Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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www.philhealth.gov.ph

PhilHealth@24: Tungo sa Kalusugan Para sa Lahat

Case No. _____

Annex "C1 – Mobility Impairment"

CHECKLIST OF MANDATORY SERVICES
Z BENEFITS FOR CHILDREN WITH MOBILITY IMPAIRMENT

ASSESSMENT, PRESCRIPTION *AND MEASUREMENT*
Tranche 1

HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	*SEX* ☐ *Male* ☐ *Female*
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER (*answer only* if patient is a dependent)	1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

Place a (✓) on the appropriate boxes or write NA if not applicable

MANDATORY SERVICES
I. ASSESSMENT
☐ Assessment done by a rehabilitation medicine specialist
II. MEASUREMENT
☐ *Measurement done by a prosthetist/orthotist or wheelchair professional* *Indicate date of measurement:* _____

III. PRESCRIPTION		
Place a (✓) on the box for the appropriate assistive device that was prescribed to the child:		
Upper Extremity Prosthesis	☐ Shoulder disarticulation ☐ Above elbow ☐ Below elbow ☐ Hand glove (2 or more fingers) ☐ Finger (1 finger)	Laterality ☐ Right ☐ Left ☐ Both

Place a (✓) on the box for the appropriate assistive device that was prescribed to the child:		
Lower Extremity Prosthesis	☐ Hip disarticulation ☐ Above knee or with knee disarticulation ☐ Below knee or ankle disarticulation ☐ Partial foot	Laterality ☐ Right ☐ Left ☐ Both
Orthosis	☐ Talipes Equinovarus (Club Foot) ☐ Ankle foot orthosis (AFO) ☐ Knee ankle foot orthosis (KAFO) ☐ Hip knee ankle foot orthosis (HKAFO)	Laterality ☐ Right ☐ Left ☐ Both
	☐ Spinal bracing / orthosis	
Seating Device for ages 6 months to less than 7 years old	☐ Seating device	
Wheelchair for ages 7 to 17 years and 364 days old	☐ Basic Wheelchair ☐ Intermediate Wheelchair	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Rehabilitation Medical Specialist	(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)