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

Place a (✓) on the box for the age group, category of hearing impairment and mandatory service rendered to the child:

<table>
<thead>
<tr>
<th>Age Group at Pre-authorization</th>
<th>Category of Hearing Impairment</th>
<th>Mandatory Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 5 to less than 18 years old</td>
<td>Moderate hearing loss&lt;br&gt;Severe to profound hearing loss</td>
<td>Hearing aid fitting&lt;br&gt;Hearing aid replacement&lt;br&gt;Hearing aid verification&lt;br&gt;Batteries&lt;br&gt;Ear mold</td>
</tr>
</tbody>
</table>

Certified correct by:

(Printed name and signature) Attending Otolaryngologist

Certified correct by:

(Printed name and signature) Executive Director/Chief of Hospital/<br>Medical Director/ Medical Center Chief

Date signed (mm/dd/yyyy)

Conforme by:

(Printed name and signature) Patient/Parent/Guardian

Date signed (mm/dd/yyyy)