHealth Benefit Eligibility Form (PBEF)	
5. PhilHealth Claim Form 2	
6. Checklist of Mandatory Service for Hearing Impairment (Annex C1)	
7. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
8. Photocopy of the ABR waveform tracing or applicable hearing test result	
DATE COMPLETED :	
DATE FILED:	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Otolaryngologist	(Printed name and signature) Executive Director/Chief of Hospital/ 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) Patient/Parent/Guardian
Date signed (mm/dd/yyyy)