



Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION

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Bawat Pilipino MIYEMBRO
Bawat miyembro PROTEKTADO
Kalusugan natin SEGURADO

Case No. _____

Annex "C2 – Hearing Impairment"

**CHECKLIST OF MANDATORY SERVICES
Z BENEFITS FOR HEARING IMPAIRMENT**

HEARING AID PROVISION (TRANCHE 2)

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 (answer only 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"/>

Place a (✓) on the box for the appropriate age group, category of hearing impairment and services that were rendered to the child:		
Age Group at Pre-authorization	Category of Hearing Impairment	Mandatory Services
<input type="checkbox"/> Age 0 to less than 3 years old	<input type="checkbox"/> Moderate hearing loss <input type="checkbox"/> Severe to profound hearing loss	<input type="checkbox"/> Hearing aid fitting <input type="checkbox"/> Hearing aid device <input type="checkbox"/> Hearing aid verification <input type="checkbox"/> Batteries <input type="checkbox"/> Ear mold
<input type="checkbox"/> Age 3 to less than 6 years old	<input type="checkbox"/> Moderate hearing loss <input type="checkbox"/> Severe to profound hearing loss	
<input type="checkbox"/> Age 6 to less than 18 years old	<input type="checkbox"/> Moderate hearing loss	

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"/>	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"/>
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient/Parent/Guardian
Date signed (mm/dd/yyyy)