



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 "E3.1 – Hearing Impairment"

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"/>

**CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT-FOR EAR MOLD
REFITTING**

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E3.1)	
2. PhilHealth Claim Form2 (CF2)	
3. Checklist of Mandatory Service for Hearing Impairment (Annex C3)	
4. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
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. <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)