

PHILHEALTH CIRCULARNo. 2026 - 0014**TO : ALL CONTRACTED HEALTH FACILITIES FOR Z BENEFITS PACKAGE FOR CHILDREN WITH DEVELOPMENTAL IMPAIRMENTS AND DISABILITIES, AND OTHERS CONCERNED****SUBJECT : Z Benefits for Children with Developmental Impairments and Disabilities (Revision 1)****I. RATIONALE**

Data from 2012 to 2015 coming from the two leading pediatric rehabilitation units in the country show that the Autism Spectrum Disorders (ASD), Attention Deficit-Hyperactivity Disorder (ADHD), Cerebral Palsy, and Global Developmental Delay rank as the four leading consults for developmental disability (PGH and PCMC, 2015). A recent study estimates that 5M¹ children live with disabilities. The disability may affect one or more of the following developmental domains: (a) mental, (b) intellectual, (c) learning, (d) speech, language and communication, and (e) physical².

Timing is crucial in potentially mitigating the impact of developmental disability. Developmental disability can be properly diagnosed such that specific and individual plans for therapy services can be crafted. With rehabilitation therapy, children can attain their highest level of development, optimize their capacities and increase their participation in education and the community. However, this specialized care is often inaccessible to children who belong to poor communities. *The lack of specialized care magnifies the burden* among households who have to manage the needs of children with developmental disabilities on top of the difficulty of meeting even their basic necessities.

The Philippine Health Insurance Corporation (PhilHealth) is mandated to ensure financial risk protection for all Filipinos, with provisions towards persons with disabilities. Thus, the PhilHealth Board, per Board Resolution

¹Second Congressional Commission on Education. (2025, November 20). 5 million Filipino children with disabilities remain underserved – EDCOM 2 study. EDCOM 2.

²Department of Health. Administrative Order No. 2025-0014: National Policy on the Institutionalization of Disability Categorization in the Philippines.

No. 2125 s. 2016, approved an improved, rationalized and relevant benefit package for children with disabilities with the perspective of capturing the preventive to curative approach to patient care. *PhilHealth Circular No. 2017-0029 (Z Benefits for Children with Developmental Disabilities)* was issued to describe the benefit package for children with developmental disabilities, covering services from assessment to rehabilitation therapy, aimed at increasing the functional capacities of the children, and improving quality of life for both children and the caregivers. Furthermore, the package was designed as a Z Benefits to prevent catastrophic spending among the marginalized that are enrolled in the program while ensuring the provision of quality healthcare services.

II. OBJECTIVES

This first revision to *PhilHealth Circular No. 2017-0029* aims to modify the minimum requirements for a multi-disciplinary team and allow the use of a broader set of assessment tools to ensure equitable access to quality healthcare services and financial risk protection.

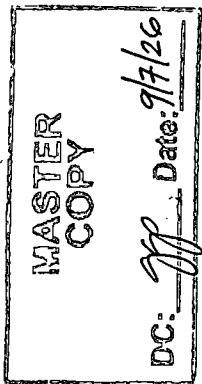
III. SCOPE

This PhilHealth Circular shall govern the implementation of the revised Z Benefits Package for children with developmental impairments and disabilities, which provides for developmental and functional assessment, rehabilitation planning, rehabilitation therapy and discharge assessment, and shall apply to all contracted health facilities (HFs) and other stakeholders involved in the implementation of the Z Benefits package.

IV. DEFINITION OF TERMS

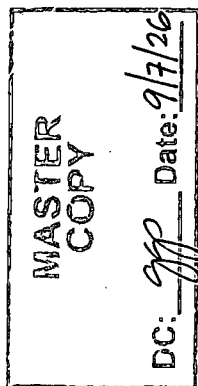
- A. Assessment** - process of examination, interaction, and observation of a child with a potential developmental disability, and the degree of limitations in function, activity and participation. Assessment is required to determine the provision of rehabilitation services.
- B. Contracted Health Facility (HF)³** – any health facility that enters into a contract with the Corporation for the provision of specialized care.
- C. Copayment** – a predetermined amount agreed upon by the contracted HF and PhilHealth for user charges related to amenities, choice of accredited physician who is within the MDT, specialist fees for private patients, or any perceived additional service not included in the benefits package or upgrade of services chargeable to patients at point of service. Copayment is an example of an out-of-pocket payment or

³Philippine Health Insurance Corporation. *PhilHealth Circular No. 2022-0012: Contracting of a Health Facility as a Z Benefit Provider (Revision 1)*



cost-sharing mechanism intended to distribute the cost of healthcare between the insured and the insurer before accessing service to control moral hazards and prevent adverse incentives in healthcare utilization.

- D. Cost-sharing** – *the direct payment of a portion of health care costs by the members/dependents when receiving health services. This term generally includes deductibles, coinsurance, and copayments, or similar charges.*
- E. Developmental Disability**⁴ – *restricted participation and limited activity performance as a result of the interaction of health conditions and personal/social factors on aforementioned impairments.*
- F. Developmental Impairment**⁵ – *a body structure loss or functional deficits in the nervous system, eye/ear and related structures, voice and speech, movement.*
- G. Fee Schedule** – *a predetermined list of fees or charges that outlines the prices or reimbursements for various medical procedures, services, or treatments. This list of items with equivalent rates is used to reimburse healthcare providers on a fee-for-service with a cap or a fixed amount.*
- H. Free-standing Rehabilitation or Therapy Center** – *an organized stand-alone health facility with access to an appropriate specialist that operates independently inside or outside the hospital and offers provision of care needed by a child with developmental disabilities.*
- I. Intellectual Disability**⁶ – *an impairment or deficit in intellectual functions and adaptive functioning that leads to the inability of an individual to perform their activities and/or restrict participation in their community.*
- J. Learning Disability**⁷ – *impairments or deficits in learning and using academic skills that lead to the inability of an individual to perform their activities and/or restrict participation in their community in at least one of the six areas/domains for at least six months despite interventions that target the difficulties.*
- K. Lost to follow-up** – *means the patient has not come back as advised for immediate next rehabilitation visit or within four weeks from last patient-attended clinic visit. Failure to visit the clinic for a treatment more than four weeks from advised scheduled rehabilitation visit renders the patient “lost to follow-up”.*



⁴(Department of Health, 2025)

⁵World Health Organization. International Classification of Functioning.

⁶(Department of Health, 2025)

⁷(Department of Health, 2025)

L. Mandatory Services – the minimum services that PhilHealth covers that the contracted HFs must provide based on clinical practice guidelines (CPG) and/or expert consensus as approved by the Corporation.

M. Member Empowerment Form (ME Form) – a document showing that the patient is fully informed of their benefits package, treatment options, treatment schedule and follow-up visits, roles, and responsibilities. The ME Form also documents that the contracted health facility provided education, counseling, and other pertinent courses of action. The beneficiary or their guardian or representative and the attending healthcare provider in charge jointly sign the ME form.

N. Mental Disability⁸ - disturbance in global and specific mental functions that lead to limited activity participation & restricted community participation.

1. Global: Consciousness, orientation, psychosocial, temperament and personality, energy and drive, sleep

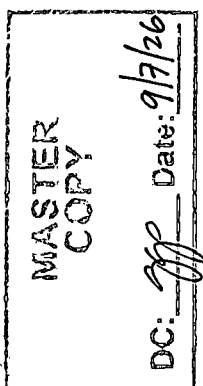
2. Specific: Attention, memory, psychomotor, emotional, perpetual thoughts, higher level cognitive functions, language

O. Multidisciplinary-Interdisciplinary Team (MDT) – an approach to patient care involving team members from different professional backgrounds or work disciplines, with each member providing specific services while working collaboratively together to provide the best care to the patient.

P. Pre-authorization – an approval process from PhilHealth that gives the contracted HF the information that the patient has passed the eligibility and minimum clinical selections criteria required for availment of the Z benefits.

Q. Rehabilitation Therapy - physical therapy, and/or occupational therapy, and/or speech therapy services aimed at achieving developmental and functional gains for the children with developmental disability, and improved quality of lives, based on specific standardized developmental and functional assessment tools, the WHO-ICF Checklist and WHOQOL, and the goals and needs of the clients and their families.

R. Speech, Language, and Communication Disability⁹ - speech and language impairments (articulation, fluency, receptive and/or expressive processes) due to a disease or condition that leads to the



⁸(Department of Health, 2025)

⁹(Department of Health, 2025)

inability of an individual to perform their activities and/or restrict participation in their community.

V. POLICY STATEMENTS

A. The expansion of the Z Benefits package for children with developmental impairments and disabilities shall be implemented progressively in two (2) phases.

- 1. The first phase aims to increase the access and facilitate patients' availment of covered services under this Z Benefit.*
- 2. The second phase aims to expand service coverage subject to the available resources as determined by the Corporation.*

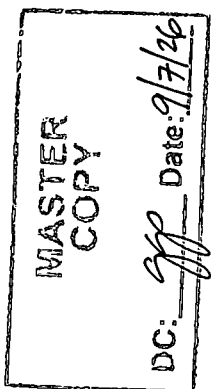
B. Contracting Health Facilities

- 1. PhilHealth shall engage with capable health facilities for the provision of specialized multi - and interdisciplinary health care delivery for this Z Benefits package following the existing rules of the Corporation, including its future amendments.*
- 2. PhilHealth shall issue updated health facility standards for contracting, which shall be uploaded to the PhilHealth website.*
- 3. Supplemental rules for accrediting contracting health facilities shall be referred to the Supplemental Rules on Contracting Health Facilities for the Z Benefits Package for Children with Developmental Impairments and Disabilities (Annex A).*

C. In the event of minor revisions or updates to the requirements, forms, or other details contained in the annexes of this benefits package, PhilHealth shall issue the appropriate issuance and ensure the uploading of the updated documents or forms on the PhilHealth website.

