



*Republic of the Philippines*  
**PHILIPPINE HEALTH INSURANCE CORPORATION**

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[www.philhealth.gov.ph](http://www.philhealth.gov.ph)



Case No. \_\_\_\_\_

**Annex "E2.2 – Visual Disability"**

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>
MEMBER (answer only if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>

**CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2)**  
**Visual Disability, Categories 2, 3, and 4**

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E2.2)	
2. PhilHealth Claim Form2 (CF2)	
3. Checklist of Mandatory Service for Visual Disabilities (Tranche 2) (Annex C2.2)	
4. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
5. Proof of device use	
DATE COMPLETED :	
DATE FILED :	

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. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>	PhilHealth Accreditation No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient/Parent/Guardian
Date signed (mm/dd/yyyy)