

Annex E: ZMORPH Checklist of Requirements for Reimbursement

As of October 2022



Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

HEALTH FACILITY (HF)	
ADDRESS OF HF	
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix SEX <input type="checkbox"/> Male <input type="checkbox"/> Female 2. PhilHealth ID Number <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"/>
B. MEMBER	(<i>Answer only if the patient is a dependent; otherwise, write, "same as above"</i>) 1. Last Name, First Name, Middle Name, Suffix 2. PhilHealth ID Number <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 ZMORPH

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E-ZMORPH)	
2. Photocopy of approved Pre –Authorization Checklist & Request (Annex A-ZMORPH)	
3. Photocopy of completely accomplished ME FORM (Annex B)	
4. Properly accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
5. Discharge Checklist for ZMORPH (Annex C-ZMORPH)	
6. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
7. Original or certified true copy (CTC) of Statements of Account (SOA)	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Rehabilitation Medicine Specialist	(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"/>	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"/>
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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