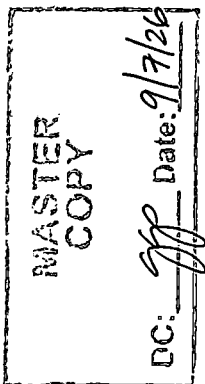
D. Benefits Availment

- 1. All Filipinos are automatically entitled to avail of this benefits package provided that they fulfilled the selection criteria as listed in this policy. PhilHealth beneficiaries shall comply with the existing membership eligibility rules.*

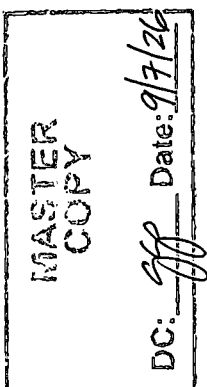


2. Patients Assessment and Selections Criteria

- a. The provision of services for the Z Benefits for *children with developmental impairments* and disabilities shall cover only those cases that fulfill the following selections criteria:
 - a.1. Chronological age must be zero to 17 years and 364 days old; and
 - a.2. *The child presents with functional problems secondary to delays, regressions, or deviations in any of the following developmental domains: mental, intellectual, learning, speech, language and communication, and physical.*
3. In order to qualify for the Z Benefits, children shall be assessed by appropriate health care providers at the contracted HF. If qualified, these children shall be enrolled in this program. *The contracted HF shall conduct the following:*
 - a. *The initial and discharge assessment shall be done by any of the following Medical Specialist:*
 - a.1. *Physical Medicine and Rehabilitation Specialist/ Psychiatrist;*
 - a.2. *Neurodevelopmental Pediatrician;*
 - a.3. *Developmental and Behavioral Pediatrician;*
 - a.4. *Pediatric Neurologist;*
 - a.5. *Child and Adolescent Psychiatrist.*
 - b. *The initial assessment, discharge assessment, and rehabilitation therapy shall be provided by any of the following allied health professionals:*
 - b.1. *Physical Therapist;*
 - b.2. *Occupational Therapist;*
 - b.3. *Speech and Language Pathologist or Speech Therapist;*
 - b.4. *Child Psychologist.*
4. *The following rules shall apply to all eligible patients availing of this Z benefits package:*
 - a. *The contracted HF may apply the patient for pre-authorization at any of the treatment phases.*



- b. *Prior to the availment of the Z Benefits, the designated liaison of the contracted HF shall submit the following documents to the Local Health Insurance Office (LHIO) or the office of the Head of the PhilHealth Benefits Administration Section (BAS) who has jurisdiction over the contracted HFs, for approval:*
- b.1. *Properly accomplished Pre-authorization Checklist and Request Form (Annex B); and*
- b.2. *Properly accomplished Member Empowerment (ME Form) (Annex C).*
- c. *PhilHealth shall approve the request based on the selection criteria outlined in the pre-authorization. Once approved, the contracted HF may render the services of the benefit package to the patient.*
- d. *Contracted HFs shall follow the prescribed process of seeking approval for the pre-authorization as described in PhilHealth Circular No. 2021-0022 Section V.D. (The Guiding Principles of the Z Benefits, Revision 1).*
- e. *The approved Pre-Authorization Checklist and Request shall be valid for one (1) fiscal year from the date of approval by PhilHealth. All contracted HFs are responsible for tracking the validity of their approved pre-authorization. In cases when the validity has lapsed, the contracted HF should inform PhilHealth and submit a new Pre-Authorization Checklist and Request, provided that the child is still below 18 years old.*
5. *The patient may avail of the benefits packages for a maximum of three (3) cycles for initial and discharge assessments, and rehabilitation therapy services based on the recommendations of the medical specialist, provided that the patient fulfills the selection criteria.*
6. *The forty-five (45) day annual benefit limit shall not apply when a patient avails of this benefits package, following the existing rules of the Corporation¹⁰.*
7. *The contracted HF shall discuss the ME Form with the patient/ parent/ guardian and explain the cost-sharing aspect of the benefits package. The primary purpose of the ME Form is to empower patients to actively participate in healthcare decision-making by*



¹⁰PhilHealth Circular No. 2025-0007: Lifting the 45-Day Benefit Limit Rule

providing them with essential information and education regarding their health condition and available treatment options.

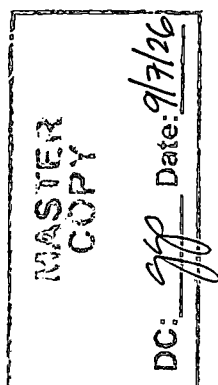
8. *The contracted HF may charge copayment or out-of-pocket (OOP) expenses for amenities or services that are not covered by the Z benefits package. This copayment is mutually agreed upon by the patients, parents, legal guardian or patient's representatives and contracted HFs during the discussion of the ME Form for services beyond the scope of essential health services.*
9. *PhilHealth shall reimburse drugs listed in the latest edition of the Philippine National Drug Formulary (PNDF). PhilHealth reiterates the mandate of the Health Technology Assessment, which provides a positive recommendation for any proposal to cover drugs/medicines, biologicals not listed in the latest PNDP, new technologies, diagnostic procedures, surgical interventions, and other treatment interventions.*

E. Minimum Standards of Care (Mandatory Services)

1. *The contracted HF for the Z Benefits for children with developmental impairments and disabilities shall provide the following mandatory services based on the patient's conditions.*

Mandatory Services	
a.	<i>The assessment (initial and discharge) and rehabilitation plan shall be conducted by <u>any</u> of the medical specialists listed in Section V.D.3.a of this policy using any of the standardized tests for developmental assessments and functional tests as recommended by their respective professional societies/organizations.</i>
b.	<i>The assessment (initial and discharge) and rehabilitation plan by <u>any</u> of the allied health professional/s listed in Section V.D.3.b using any of the standardized tests as recommended by their respective professional societies/organizations.</i>
c.	<i>Rehabilitation therapy rendered by a physical therapist or occupational therapist or speech and language pathologist/speech therapist or child psychologist.</i>

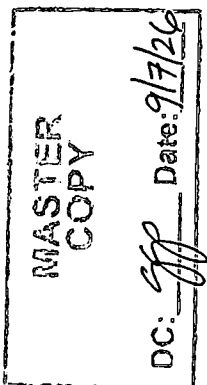
Table 1: Mandatory Services for Z Benefits for Children with Developmental Impairments and Disabilities



2. One cycle of package availment consists of initial assessment, rehabilitation therapy sessions (*maximum of 90 sessions*), and a discharge assessment, *which shall be completed in accordance with the set plan.*
3. A re-evaluation of the child by the attending physiatrist, developmental pediatrician and allied health professional is required before one cycle of care can be availed of for a second or third (final) time, *following the provision of Section V.D.5 of this policy.*
4. Patients can avail the services that are not covered in this Z Benefits through other existing PhilHealth benefits. These include but are not limited to the utilization of the medicines, laboratory tests and diagnostic procedures under the YAKAP and GAMOT benefits (e.g., Chest X-ray, blood tests, among others), subject to the existing rules of the Corporation on the covered services and benefits availment, including its subsequent amendments.
5. Other services such as psychometric tests may be utilized through other health financial assistance provided by other government agencies, subject to their existing rules.

F. Responsibilities of the Contacted Health Facilities

1. The contracted HFs shall adhere to the selection criteria as specified in the Pre-authorization Checklist and Request (Annex B).
2. Contracted HFs shall be responsible for developing an efficient process for assessing Z Benefits patients that is applicable in their local setting.
3. Children needing assistive technologies to improve mobility, function and communication shall be referred and/or advised to avail of the other Z packages for children with disabilities.
4. The contracted HF shall document in the patient's record the rehabilitation therapy sessions, and their respective dates, including all services rendered.
5. The contracted HFs shall not balance bill any patient beyond the amount prescribed in the benefits package for covered services. In cases of copayment, the contracted HF shall not charge the patient more than the agreed copayment at the point of service.



6. *The contracted HFs must appoint at least one (1) Z Benefits Coordinator whose responsibilities are outlined in the PhilHealth (PC) No. 2021-0022 titled "The Guiding Principles of the Z Benefits (Revision 1)" or existing rules.*
7. *The contracted HFs shall maintain a digital or physical copy of all medical records submitted by the patients for monitoring and post-audit purposes by PhilHealth.*
8. *As stipulated in the Universal Healthcare Act, Chapter IV, Sec. 18 (b), there shall be no differentiation between facility and professional fees (PF). PhilHealth shall credit all payments to the accounts of contracted private and public HFs.*

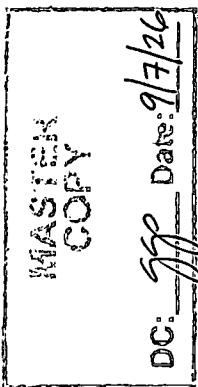
G. Responsibilities of the Patients, Parents, Legal Guardian or Patient's Representatives

1. *All patients shall adhere to the treatment plan including follow-up appointments as agreed with their attending medical specialist and allied health professionals;*
2. *All patients shall sign or affix their signature or thumb mark on documents that require the patient's approval or consent. In case the patient cannot sign or affix a thumb mark, an authorized representative (parents, legal guardian or patient representative) may act on behalf of the patient.*

H. Package Code, Rate, Tranche Payment, and Claims Filing Schedule

1. *The rates for assessment, rehabilitation therapy and discharge assessment, tranche payment and claims filing schedule of the Z Benefits for children with developmental impairments and disabilities are specified in the following tables:*

Package Code	Description of services	Tranche	Rate (Php)	Maximum Availment*	Filing Period
Z017.1	Developmental and functional assessment by a medical specialist only	1	3,626	1 per cycle year for a maximum of three cycles	Within 60 calendar days after assessment by the medical specialist



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Package Code	Description of services	Tranche	Rate (Php)	Maximum Availment*	Filing Period
Z017.2	Developmental and functional assessment by a medical specialist and one allied health professional or rehabilitation therapist	1	3,626	1 per cycle year for a maximum of three cycles	Within 60 calendar days after assessment by the medical specialist
		2	550		Within 60 calendar days after submission of rehabilitation plan of care by the rehabilitation therapist or allied health professional
Z017.3	Developmental and functional assessment by a medical specialist and two allied health professionals or rehabilitation therapists	1	3,626	1 per cycle year for a maximum of three cycles	Within 60 calendar days after assessment by the medical specialist
		2	1,100		Within 60 calendar days after submission of rehabilitation plan of care by the rehabilitation therapist or allied health professional
Z017.4	Developmental and functional assessment by medical specialist and three allied health professionals or rehabilitation therapists	1	3,626	1 per cycle year for a maximum of three cycles	Within 60 calendar days after assessment by the medical specialist
		2	1,650		Within 60 calendar days after submission of rehabilitation plan of care by the

Package Code	Description of services	Tranche	Rate (Php)	Maximum Availment*	Filing Period
					rehabilitation therapist or allied health professional
*One cycle of care can be availed of for a second or third time during the duration of eligibility as specified in the recommendations of the Discharge Assessment.					

