Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 Trunkline (02) 441-7444
www.philhealth.gov.ph

Case No. _____

Annex "C2 – EMORPH"

DISCHARGE CHECKLIST FOR EXPANDED ZMORPH
Tranche 2

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐☐ - ☐

Place a check mark (✓) on the type of prostheses or orthosis to be given to the patient:

Z Benefits		Right	Left	Both
I. Lower limb prosthesis	1. Above knee/ knee disarticulation			
	2. Hip disarticulation			
	3. Van Ness Rotationplasty			
II. Upper limb prosthesis	4. Below elbow			
	5. Above elbow			
III. Lower limb orthosis	6. Ankle foot			
	7. Knee ankle foot			
	8. Hip knee ankle foot			
IV. Spinal orthosis	☐ Thoracolumbosacral	☐ Lumbosacral	☐ Cervicothoracic	

Rehabilitation Sessions	Dates Performed					
Physical therapy OR						
Occupational therapy						

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. ☐☐☐☐–☐☐☐☐☐☐–☐	PhilHealth Accreditation No. ☐☐☐☐–☐☐☐☐☐☐–☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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