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 "C2.2 – Visual Disabilities"

CHECKLIST OF MANDATORY SERVICES
Z BENEFITS FOR VISUAL DISABILITIES, CATEGORIES 2, 3 and 4

APPROPRIATE ASSISTIVE DEVICE

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (answer only if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

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

MANDATORY SERVICES	OTHER SERVICES, AS NEEDED
Any one of the following: Optical aid 1: Low power distance, category 2,3 and 4 visual impairment eyeglasses + low power optical device; or Optical aid 2: High power distance, category 2, 3 and 4 visual impairment progressive eyeglasses + high optical device Electronic assistive device Description: ________________________ ____________________________________	Optical aid 3: colored filter, category 2, 3 and 4 visual impairment Ocular prosthesis

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Ophthalmologist	(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)