Table 2: Package Code, Rate, Tranche Payment and Claims Filing Schedule for Developmental and Functional Assessment

Package Code	Description of services	Tranche	Rate (Php)	Maximum Availment ^a	Filing Period
Z017.5	Rehabilitation Therapy ^{b c}	Nine tranches (as needed)	5,000 per tranche (500/session)	Nine sets of therapies per one year cycle starting from the first day of initial team assessment	Within 60 calendar days after the last session for one set of therapies completed

^aOne cycle of care can be availed of for nine times during the duration of eligibility as specified in the recommendations of the Discharge Assessment.

^bEligible children with developmental *impairment and* disability can only avail of a maximum of nine sets of therapies. Each set of therapies has a maximum of 10 sessions.

^c*Rehabilitation therapy with less than 10 sessions on the last set of the therapies based on the plan shall be paid on a pro-rated basis.*

Table 3: Package Code, Rate, Tranche Payment and Claims Filing Schedule for Rehabilitation Therapy

Package Code	Description of services	Tranche	Rate (Php)	Maximum Availment*	Filing Period
Z017.6	Discharge assessment by a medical specialist	1	3,626	1 per cycle year for a maximum of three cycles	1 per cycle year for a maximum of three cycles Within 60 calendar days after submission of discharge assessment and plan

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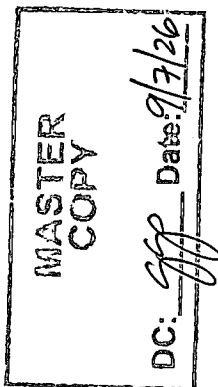
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Z017.7	Discharge assessment by one rehabilitation therapist or allied health professional and a medical specialist	1	550	1 per cycle year for a maximum of three cycles	Within 60 calendar days after submission of discharge assessment and plan
	Discharge assessment by one rehabilitation therapist or allied health professional and a medical specialist	2	3,626	1 per cycle year for a maximum of three cycles	Within 60 calendar days after submission of discharge assessment and plan
Z017.8	Discharge assessment by two rehabilitation therapists or allied health professionals and a medical specialist	1	1,100	1 per cycle year for a maximum of three cycles	Within 60 calendar days after submission of discharge assessment and plan
		2	3,626		
Z017.9	Discharge assessment by three rehabilitation therapists or allied health professionals and a medical specialist	1	1,650	1 per cycle year for a maximum of three cycles	Within 60 calendar days after submission of discharge assessment and plan
		2	3,626		
*One cycle of care can be availed of for a second or third time during the duration of eligibility as specified in the recommendations of the discharge assessment.					

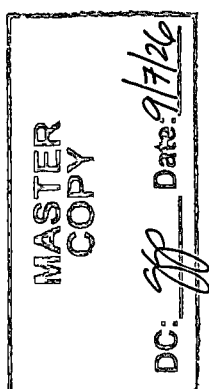
Table 4: Package Code, Rate, Tranche Payment and Claims Filing Schedule for Discharge Assessment

I. Claims Filing and Reimbursement

1. After receipt of the approved Pre-authorization Checklist and Request by the contracted *HF*, the contracted *HF* can only file a claim for reimbursement upon rendering all mandatory services specified in *Section V.E. Table 1*, of this *PhilHealth* Circular, within the context of a multi- and interdisciplinary approach to patient care.



2. *The contracted HF shall be responsible for the accuracy, adherence to rules, and efficient handling of all claims filed on behalf of the patients. All required documents, forms, and attachments must be properly filled out and signed by the authorized signatory prior to submission of claims within the prescribed period.*
3. *The contracted HFs shall indicate the Z Benefits package code in the Claim Form 2 (CF2) corresponding to the services provided to the patient.*
4. *The contracted HFs shall properly indicate the OOP and/or copayment of the member/patient and other funding sources in PhilHealth Claim Form 2 (CF2) Part III, "Consumption Benefits" and in the Statement of Account (SOA).*
5. *The contracted HFs shall follow the existing rules of the SOA¹¹ requirement for claims submission under the Z Benefits.*
6. *For rehabilitation therapy services requiring less than ten (10) sessions on the last set, the contracted HF shall file the claims according to the prescribed or rendered number of sessions. The reimbursement shall be paid on a pro-rated basis as stated in Section V.H table 3 of this policy.*
7. *One cycle should be completed within the applicable fiscal year and it begins when a designated health team in the contracted HF first sees a child. All services within a given cycle are considered expended and cannot be carried over to the next cycle.*
8. *The written recommendation from the attending medical specialist to continue rehabilitation therapy must be presented to PhilHealth when filing to avail for the package for a second or third cycle.*
9. *The claim application filed by the contracted HF shall include the following documentation:*
 - a. *Transmittal Form (Annex D) of claims for the Z Benefit Package to be used by the contracted HF per batch of claims;*
 - b. *Photocopy of the approved Pre-authorization Checklist and Request (Annex B) signed by the patient, parent, legal guardian or patient representative, and the health care providers who are members of the multi- and interdisciplinary team managing the patient, as applicable, for the first tranche;*



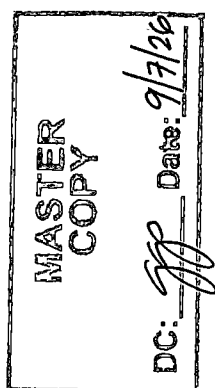
¹¹PhilHealth Circular No. 2022-0024: Statement Of Account (SOA) Requirement For Z Benefit Claims Submission

- c. PhilHealth Benefit Eligibility Form (PBEF) printout or its equivalent (e.g. PhilHealth Claim Form 1 or CF1) attached as proof of eligibility during the pre-authorization process;
- d. Photocopy of the properly accomplished ME Form (*Annex C*) for the first tranche;

A copy of the properly accomplished ME Form shall be provided to the patient by the contracted *HF* and the signed original copy should be attached in the patient's chart as a permanent record;

- e. Properly accomplished PhilHealth CF2 for all tranches;
 - f. Checklist of Mandatory Services (*Annex E*) for the corresponding tranches;
 - g. Corresponding Checklist of Requirements for Reimbursement (*Annex F*); and
 - h. Photocopy of the accomplished Z Satisfaction Questionnaire (*Annex G*) for services rendered for that particular tranche;
 - i. Photocopy of certificate from medical specialist and rehabilitation therapist (*Annex H*) for assessment and recommendations
10. *The following forms for the claims filing are summarized in the table below:*

First Payment (Initial Assessment)	Rehabilitation Tranches (up to 9 claims)	Final Payment (Discharge Assessment)
a. Checklist of Requirements for Reimbursement b. Pre-authorization Checklist and Request c. ME Form d. PBEF or CF1 e. PhilHealth CF2 f. Checklist of Mandatory Services g. Z Satisfaction Questionnaire	a. Checklist of Requirements for Reimbursement b. PhilHealth CF2 c. Checklist of Mandatory Services d. Z Satisfaction Questionnaire	a. Checklist of Requirements for Reimbursement b. PhilHealth CF2 c. Checklist of Mandatory Services d. Z Satisfaction Questionnaire e. Certificate of assessment and recommendations



First Payment (Initial Assessment)	Rehabilitation Tranches (up to 9 claims)	Final Payment (Discharge Assessment)
h. Certificate of assessment and recommendations		

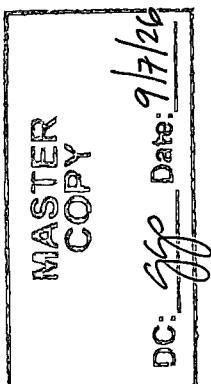
Table 5: Summary of Forms to be Utilized in Claims Filing and Reimbursement

11. There shall be no direct filing of claim by members/beneficiaries.
12. *In the event that the patient expires or is declared “lost to follow-up” in the course of the rehabilitation therapy, the contracted HF may still file claims for the payment of services rendered to PhilHealth. For rehabilitation therapy sessions, PhilHealth shall reimburse the contracted HF on a pro-rated basis, corresponding to the number of rehabilitation therapy services actually rendered to the patient on the last applicable set.*

The contracted HF shall file claims based on the applicable scenarios:

- a. *The contracted HF shall submit to PhilHealth a notarized sworn declaration for patients declared lost to follow-up. The contracted HF shall submit their claims within sixty (60) days from such declaration.*
- b. *If the patient expires at any time during the treatment phase, the contracted HF shall submit a photocopy of the death certificate or a notarized sworn declaration issued by the authorized government agencies as an attachment to the claims. The contracted HF shall submit their claims within sixty (60) days from the receipt or issuance (whichever is applicable) of the death certificate or notarized sworn declaration issued by the authorized government agencies.*

13. *Patients who were declared lost to follow-up by a contracted HF, may re-enroll to this Z Benefits package at any contracted HF, provided that the patients still fulfills the selection criteria.*
14. *Contracted HFs shall follow all relevant laws, such as RA No. 10754 or the “Act Expanding the Benefits and Privileges of Persons with Disability (PWD),” including prospective laws providing mandatory discounts, guidelines of the Bureau of Internal Revenue (BIR), and the order of charging based on DOH- DSWD-PCSO-PHIC Joint Administrative Order No. 2020-0001 [Operational Guidelines for the Implementation of the Medical and Financial Assistance to*



Indigent and Financially-Incapacitated Patients pursuant to Republic Act No. 11463 also known as "Malasakit Centers Act of 2019"].

Accordingly, PhilHealth benefits and all mandatory discounts provided by law, such as PWD discounts, shall be deducted first from the patient's total hospital bill. Benefits from private health insurance (PHI), health maintenance organizations (HMO), or employee benefits shall be applied only after PhilHealth deductions and shall complement the PhilHealth benefits package.

