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 "B – ME Form"

MEMBER EMPOWERMENT FORM
Inform, Support & Empower

Instructions:
1. The health care provider shall explain and assist the patient in filling-up the ME form.
2. Legibly print all information provided.
3. For items requiring a "yes" or "no" response, tick appropriately with a check mark (√).
4. Use additional blank sheets if necessary, label properly and attach securely to this ME form.
5. The ME form shall be reproduced by the contracted health care institution (HCI) providing specialized care.
6. Triplicate copies of the ME form shall be made available by the contracted HCI—one for the patient; one as file copy of the contracted HCI providing the specialized care and one for PhilHealth.
7. **For patients availing of the Z MORPH for the fitting of external lower limb prosthesis write N/A for items B2, B3, C4, and D6 and for PD First Z Benefits, write N/A for items B2 and B3.**

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI

A. Member/Patient Information		
PATIENT (Last name, First name, Middle name, Suffix)		
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐		
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)		
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐		
PERMANENT ADDRESS		
Birthday (mm/dd/yyyy)	Age	Sex
Telephone Number	Mobile Number	Email Address

B. Clinical Information	
1. Description of condition	
2. Applicable Treatment Plan agreed upon with healthcare provider	
3. Applicable alternative Treatment Plan agreed upon with health care provider	

C. Treatment Schedule and Follow-up Visit/s	
1. Date of initial admission to HCI or consult[a] (mm/dd/yyyy) [a]For ZMORPH, this refers to the external lower limb pre-prosthesis rehabilitation consult. For PD First, this refers to the date of medical consultation or visit to the PD Provider prior to the start of the first PD exchange.	
2. Date/s of succeeding admission to HCI or consult[b] (mm/dd/yyyy) [b] For ZMORPH, this refers to the external lower limb measurement, fitting and adjustments For the PD First, this refers to the next visit to the PD Provider.	
3. Date/s of follow-up visit/s[c] (mm/dd/yyyy) [c] For ZMORPH, this refers to the external lower limb post-prosthesis rehabilitation consult.	

D. Member Education		
Put a (✓) opposite appropriate answer or NA if not applicable.	YES	NO
1. My health care provider explained the nature of my condition.		
2. My health care provider explained the treatment options[d]. [d] For ZMORPH, this refers to the need for pre- and post-external lower limb prosthesis rehabilitation.		
3. The possible side effects/adverse effects of treatment were explained to me.		
4. My health care provider explained the mandatory services and other services required for the treatment of my condition.		
5. I am satisfied with the explanation given to me by my health care provider.		
6. I have been fully informed that I will be cared for by all the pertinent medical specialties, as needed, present in the PhilHealth contracted HCI of my choice and that preferring another contracted HCI for the said specialized care will not affect my treatment in any way.		
7. My health care provider explained the importance of adhering to my treatment plan. This includes completing the course of treatment in the contracted HCI where my treatment was initiated. Note: Non-adherence of the patient to the agreed treatment plan in the HCI may result to denial of filed claims for the succeeding tranches and which should not be filed as case rates.		

Put a (✓) opposite appropriate answer or NA if not applicable.	YES	NO
8. My health care provider gave me the schedule/s of my follow-up visit/s.		
9. My health care provider gave me information where to go for financial and other means of support, when needed. a. Government agency (ex. PCSO, PMS, LGU, etc.) b. Civil society or non-government organization c. Patient Support Group d. Corporate Foundation e. Others (ex. Media, Religious Group, Politician, etc.)		
10. I have been furnished by my health care provider with a list of other contracted HCIs for the specialized care of my condition.		
11. I have been fully informed by my health care provider of the PhilHealth membership policies and benefit availment on the Z Benefits: a. I fulfill all selections criteria for my condition.		
b. The "no balance billing" (NBB) was explained to me. Note: NBB policy is applicable to the following members when admitted in ward accommodation: sponsored, indigent, household help, senior citizens and iGroup members with valid Group Policy Contract (GPC) and their qualified dependents.		
c. I understand the NBB policy.		
For sponsored, indigent, household help, senior citizens and iGroup members with valid GPC and their qualified dependents, answer C.1, C.2 and C.3. c.1. I understand that I can opt out from the NBB and may be charged a fixed copay		
c.2. I opt out from the NBB policy of PhilHealth		
The following are applicable to formal and informal economy, lifetime members and their qualified dependents (d.1 and d.2) d. I understand the fixed copay for members belonging to the formal and informal economy, lifetime members and senior citizens.		
d.1. I understand that as a member belonging to the formal and informal economy, lifetime members, the contracted HCI can charge me a fixed copay.		
d.2. I understand that the fixed copay is for other services needed to treat my condition.		
e. Only five (5) days shall be deducted from the 45 days annual benefit limit for the duration of my treatment under the Z Benefits.		
f. I shall update my premium contributions in order to avail the Z Benefits and other PhilHealth benefits.		

E. Member Roles and Responsibilities		
Put a (✓) opposite appropriate answer or NA if not applicable.	YES	NO
1. I understand that I am responsible for adhering to my treatment schedule.		
2. I understand that adherence to my treatment schedule is important in terms of clinical outcomes and a pre-requisite to the full entitlement of the Z benefits.		
3. I understand that it is my responsibility to follow and comply with all the policies and procedures of PhilHealth and the health care provider in order to avail of the full Z benefit package. In the event that I fail to comply with policies and procedures of PhilHealth and the health care provider, I waive the privilege of availing the Z benefits.		

F. Printed Name, Signature, Thumb Print and Date		
Printed name and signature of patient* * For minors, the parent or guardian affixes their signature or thumb print here on behalf of the patient.	Thumb print (if patient is unable to write)	Date (mm/dd/yyyy)
Printed name and signature of Attending Doctor		Date (mm/dd/yyyy)
Witnesses:		
Printed name and signature of HCI staff member		Date (mm/dd/yyyy)
Printed name and signature of spouse/ parent/ next of kin /authorized guardian or representative		Date (mm/dd/yyyy)

G. PhilHealth Contact Details		
Name of PhilHealth CARES assigned at the HCI		
Telephone number	Mobile number	Email address

H. Consent to access patient record	I. Consent to enter medical data in the Z benefit information & tracking system (ZBITS)
I consent to the examination by PhilHealth of my medical records for the sole purpose of verifying the veracity of the Z-claim	I consent to have my medical data entered electronically in the ZBITS as a requirement for the Z Benefits. I authorize PhilHealth to disclose my personal health information to its contracted partners.
I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with the Z claim for reimbursement before PhilHealth.	

Printed name and signature of patient* * For minors, the parent or guardian affixes their signature or thumb print here on behalf of the patient.	Thumb print (if patient is unable to write)	Date (mm/dd/yyyy)
Printed name and signature of patient's representative		Date (mm/dd/yyyy)
Relationship of representative to patient (tick appropriate box) ☐ spouse ☐ parent ☐ child ☐ next of kin ☐ guardian		