



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

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



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

**Annex "C1.4 – EMORPH"**

**DISCHARGE CHECKLIST FOR EXPANDED ZMORPH  
Spinal Orthosis**

**Tranche 1**

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 (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"/>

Place a (✓) or NA if not applicable

CRITERIA	Yes
1. Spinal orthosis provided is as prescribed with proper alignment and appropriate fit	
2. The [body segment] trunk/torso is free of blisters, vascular compromise, pain, hypersensitivity after 30 minutes of use	
3. Spinal orthosis user possesses competent skill and knowledge regarding donning, doffing, cleaning, precautions and falling techniques	

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"/> - <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)