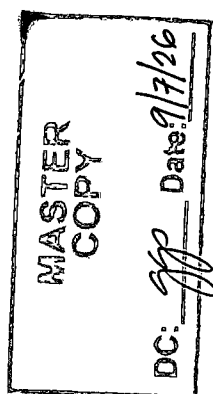
- 15. Contracted HF's may file a motion for reconsideration (MR) or appeal for claims denied by PhilHealth following existing policies.*
- 16. Existing rules on late filing shall apply. If the delay in the claims filing is due to natural calamities or other fortuitous events, the existing policy of the Corporation on the provisions of special privileges to those affected by fortuitous events shall apply.*

J. Claims Payment and Evaluation

- 1. PhilHealth shall reimburse covered services as specified in the applicable benefits package. For patients who are expired, declared lost to follow-up or with incomplete rehabilitation sessions on the last set, shall be paid on a pro-rated basis according to the services provided.*
- 2. PhilHealth shall review the completeness of all forms submitted by the contracted HF's. The PhilHealth Regional Offices (PROs) and LHIOs shall have the prerogative not to accept incomplete documents. However, they should directly coordinate with the contracted HF's regarding the deficiencies in the documents submitted. Once the documents are complete, the contracted HF shall submit these to PhilHealth for payment of claims within the required filing schedule.*
- 3. PhilHealth shall apply the "return to sender (RTS)" policy only for claims documents with incomplete data or documentary requirements. However, inconsistencies in the data or information contained in the documents or non-provision of a mandatory service are grounds for automatic denial of the claim.*

Upon receipt of the notice of RTS, the contracted HF's shall comply with the deficiencies within the prescribed period based on the existing rules and regulations set by PhilHealth.

- 4. PhilHealth shall have the right to subject any or all claims to medical review before and/or after payment or reimbursement of the contracted HF's, following the existing policy.*



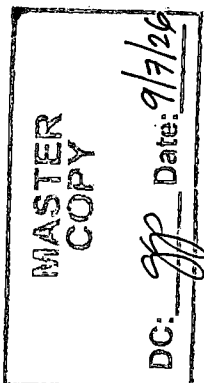
5. *PhilHealth shall process the claims without reference to any prior service. Claims for each treatment phase within the same date or period shall not be considered as overlapping claims.*
6. *Any change of member/patient category upon enrollment shall not affect the claims filed by the contracted HF.*
7. *PhilHealth shall process all claims submitted by the contracted HFs within thirty (30) working days upon receipt of claims applications, provided that the mandatory documents and attachments are complied with.*
8. *Claims filed by the contracted HF shall be denied based on the following instances:*
 - a. *If a mandatory service was not provided by the contracted HF;*
 - b. *Late filing;*
 - c. *Inconsistency of data and information contained in the claims application.*

K. Marketing and Promotion

1. *PhilHealth shall conduct communication and social marketing activities to educate the general public, increase public awareness of the benefits package, and promote informed decision-making and participation among patients, healthcare professionals, healthcare providers, and other stakeholders. Marketing and promotional activities shall be undertaken in accordance with the Social Marketing and Communication Plan of PhilHealth.*
2. *To further reach the general public, particularly beneficiaries, PhilHealth likewise encourages contracted HFs to advertise the Z Benefits packages through different communication channels, including but not limited to respective remote or online platforms, provided that these are in accordance with the policies of each benefits package and the Social Marketing and Communication Plan of PhilHealth.*

L. Monitoring

1. *PhilHealth shall enforce current policies on monitoring the performance of contracted HFs in implementing the Z Benefits package for children with developmental impairments and disabilities. PhilHealth shall likewise establish strict control mechanisms to ensure quality healthcare delivery and to prevent adverse provider behaviors and non-compliance with existing rules.*



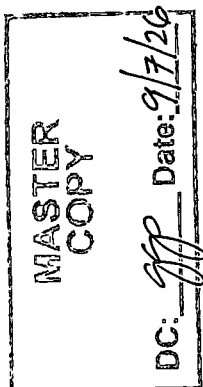
2. *PhilHealth also encourages content experts to review and conduct appropriate studies on healthcare providers' actual practices during the implementation of the Z Benefits package for children with developmental impairments and disabilities, especially documenting adverse provider behaviors resulting in cost-push inflation, such as unwarranted increases in hospital charges.*
3. *PhilHealth beneficiaries are strongly encouraged to provide feedback or report any concerns about the implementation of the Z Benefits policy or their benefit availment experience, by contacting the Corporate Action Center (CAC) through the hotline at (02) 8862-2588 or via email at actioncenter@philhealth.gov.ph.*
4. *Field monitoring activities shall be conducted to monitor service provision by contracted HFs, following the guidance, tools, and consent forms provided in PC No. 2021-0022.*
5. *The Corporation, in collaboration with relevant stakeholders and experts, shall establish performance indicators and outcome measures to monitor compliance with the policies of this PhilHealth Circular and the general treatment algorithm, and shall incorporate these indicators into relevant monitoring policies.*

M. Policy Review

PhilHealth shall conduct a regular policy review of the Z Benefits package in consultation and collaboration with relevant stakeholders, experts, and technical staff representatives of the Corporation. This PhilHealth Circular shall be enhanced as necessary based on the results of the policy review.

N. Annexes (Posted on the official website of PhilHealth)

- Annex A : Supplemental Rules in Accrediting and Contracting Health facilities for the Z Benefits Package for Children with Developmental Impairments and Disabilities*
- Annex B : Pre-authorization Checklist and Request Form*
- Annex C : Member Empowerment (ME Form)*
- Annex D : Transmittal Form for the Z Benefits*
- Annex E : Checklists of Mandatory Services*
Annex E.1: Developmental and Functional Assessment by Medical Specialist
Annex E.2: Developmental and Functional



Assessment by Allied Health Professionals

Annex E.3.1: Rehabilitation Therapy Services by Physical Therapy

Annex E.3.2: Rehabilitation Therapy Services by Occupational Therapy

Annex E.3.3: Rehabilitation Therapy Services by Speech and Language Pathologist/ Speech Therapist

Annex E.3.4: Psychological Services

Annex F : Checklists of Requirements for Reimbursement

Annex F.1: Developmental and Functional Assessment (Tranche 1)

Annex F.2: Developmental and Functional Assessment (Tranche 2)

Annex F.3: Rehabilitation Therapy

Annex G : Z Satisfaction Questionnaire

Annex H : Certificate from Medical Specialist/s and Rehabilitation Therapist/s for Assessment and Recommendations

Annex I : General Process Flow for the Provision of Care for a Child with Neurodevelopmental Disorder or Developmental Impairments and Disability

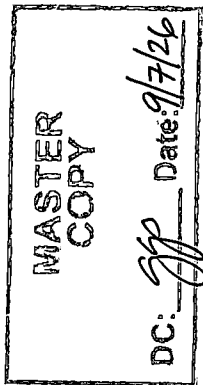
Annex J : Sample Claim Form 2

VI. PENALTY CLAUSE

Any violation of this PhilHealth Circular shall be dealt with and penalized in accordance with pertinent provisions of R.A. No. 7875, as amended by R.A. Nos. 9241 and 10606 (National Health Insurance Act of 2013), R.A. No. 11223 (Universal Health Care Act), and their respective Implementing Rules and Regulations, including the PhilHealth Rules on Administrative Cases (PROAC).

VII. TRANSITORY CLAUSE

A. Upon publication of this PhilHealth Circular, PhilHealth shall disseminate information to contracted HFs, ensure the availability of forms specified in this policy on the PhilHealth website, and implement the necessary enhancements in the claims system.



- B. While the necessary system is being developed, the contracted HFs shall submit the claims manually. PhilHealth shall issue a corresponding advisory to inform the health facilities once the benefits package is fully integrated into the system.*
- C. The contracted HFs may submit a new pre-authorization checklist and request form to the concerned PRO or LHIO for all patients enrolled in this benefit package.*
- D. Submission and processing of claims with an approved pre-authorization prior to the effectivity of this PhilHealth Circular shall follow the rules prescribed in PC No. 2017-0029 titled "Z Benefits for Children with Developmental Disabilities."*
- E. All pre-authorization requests that were received by the PROs upon effectivity of this PhilHealth Circular shall follow the rules on patient enrollment and benefits availment as stated in this policy.*
- F. All contracted health facilities with an existing contract under the Z Benefits for Children with Developmental Disability shall remain eligible to provide the services under this policy while their contracts are pending for amendment/revision.*
- G. The contracted HF is eligible to implement the existing terms of copayment rate, provided that it is consistent with the provision of this policy.*

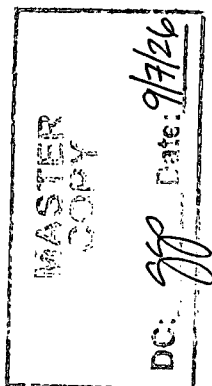
VIII. SEPARABILITY CLAUSE

In the event that any part or provision of this PhilHealth Circular is declared unauthorized or invalid by any Court of Law or competent authority, those provisions not affected by such declaration shall remain valid and effective.

IX. REPEALING CLAUSE

This PhilHealth Circular amends PhilHealth Circular No. 2017 - 0029 titled "Z Benefits for Children with Developmental Disabilities".

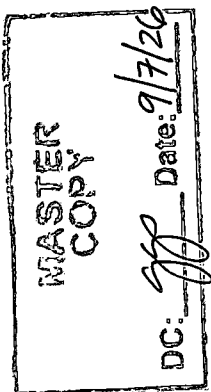
All other PhilHealth Circulars, issuances, rules, and regulations or parts thereof that are contrary to and inconsistent with this PhilHealth Circular are hereby repealed, amended, or modified accordingly.



X. DATE OF EFFECTIVITY

This PhilHealth Circular shall take effect immediately upon publication in the Official Gazette or any newspaper of general circulation. Three (3) certified true copies shall be filed with the Office of the National Administrative Register (ONAR) of the University of the Philippines Law Center.


