Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8441-7442 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

DISCHARGE CHECKLIST FOR THE Z BENEFITS
Orthopedic Implants

Tranche 2

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	**(Answer only if the patient is a dependent; otherwise, write, "same as above")** 1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

(Place a ✓opposite appropriate answer)

IMPLANT PROVIDED	RIGHT	LEFT	BOTH
☐ Total hip prosthesis, cemented			
☐ Total hip prosthesis, cementless			
☐ Partial hip prosthesis, bipolar			
☐ Total hip prosthesis, hybrid			
☐ Partial hip prosthesis, unipolar modular			
☐ Multiple screw fixation, 6.5 mm cannulated cancellous screws with washer			
☐ Compression hip screw set			
☐ Proximal femoral locked plate			
☐ *Proximal femoral nail*			
☐ Intramedullary nail with interlocking screws-*Femur*			
☐ *Intramedullary nail with interlocking screws-Tibia*			
☐ Locked compression plate – broad, metaphyseal, *proximal* and distal femoral			
☐ *Locked compression plate – broad, metaphyseal, proximal and distal tibia*			
☐ Knee prosthesis			
☐ Arm and forearm, plating			
☐ Partial hip prosthesis, pinning			
☐ Wrist, plating			
☐ Wrtist, pinning			

(Place a ✓ if DONE)

REHABILITATION SESSIONS	DATES PERFORMED (min of 4 per package)				
Physical therapy OR occupational therapy	Package 1				
	Package 2 (for multiple injury)				

FOLLOW UP VISIT	Date:

Conforme by:	Certified correct by:
(Printed name and signature) Patient/Parent/Guardian	(Printed name and signature) Attending Rehabilitation Specialist
Date signed (mm/dd/yyyy)	PhilHealth Accreditation No. ____-_____-_
	Date signed (mm/dd/yyyy)