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 "C1 – Mobility Impairment"

CHECKLIST OF MANDATORY SERVICES
Z BENEFITS FOR CHILDREN WITH MOBILITY IMPAIRMENT

ASSESSMENT AND PRESCRIPTION
Tranche 1

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

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

MANDATORY SERVICES
I. ASSESSMENT
☐ Assessment done by a rehabilitation medicine specialist

II. 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
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	

Place a (✓) on the box for the appropriate assistive device that was prescribed to the child:	
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)