BEVERLY LORRAINE C. HO, MD, MPH
Acting President and Chief Executive Officer
Date signed: 9/3/26



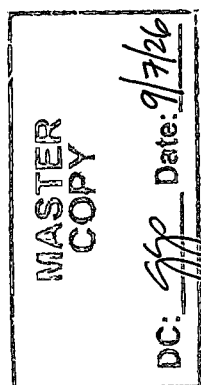
Annex A: Supplemental Rules in Accrediting and Contracting Health facilities for the Z Benefits Package for Children with Developmental Impairments and Disabilities



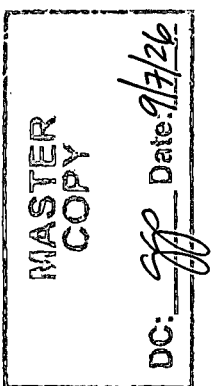
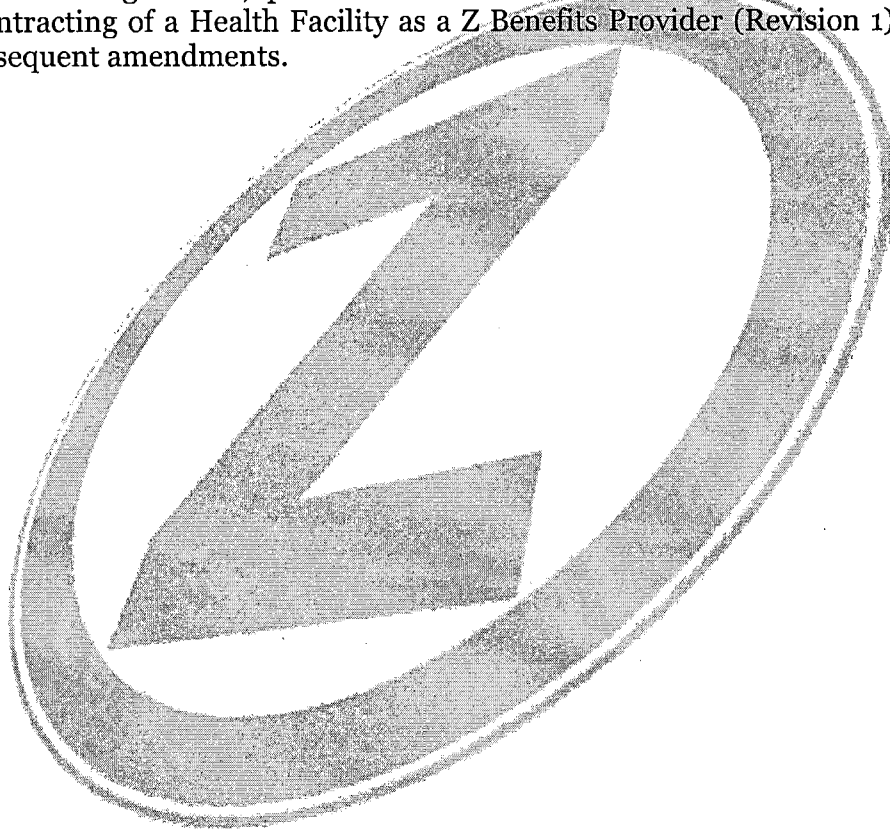
Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial X teamphilhealth

Supplementary Rules in Accrediting and Contracting Health Facilities

1. PhilHealth shall contract qualified accredited HFs to offer the services under the Z Benefits for Children with Developmental Impairments and Disabilities. These contracted HFs are required to provide the offered services of the benefits package to qualified patients.
2. The HF should have the following medical specialists and allied health professionals to provide the services under the Z Benefits for children with developmental impairments and disabilities:
 - a. Any of the following Medical Specialists:
 - a.1. Physical Medicine and Rehabilitation Specialist/ Physiatrist;
 - a.2. Neurodevelopmental Pediatrician;
 - a.3. Developmental and Behavioral Pediatrician;
 - a.4. Pediatric Neurologist;
 - a.5. Child and Adolescent Psychiatrist.
 - b. Any of the following allied health professionals:
 - b.1. Physical Therapist;
 - b.2. Occupational Therapist;
 - b.3. Speech and Language Pathologist or Speech Therapist;
 - b.4. Child Psychologist.
3. The contract shall contain the terms and conditions agreed upon by PhilHealth and the accredited HFs. In cases of copayment, the contracted HF shall not charge the patient more than the agreed copayment at the point of service.
4. The accredited HFs shall submit co-payment proposals to PhilHealth. They shall identify amenities, the choice of an accredited physician within the MDT, specialist fees for private patients, or any perceived additional services not included in the benefits package, or upgrades of services chargeable to patients at the point of service. In cases of cost variance, the contracted HFs shall provide the necessary information to support the co-payment proposal or adjustment to the existing rates.
5. PhilHealth shall negotiate the proposed rates of the health services considered for inclusion in the co-payment arrangement submitted by the accredited HFs.
6. PhilHealth shall examine the co-payment proposal of the accredited HFs if these services are necessary for the patient's care but are not included in the identified essential health services.



7. The prescribed HF Standards of Providers for Children with Developmental Impairments and Disabilities shall be provided in a separate issuance and can be accessed on the PhilHealth official website.
8. For further guidance, please refer to PhilHealth Circular No. 2022-0012 "Contracting of a Health Facility as a Z Benefits Provider (Revision 1)" or its subsequent amendments.



Annex B: Pre-authorization Checklist and Request for Children with Developmental Impairment or Disabilities



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 (02) 8662-2588 www.philhealth.gov.ph
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Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number - -	
B. MEMBER	☐ Same as patient (Answer the following only if the patient is a dependent)	
	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number - -	

Fulfilled selections criteria ☐ **Yes** If yes, proceed to pre-authorization application
 ☐ **No** If no, specify reason/s and encode _____

PRE-AUTHORIZATION CHECKLIST Z BENEFITS FOR CHILDREN WITH DEVELOPMENTAL IMPAIRMENT OR DISABILITIES

Place a (✓) if yes or as applicable

	General Qualifications	Status
1.	The child's chronological age is 0 to 17 years and 364 days old	
2.	The child presents with functional problems secondary to delays, regressions, or deviations in <u>any</u> one of the following developmental domains:	☐ <i>Mental</i> ☐ <i>Intellectual</i> ☐ <i>Learning</i> ☐ <i>Language and Communication</i> ☐ <i>Physical</i>
3.	The child was assessed by <u>any</u> or both of the following medical specialists:	☐ Physical Medicine and Rehabilitation Specialist/Physiatrist ☐ Neurodevelopmental Pediatrician ☐ Developmental and Behavioral Pediatrician ☐ <i>Pediatric Neurologist</i> ☐ <i>Child and Adolescent Psychiatrist</i>

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Place a (✓) on the appropriate box/es for the appropriate assessment/s or evaluation/s that will be given to the child:

- ☐ Speech Therapy Assessment
- ☐ Occupational Therapy Assessment
- ☐ Physical Therapy Assessment
- ☐ *Psychological Assessment*

Conforme by Patient/Parent/Guardian:

Attested by Attending Medical Specialist

Printed name and signature

Printed name and signature

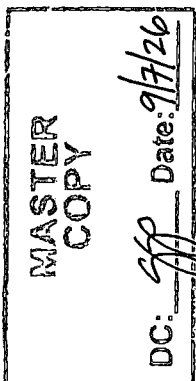
PhilHealth
Accreditation No.

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Note:

Once approved, the contracted hospital shall print the approved pre-authorization form and have this signed by the patient, parent or guardian and health care providers, as applicable. This form shall be submitted to the Local Health Insurance Office (LHIO) or the PhilHealth Regional Office (PRO) when filing the first tranche.

There is no need to attach laboratory results. However, these should be included in the patient's chart and may be checked during the field monitoring of the Z Benefits. Please do not leave any item blank.



Annex B: Pre-authorization Checklist and Request for Children with Developmental Impairment or Disabilities



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PRE-AUTHORIZATION REQUEST Z BENEFITS FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z benefit package for _____ in _____
 (Patient's last, first, suffix, middle name) (Name of HF)
 under the terms and conditions as agreed for availment of the Z Benefit Package.

The patient is aware of the PhilHealth policy on copayment and agreed to avail of the benefit package (please tick appropriate box):

- ☐ Without copayment
☐ With copayment, for the purpose of: _____

Certified correct by:

Certified correct by:

(Printed name and signature)
 Attending Medical Specialist

(Printed name and signature)
 Executive Director/Chief of Hospital/
 Medical Director/ Medical Center Chief/
 Head of Health Facility

PhilHealth
 Accreditation
 No.

PhilHealth
 Accreditation
 No.

Conforme by:

(Printed name and signature)
 Patient/Parent/Guardian

(For PhilHealth Use Only)

- ☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

(Printed name and signature)

Head or authorized representative, Benefits Administration Section (BAS)

INITIAL APPLICATION			COMPLIANCE TO REQUIREMENTS		
Activity	Initial	Date			
Received by LHIO/BAS:			☐ APPROVED ☐ DISAPPROVED (State reason/s) _____ (Printed name and signature) Head or authorized BAS representative		
Endorsed to BAS (if received by LHIO):					
☐ Approved ☐ Disapproved					
Released to HF:			Activity	Initial	Date
This pre-authorization is valid for one (1) fiscal year from date of approval of request.			Received by BAS:		
			☐ Approved ☐ Disapproved		
			Released to HF:		



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Annex C: Member Empowerment (ME Form)



Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

Citystate Centre, 709 Shaw Boulevard, Pasig City

(02) 8662-2588 www.philhealth.gov.ph

PhilHealthOfficial teamphilhealth

Numero ng kaso: _____
Case No.

MEMBER EMPOWERMENT FORM

Magpaalám, tumulong, at magbigay kapangyarihan
Inform, Support & Empower

Mga Panuto: Instructions:

Ipaliliwanag at tutulungan ng kinatawan ng ospital ang pasyente sa pagsasagot ng ME form.

The health care provider shall explain and assist the patient in filling-up the ME form.

Isulat nang maayos at malinaw ang mga impormasyon na kinakailangan.

Legibly print all information provided.

Para sa mga katanungang nangangailangan ng sagot na "oo" o "hindi", lagyan ng marka () ang angkop na kahon.

For items requiring a "yes" or "no" response, tick appropriately with a check mark ().

Gumamit ng karagdagang papel kung kinakailangan. Lagyan ito ng kaukulang marka at ilakip ito sa ME form.

Use additional blank sheets if necessary, label properly and attach securely to this ME form.

Ang kinontratang ospital na magkakaloob ng dalubhasang pangangalaga sa pagpaparami ng kopya ng ME Form.

The ME form shall be reproduced by the contracted health facility (HF) providing specialized care.

Dalawang kopya ng ME form ang kailangang ibigay ng kinontratang ospital. Ang mga kopyang nabanggit ay ilalaan para sa pasyente at sa ospital.

Duplicate copies of the ME form shall be made available by the contracted HF—one for the patient and one as file copy of the contracted HF providing the specialized care.

