Case No. _______________  

Annex "E1 – EMORPH"

<table>
<thead>
<tr>
<th>HEALTH CARE INSTITUTION (HCI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS OF HCI</td>
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<table>
<thead>
<tr>
<th>PATIENT (Last name, First name, Middle name, Suffix)</th>
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<table>
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<tr>
<th>PHILHEALTH ID NUMBER OF PATIENT</th>
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<tr>
<td>MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)</td>
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</table>

<table>
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<th>PHILHEALTH ID NUMBER OF MEMBER</th>
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**CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 1)**

**Expanded ZMORPH**

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Please Check</th>
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</thead>
<tbody>
<tr>
<td>1. Transmittal Form (Annex H)</td>
<td></td>
</tr>
<tr>
<td>2. Checklist of Requirements for Reimbursement (Annex E1-EMORPH)</td>
<td></td>
</tr>
<tr>
<td>3. Photocopy of approved Pre –Authorization Checklist &amp; Request</td>
<td></td>
</tr>
<tr>
<td>(Annex A-EMORPH)</td>
<td></td>
</tr>
<tr>
<td>4. Photocopy of completely accomplished ME FORM (Annex B)</td>
<td></td>
</tr>
<tr>
<td>5. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit</td>
<td></td>
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<tr>
<td>Eligibility Form (PBEF) and CF 2</td>
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<tr>
<td>6. Discharge Checklist for Expanded ZMORPH (Tranche 1) (Annex C1-EMORPH)</td>
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<tr>
<td>7. Photocopy of completed Z Satisfaction Questionnaire (Annex D)</td>
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**DATE COMPLETED:**

**DATE FILED:**

Certified correct by:

<table>
<thead>
<tr>
<th>(Printed name and signature)</th>
<th>(Printed name and signature)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending Rehabilitation Medicine Specialist</td>
<td>Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PhilHealth Accreditation No.</th>
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Conforme by:

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<th>(Printed name and signature)</th>
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<tbody>
<tr>
<td>Patient/Parent/Guardian</td>
<td></td>
</tr>
</tbody>
</table>

| Date signed (mm/dd/yyyy)    |          |          |

As of October 2016