



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

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



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

**Annex “J – Visual Disabilities”**

**Z BENEFITS FOR CHILDREN WITH VISUAL DISABILITIES**

PATIENT (Last name, First name, Middle name, Suffix)	BIRTHDAY (mm/dd/yyyy)
ADDRESS	
CONTACT NUMBER	

**CERTIFICATE OF COMPLETED TRAINING AND REHABILITATION SESSIONS**

This certifies that patient \_\_\_\_\_, has completed the following training and rehabilitation for children with visual disabilities as needed:

- Training on the use of the device
- Training on activities of daily living
- Visual skills training
- Environmental adaptation
- Others, specify \_\_\_\_\_

Remarks (if any): \_\_\_\_\_

Conforme by Patient/Parent/Guardian:

Certified by:

\_\_\_\_\_  
Printed name and signature

\_\_\_\_\_  
Printed name and signature  
Attending therapist