Para sa mga pasyenteng gagamit ng Z Benefit for Mobility Orthoses Rehabilitation Prosthesis Help (ZMORPH), ukol sa pagpapalit ng artipisyal na ibabang bahagi ng hita at binti, o Z Benefits para sa mga batang may kapansanan, isulat ang N/A sa tala B2, B3 at D6. Para naman sa Peritoneal Dialysis (PD) First Z Benefits, isulat ang N/A para sa tala B2 at B3.

For patients availing of the Z Mobility Orthoses Rehabilitation Prosthesis Help (ZMORPH) for fitting of the external lower limb prosthesis, or Z Benefits for children with disabilities, write N/A for items B2, B3 and D6 and for PD First Z Benefits, write N/A for items B2 and B3.

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PANGALAN NG OSPITAL
HEALTH FACILITY (HF)

ADRES NG OSPITAL
ADDRESS OF HF



A. Impormasyon ng Miyembro/ Pasyente**A. Member/Patient Information**

PASYENTE (Apelyido, Pangalan, Panggitnang Apelyido, Karagdagan sa Pangalan)

PATIENT (Last name, First name, Middle name, Suffix)

NUMERO NG PHILHEALTH ID NG PASYENTE - -

PHILHEALTH ID NUMBER OF PATIENT

MIYEMBRO (kung ang pasyente ay kalipikadong makikinabang) (Apelyido, Pangalan, Panggitnang Apelyido, Karagdagan sa Pangalan)

MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)

NUMERO NG PHILHEALTH ID NG MIYEMBRO - -

PHILHEALTH ID NUMBER OF MEMBER

PERMANENTENG TIRAHAN

PERMANENT ADDRESS

Petsa ng Kapanganakan (Buwan/Araw/Taon)
Birthday (mm/dd/yyyy)Edad
AgeKasarian
SexNumero ng Telepono
Telephone NumberNumero ng Cellphone
Mobile NumberEmail Address
Email AddressKategorya bilang Miyembro:
Membership Category:Direct contributor
Direct contributor

- ☐ Empleado ng pribadong sektor
Employed private
- ☐ Empleado ng gobyerno
Employed government
- ☐ May sariling pinagkakakitaan
Self-earning
- ☐ Indibidwal
Individual
- ☐ Sole proprietor
Sole proprietor
- ☐ Group enrollment scheme
Group enrollment scheme

- ☐ Kasambahay / Household Help
- ☐ Tagamaneho ng Pamilya/ Family driver
- ☐ Filipinong Manggagawa sa ibang bansa
Migrant Worker/OFW
- ☐ Land-based ☐ Sea-based
Land-based Sea-based
- ☐ Habambuhay na kaanib/ Lifetime Member
- ☐ Filipino na may dalawang
pagkamamamayan/Nakatira sa ibang bansa
Filipino with Dual Citizenship/Living abroad
- ☐ Foreign national/Foreign national

Indirect contributor
Indirect contributor

- ☐ Listahanan
Listahanan
- ☐ 4Ps/MCCT
4Ps /MCCT
- ☐ Nakatatandang mamamayan
Senior Citizen (RA 10645)
- ☐ PAMANA
PAMANA
- ☐ KIA/KIPO
KIA/KIPO
- ☐ Bangsamoro/Normalization

- ☐ Inisponsuran ng LGU
LGU-sponsored
- ☐ Inisponsuran ng NGA
NGA-sponsored
- ☐ Inisponsuran ng pribadong sektor
Private-sponsored
- ☐ Taong may kapansanan
Person with disability

Iba pa
Others☐ Point of Service (POS) Financially IncapableMASTER
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B. Impormasyong Klinikal**B. Clinical Information**

1. Paglalarawan ng kondisyon ng pasyente <i>Description of condition</i>	
2. Napagkasunduang angkop na plano ng gamutan sa ospital <i>Applicable Treatment Plan agreed upon with healthcare provider</i>	
3. Napagkasunduang angkop na alternatibong plano ng gamutan sa ospital <i>Applicable alternative Treatment Plan agreed upon with health care provider</i>	

C. Talatakdaan ng Gamutan at Kasunod na Konsultasyon**C. Treatment Schedule and Follow-up Visit/s**

1. Petsa ng unang pagkakaospital o konsultasyon ^a (buwan/araw/taon) <i>Date of initial admission to HF or consult ^a (mm/dd/yyyy)</i> ^a Para sa ZMORPH/ mga batang may kapansanan, ito ay tumutukoy sa pagkonsulta para sa rehabilitasyon ng external lower limb pre-prosthesis/ device. Para naman sa PD First, ito ay ang petsa ng konsultasyon o pagdalaw sa PD provider bago magsimula ang unang PD exchange. ^a For ZMORPH/children with disabilities (CWDs), this refers to the consult prior to the provision of the device and/or rehabilitation. For PD First, this refers to the date of medical consultation or visit to the PD Provider prior to the start of the first PD exchange.	
2. Pansamantalang Petsa ng susunod na pagpapa-ospital o konsultasyon ^b (buwan/araw/taon) <i>Tentative Date/s of succeeding admission to HF or consult ^b (mm/dd/yyyy)</i> ^b Para sa ZMORPH/ mga batang may kapansanan, ito ay petsa ng paglalapat at pagsasaayos ng device. Para naman sa PD First, ito ay ang kasunod na pagbisita sa PD Provider. ^b For ZMORPH/CWDS, this refers to the measurement, fitting and adjustments of the device. For the PD First, this refers to the next visit to the PD Provider.	
3. Pansamantalang Petsa ng kasunod na pagbisita ^c (buwan/araw/taon) <i>Tentative Date/s of follow-up visit/s ^c (mm/dd/yyyy)</i> ^c Para sa ZMORPH/ mga batang may kapansanan, ito ay tumutukoy sa rehabilitasyon ng external lower limb post-prosthesis.	

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9/7/26

DC: [Signature]

^c For ZMORPH/CWD, this refers to the external lower limb post-prosthesis rehabilitation consult.

D. Edukasyon ng Miyembro D. Member Education

Lagyan ng tsek (✓) ang angkop na sagot o NA kung hindi nauukol <i>Put a check mark (✓) on the appropriate answer or NA if not applicable.</i>	OO YES	HINDI NO
1. Ipinaliwanag ng kinatawan ng ospital ang uri ng aking karamdaman. <i>My health care provider explained the nature of my condition/disability.</i>		
2. Ipinaliwanag ng kinatawan ng ospital ang mga pagpipiliang paraan ng gamutan/interbensyon ^d <i>My healthcare provider explained the treatment options/intervention^d.</i> ^d Para sa ZMORPH, ito ay ukol sa pangangailangan ng pagbibigay at rehabilitasyon para sa pre at post-device. ^d For ZMORPH, this refers to the need for pre- and post-device provision and rehabilitation.		
3. Ipinaliwanag ng kinatawan ng ospital ang mga posibleng mga epekto/masamang epekto ng gamutan/ interbensyon. <i>The possible side effects/adverse effects of treatment/intervention were explained to me.</i>		
4. Ipinaliwanag ng kinatawan ng ospital ang kailangang serbisyo para sa gamutan ng aking karamdaman/ interbensyon. <i>My health care provider explained the mandatory services and other services required for the treatment of my condition/intervention.</i>		
5. Lubos akong nasiyahan sa paliwanag na ibinigay ng ospital. <i>I am satisfied with the explanation given to me by my health care provider</i>		
6. Naibigay sa akin nang buo ang impormasyon na ako ay mahusay na aalagaan ng mga dalubhasang doktor sa aking piniling kinontratang ospital ng PhilHealth at kung gustuhin ko mang lumipat ng ospital ay hindi ito maka-aapekto sa aking pagpapagamot. <i>I have been fully informed that I will be cared for by all the pertinent medical and allied specialties, as needed, present in the PhilHealth contracted HF of my choice and that preferring another contracted HF for the said specialized care will not affect my treatment in any way.</i>		
7. Ipinaliwanag ng kinatawan ng ospital ang kahalagahan ng pagsunod sa panukalang gamutan/interbensyon. Kasama rito ang pagkompleto ng gamutan/interbensyon sa unang ospital kung saan nasimulan ang aking gamutan/interbensyon. <i>My health care provider explained the importance of adhering to my treatment plan/intervention. This includes completing the course of treatment/intervention in the contracted HF where my treatment/intervention was initiated.</i> Paalala: Ang hindi pagsunod ng pasyente sa napagkasunduang gamutan/interbensyon sa ospital ay maaaring magresulta sa hindi pagbabayad ng mga kasunod na claims at hindi dapat itong ipasa bilang case rates. <i>Note: Non-adherence of the patient to the agreed treatment plan/intervention in the HF may result in denial of filed claims for the succeeding tranches and which should not be filed as case rates.</i>		

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nc. *off* Date: 9/7/26

Lagyan ng tsek (✓) ang angkop na sagot o NA kung hindi nauukol Put a check mark(✓) on the appropriate answer or NA if not applicable.	OO YES	HINDI NO
8. Binigyan ako ng ospital ng talaan ng mga susunod kong pagbisita. <i>My health care provider gave me the schedule/s of my follow-up visit/s.</i>		
9. Ipinaalam sa akin ng ospital ang impormasyon tungkol sa maaari kong hingan ng tulong pinansiyal o ibang pang suporta, kung kinakailangan. a. Sangay ng pamahalaan (Hal.: PCSO, PMS, LGU, etc.) b. Civil society o non-government organization c. Patient Support Group d. Corporate Foundation e. Iba pa (Hal. Media, Religious Group, Politician, etc.) <i>My health care provider gave me information where to go for financial and other means of support, when needed.</i> a. Government agency (ex. PCSO, PMS, LGU, etc.) b. Civil society or non-government organization c. Patient Support Group d. Corporate Foundation e. Others (ex. Media, Religious Group, Politician, etc.)		
10. Nabigyan ako ng kopya ng listahan ng mga kinontratang ospital para sa karampatang paggagamot ng aking kondisyon o karamdaman. <i>I have been furnished by my health care provider with a list of other contracted HFs for the specialized care of my condition.</i>		
11. Nabigyan ako ng sapat na kaalaman hinggil sa benepisyo at tuntunin ng PhilHealth sa pagpapa-miyembro at paggamit ng benepisyong naaayon sa Z benefits: <i>I have been fully informed by my health care provider of the PhilHealth membership policies and benefit availment on the Z Benefits:</i> a. Kaalipikado ako sa mga itinakdang batayan para sa aking kondisyon/kapansanan. <i>I fulfill all selections criteria for my condition/disability.</i>		
b. Ipinaliwanag sa akin ang polisiya hinggil sa "No Balance Billing" (NBB) <i>The "no balance billing" (NBB) policy was explained to me.</i> Paalala: Ang polisiya ng NBB ay maaaring makamit ng mga sumusunod na miyembro at kanilang kalipikadong makikinabang kapag na-admit sa ward ng ospital: inisponsuran, maralita, kasambahay, senior citizens at miyembro ng iGroup na may kaukulang Group Policy Contract (GPC). <i>Note: NBB policy is applicable to the following members when admitted in ward accommodation: sponsored, indigent, household help, senior citizens and iGroup members with valid Group Policy Contract (GPC) and their qualified dependents.</i>		
Para sa inisponsuran, maralita, kasambahay, senior citizens at miyembro ng iGroup na may kaukulang Group Policy Contract (GPC) at kanilang kwalipikadong makikinabang, sagutan ang c, d at e.		

