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 

### CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT

Mobility Impairment- Yearly Services and Replacement

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Please Check</th>
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</thead>
<tbody>
<tr>
<td>1. Checklist of Requirements for Reimbursement</td>
<td></td>
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<tr>
<td>(Annex E- Mobility Impairment)</td>
<td></td>
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<tr>
<td>2. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2</td>
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<td>3. Checklist of Mandatory Services for Mobility Impairment</td>
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<td>(Annex C – Mobility Impairment)</td>
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<tr>
<td>4. Photocopy of completed Z Satisfaction Questionnaire (Annex D)</td>
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</tbody>
</table>

DATE COMPLETED:

DATE FILED:

Certified correct by:

(Printed name and signature) 
Attending Rehabilitation Medical Specialist

Certified correct by:

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

PhilHealth Accreditation No. |  
Date signed (mm/dd/yyyy)

Conforme by:

(Printed name and signature) 
Patient/Parent/Guardian

Date signed (mm/dd/yyyy)