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For sponsored, indigent, household help, senior citizens and iGroup members with valid GPC and their qualified dependents, answer c, d and e.

c. Nauunawaan ko na sakaling hindi ako gumamit ng NBB ay maaari akong magkaroon ng kaukulang gastos na aking babayaran.
I understand that I may choose not to avail of the NBB and may be charged out of pocket expenses

d. Sakaling ako ay nagpalipat sa mas magandang kuwarto ayon sa aking kagustuhan o tumanggap ng karagdagang serbisyo na hindi kasama sa benepisyo, nauunawaan ko na hindi na ako maaaring humiling sa pagamutan para makagamit ng pribilehiyong ibinibigay sa mga pasyente na NBB (kapag NBB, wala nang babayaran pa pagkalabas ng pagamutan)

In case I choose to upgrade my room accommodation or avail of additional services that are not included in the benefit package, I understand that I can no longer demand the hospital to grant me the privilege given to NBB patients (that is, no out of pocket payment upon discharge from the hospital)

e. Ninanais ko na lumabas sa polisiyang NBB ang PhilHealth at dahil dito, babayaran ko ang anumang halaga na hindi sakop ng benepisyo sa PhilHealth
I opt out of the NBB policy of PhilHealth and I am willing to pay on top of my PhilHealth benefits

f. Pumapayag akong magbayad ng hanggang sa halagang PHP _____ * para sa:
*I agree to pay as much as PHP _____ * for the following:*

☐ Paglipat ko sa mas magandang kuwarto, o

I choose to upgrade my room accommodation, or
☐ anumang karagdagang serbisyo, tukuyin

additional services, specify

* Ito ay tinantiyang halaga lamang na gagabay sa pasyente kung magkano ang kanyang babayaran at hindi dapat gawing batayan para sa pagtutuos ng kuwenta ng nagugol na gastusin sa pagkakaospital na babayaran ng PhilHealth.

This is an estimated amount that guides the patient on how much the out of pocket may be and should not be a basis for auditing claims reimbursement.

Para sa Z Benefits Package ng Breast Cancer, ang halaga ng babayaran ng pasyente ay base lamang sa yugto ng paggamot batay sa plano ng gamutan ng MDT. Walang dagdag bayad para sa benepisyo ng targeted therapy.

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<i>For the Z Benefits Package for Breast Cancer, the co-payment of the patient shall be based per treatment phase in accordance with the agreed treatment plan of the MDT. No-copayment shall be applicable for benefits under targeted therapy.</i>		
Ang mga sumusunod na katanungan ay para sa mga miyembro ng formal at informal economy at kanilang mga kwalipikadong benepisyaryo <i>The following are applicable to formal and informal economy and their qualified dependents</i> g. Naiintindihan ko na maaari akong magkaroon ng babayaran para sa halagang hindi sakop ng benepisyo sa PhilHealth. <i>I understand that there may be an additional payment on top of my PhilHealth benefits.</i> h. Pumapayag akong magbayad ng hanggang sa halagang PHP _____ * para sa aking gamutan na hindi sakop ng benepisyo ng PhilHealth. <i>I agree to pay as much as PHP _____ * as additional payment on top of my PhilHealth benefits.</i> * Ito ay tinantiyang halaga lamang na gagabay sa pasyente kung magkano ang kanyang babayaran at hindi dapat gawing batayan para sa pagtutuos ng kuwenta ng nagugol na gastusin sa pagkakaospital na babayaran ng PhilHealth. <i>This is an estimated amount that guides the patient on how much the out of pocket may be and should not be a basis for auditing claims reimbursement.</i> * Para sa Z Benefits Package ng Breast Cancer, ang halaga ng babayaran ng pasyente ay base lamang sa yugto ng paggamot batay sa plano ng gamutan ng MDT. Walang dagdag bayad para sa benepisyo ng targeted therapy. <i>For the Z Benefits Package for Breast Cancer, the co-payment of the patient shall be based per treatment phase in accordance with the agreed treatment plan of the MDT. No-copayment shall be applicable for benefits under targeted therapy.</i>		

E. Tungkulin at Responsabilidad ng Miyembro

E. Member Roles and Responsibilities

Lagyan ng (✓) ang angkop na sagot o NA kung hindi nauukol <i>Put a (✓) on the appropriate answer or NA if not applicable.</i>	OO YES	HINDI NO
1. Nauunawaan ko ang aking tungkulin upang masunod ang nararapat at nakatakda kong gamutan. <i>I understand that I am responsible for adhering to my treatment schedule.</i>		
2. Nauunawaan ko na ang pagsunod sa itinakdang gamutan ay mahalaga tungo sa aking paggaling at pangunahing kailangan upang magamit ko nang buo ang Z benefits. <i>I understand that adherence to my treatment schedule is important in terms of clinical outcomes and a pre-requisite to the full entitlement of the Z benefits.</i>		

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3. Nauunawaan ko na tungkulin kong sumunod sa mga polisiya at patakaran ng PhilHealth at ospital upang magamit ang buong Z benefit package. Kung sakali na hindi ako makasunod sa mga polisiya at patakaran ng PhilHealth at ospital, tinatalikuran ko ang aking pribilehiyong makagamit ng Z benefits. <i>I understand that it is my responsibility to follow and comply with all the policies and procedures of PhilHealth and the health care provider in order to avail of the full Z benefit package. In the event that I fail to comply with policies and procedures of PhilHealth and the health care provider, I waive the privilege of availing the Z benefits.</i>		
--	--	--

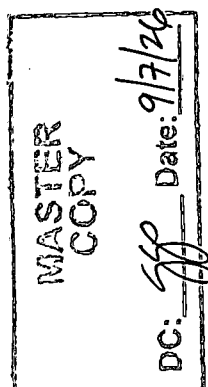
F. Pangalan, Lagda, Thumb Print at Petsa F. Printed Name, Signature, Thumb Print and Date		
Pangalan at Lagda ng pasyente: * <i>Printed name and signature of patient*</i> *Para sa mga menor de edad, ang magulang o tagapag-alaga ang pipirma o maglalagay ng thumb print sa ngalan ng pasyente. *For minors, the parent or guardian affixes their signature or thumb print here on behalf of the patient.	Thumb Print (kung hindi makakasulat ang pasyente) <i>(if patient is unable to write)</i>	Petsa (buwan/ araw/ taon)
Pangalan at lagda ng nangangalagang Doktor: <i>Printed name and signature of Attending Doctor</i>		Petsa (buwan/araw/taon) Date (mm/dd/yyyy)
Mga Saksi: <i>Witnesses:</i>		
Pangalan at lagda ng kinatawan ng ospital: <i>Printed name and signature of HF staff member</i>		Petsa (buwan/araw/taon) Date (mm/dd/yyyy)
Pangalan at lagda ng asawa/ magulang / pinakamalapit na kamag-anak/awtorisadong kinatawan <i>Printed name and signature of spouse/ parent/ next of kin /authorized guardian or representative</i> ☐ walang kasama/ no companion		Petsa (buwan/araw/taon) Date (mm/dd/yyyy)
G. Detalye ng Tagapag-ugnay ng PhilHealth para sa Z benefits G. PhilHealth Z Coordinator Contact Details		
Pangalan ng Tagapag-ugnay ng PhilHealth para sa Z benefits na nakatalaga sa ospital <i>Name of PhilHealth Z Coordinator assigned at the HF</i>		
Numero ng Telepono <i>Telephone number</i>	Numero ng CellPhone <i>Mobile number</i>	Email Address

H. Numerong maaaring tawagan sa PhilHealth H. PhilHealth Contact Details	
Opisinang Panrehiyon ng PhilHealth _____ PhilHealth Regional Office No. _____ Numero ng telepono _____ Hotline Nos. _____	

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I. Pahintulot sa pagsusuri sa talaan ng pasyente I. Consent to access patient record		J. Pahintulot na mailagay ang medical data sa Z benefit information and tracking system (ZBITS) J. Consent to enter medical data in the Z benefit information & tracking system (ZBITS)	
Ako ay pumapayag na suriin ng PhilHealth ang aking talaang medikal upang mapatunayan ang katotohanan ng Z-claim <i>I consent to the examination by PhilHealth of my medical records for the sole purpose of verifying the veracity of the Z-claim</i>		Ako ay pumapayag na mailagay ang aking impormasyong medikal sa ZBITS na kailangan sa Z benefits. Pinahihintulutan ko din ang PhilHealth na maipaalam ang aking personal na impormasyong pangkalusugan sa mga kinontratang ospital. <i>I consent to have my medical data entered electronically in the ZBITS as a requirement for the Z Benefits. I authorize PhilHealth to disclose my personal health information to its contracted partners</i>	
Ako ay nagpapatunay na walang pananagutan ang PhilHealth o sinumang opisyal, empleyado o kinatawan mula sa pahintulot na nakasaad sa itaas sapagkat kusang-loob ko itong ibinigay upang makagamit ng Z benefits ng PhilHealth. <i>I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with the Z claim for reimbursement before PhilHealth.</i>			
Buong pangalan at lagda ng pasyente* <i>Printed name and signature of patient*</i> * Para sa mga menor de edad, ang magulang o tagapag-alaga ang pipirma o maglalagay ng thumb print sa ngalan ng pasyente. * For minors, the parent or guardian affixes their signature or thumb print here on behalf of the patient.		Thumb print (Kung hindi na makasusulat) (if patient is unable to write)	Petsa (buwan/araw/taon) Date (mm/dd/yyyy)
Buong pangalan at lagda ng kumakatawan sa pasyente <i>Printed name and signature of patient's representative</i> ☐ walang kasama/ no companion		Petsa (buwan/araw/taon) Date (mm/dd/yyyy)	
Relasyon ng kumakatawan sa pasyente (Lagyan ng tsek ang angkop na kahon) <i>Relationship of representative to patient (tick appropriate box)</i> ☐ asawa ☐ magulang ☐ anak ☐ kapatid ☐ tagapag-alaga ☐ walang kasama <i>spouse parent child next of kin guardian no companion</i>			





Annex D: Transmittal Form

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
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TRANSMITTAL FORM

NAME OF CONTRACTED HEALTH FACILITY	ADDRESS OF HF
------------------------------------	---------------

Instructions for filling out this Transmittal Form. Use additional sheets if necessary.

1. Use CAPITAL letters or UPPER CASE letters in filling out the form.
2. For the period of confinement, follow the format (mm/dd/yyyy).
3. For the Z Benefits Package Code, indicate the code based on the services provided. Example: Zo3oA
- For the Case Number, copy the case number that is provided in the approved pre-authorization checklist and request.
- The Remarks column may include some relevant notes which pertain to the filed claim that need to be relayed to PhilHealth.

4.

MASTER COPY Date: 9/7/26 DC: JFF	Case Number	Name of Patient (Last, First, Middle Initial, Extension)	Period of Confinement		Z Benefits Package Code	Remarks
	Date admitted	Date discharged				
	1.					
	2.					
	3.					
	4.					
	5.					
	6.					
	7.					

Certified correct by authorized representative of the HF		For PhilHealth Use Only		Initials	Date
Printed Name and Signature	Designation	Received by Local Health Insurance Office (LHIO)			
	Date signed (mm/dd/yyyy)	Received by the Benefits Administration Section (BAS)			



E.1: Checklist of Mandatory Services –Developmental and Functional Assessment by Medical Specialist



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Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number - -	
B. MEMBER	☐ Same as patient (Answer the following only if the patient is a dependent)	
	1. Last Name, First Name, Suffix, Middle Name	
2. PhilHealth ID Number - -		

DEVELOPMENTAL AND FUNCTIONAL ASSESSMENT BY MEDICAL SPECIALIST

Place a (□) on the appropriate boxes

MANDATORY SERVICES	
MEDICAL ASSESSMENT	
Type of Assessment ☐ Initial ☐ Discharge	Assessment done by: ☐ Physical Medicine and Rehabilitation Specialist/ Physiatrist ☐ Neurodevelopmental Pediatrician ☐ Developmental and Behavioral Pediatrician ☐ Pediatric Neurologist ☐ Child and Adolescent Psychiatrist
Assessed using any of the standardized tests:	
☐ Developmental Assessments Specify: _____	☐ Functional Assessments Specify: _____
Date of Assessment (mm/dd/yyyy): _____	Date of Assessment (mm/dd/yyyy): _____

Certified correct by: (Printed name and signature) Attending <i>Medical Specialist</i>	Certified correct by: (Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief/ <i>Head of Health Facility</i>
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)



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E.2: Checklist of Mandatory Services –Developmental and Functional Assessment by Allied Health Professionals



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Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number - -	
B. MEMBER	☐ Same as patient (Answer the following only if the patient is a dependent)	
	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number - -	

DEVELOPMENTAL AND FUNCTIONAL ASSESSMENT BY ALLIED HEALTH PROFESSIONAL

Place a (✓) on the appropriate boxes

MANDATORY SERVICES	
REHABILITATION THERAPY/ALLIED HEALTH PROFESSIONAL ASSESSMENT	
Type of Assessment ☐ Initial ☐ Discharge	Assessment done by: ☐ Physical Therapist ☐ Occupational Therapist ☐ Speech and Language Pathologist or Speech Therapist ☐ Child Psychologist
Assessed using any of the following standardized tests:	
☐ Physical Therapist Specify: _____ Date of Assessment (mm/dd/yyyy): _____	☐ Occupational Therapist Specify: _____ Date of Assessment (mm/dd/yyyy): _____
☐ Speech and Language Pathologist or Speech Therapist Specify: _____ Date of Assessment (mm/dd/yyyy): _____	☐ Child Psychologist Specify: _____ Date of Assessment (mm/dd/yyyy): _____

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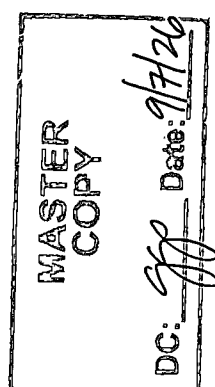
DC: Date: 9/7/26



HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number - -	
B. MEMBER	☐ Same as patient (Answer the following only if the patient is a dependent)	
	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number - -	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending <i>Medical Specialist</i>	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief/ <i>Head of Health Facility</i>
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)



Annex E.3.1: Checklist of Mandatory Services – Rehabilitation Therapy Services by Physical Therapy



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 PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number -	
B. MEMBER	☐ Same as patient (Answer the following only if the patient is a dependent)	
	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number -	

MANDATORY SERVICES

REHABILITATION THERAPY SERVICES BY PHYSICAL THERAPY ^{ab}

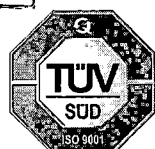
DATES OF REHABILITATION THERAPY (mm/dd/yyyy)	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

^aMaximum of 10 sessions per tranche from appropriate rehabilitation therapist/s based on assessment

^bRehabilitation therapy with less than 10 sessions on the last set of the therapies based on the plan shall be paid on a pro-rated basis.

Certified correct by:	Certified correct by:
(Printed name and signature) Attending <i>Medical Specialist</i>	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief/ <i>Head of Health Facility</i>
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)



Annex E.3.2: Checklist of Mandatory Services – Rehabilitation Therapy Services by Occupational Therapy



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Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number - - 	
B. MEMBER	☐ Same as patient (Answer the following only if the patient is a dependent)	
	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number - - 	

MANDATORY SERVICES
REHABILITATION THERAPY SERVICES BY OCCUPATIONAL THERAPY ^{a b}

DATES OF REHABILITATION THERAPY (mm/dd/yyyy)	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

^aMaximum of 10 sessions per tranche from appropriate rehabilitation therapist/s based on assessment

^bRehabilitation therapy with less than 10 sessions on the last set of the therapies based on the plan shall be paid on a pro-rated basis.

Certified correct by:	Certified correct by:
(Printed name and signature) Attending <i>Medical Specialist</i>	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief/ <i>Head of Health Facility</i>
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)



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Date: 9/7/26
 CC: [Signature]

Annex E.3.3: Checklist of Mandatory Services – Rehabilitation Therapy Services by Speech and Language Pathologist or Speech Therapist



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 PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number - -	
B. MEMBER	☐ Same as patient (Answer the following only if the patient is a dependent)	
	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number - -	

MANDATORY SERVICES

REHABILITATION THERAPY SERVICES BY SPEECH AND LANGUAGE PATHOLOGIST OR SPEECH THERAPIST^{a b}

DATES OF REHABILITATION THERAPY (mm/dd/yyyy)	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

^aMaximum of 10 sessions per tranche from appropriate rehabilitation therapist/s based on assessment

^bRehabilitation therapy with less than 10 sessions on the last set of the therapies based on the plan shall be paid on a pro-rated basis.

Certified correct by:		Certified correct by:	
(Printed name and signature) Attending <i>Medical Specialist</i>		(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief/ <i>Head of Health Facility</i>	
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)



Annex E.3.4: Checklist of Mandatory Services – Psychological Services



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Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number -	
B. MEMBER	☐ Same as patient (Answer the following only if the patient is a dependent)	
	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number -	

MANDATORY SERVICES
PSYCHOLOGICAL SERVICES ^{a b}

DATES OF REHABILITATION THERAPY (mm/dd/yyyy)	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

^aMaximum of 10 sessions per tranche from appropriate rehabilitation therapist/s based on assessment

^bRehabilitation therapy with less than 10 sessions on the last set of the therapies based on the plan shall be paid on a pro-rated basis.

Certified correct by: (Printed name and signature) Attending <i>Medical Specialist</i>	Certified correct by: (Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief/ <i>Head of Health Facility</i>
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)



Annex F.1: Checklist of Requirements for Reimbursement – Developmental and Functional Assessment (Tranche 1)



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Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number - -	
B. MEMBER	☐ Same as patient (Answer the following only if the patient is a dependent)	
	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number - -	

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex F.1)	
2. Photocopy of the approved Pre-authorization Checklist and Request Form (Annex B)	
3. Photocopy of completely accomplished ME Form (Annex C)	
4. Properly accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)	
5. Properly accomplished PhilHealth Claim Form 2	
6. Properly accomplished Checklist of Mandatory Services (Annex E.1 or E.2)	
7. Photocopy of completed Z Satisfaction Questionnaire (Annex G)	
8. Certificate of assessment and recommendations (Annex H)	
DATE COMPLETED:	
DATE FILED:	

Certified correct by: (Printed name and signature) Attending Medical Specialist PhilHealth Accreditation No. PhilHealth Accreditation No. Date signed (mm/dd/yyyy) Date signed (mm/dd/yyyy)	Certified correct by: (Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief/ Head of Health Facility 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



Annex F.1: Checklist of Requirements for Reimbursement – Developmental and Functional Assessment (Tranche 1)



Republic of the Philippines

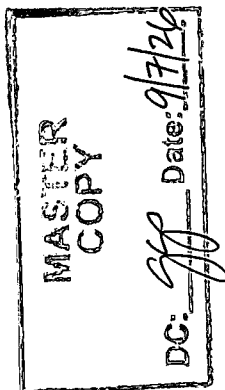
PHILIPPINE HEALTH INSURANCE CORPORATION

Citystate Centre, 709 Shaw Boulevard, Pasig City

(02) 8662-2588 www.philhealth.gov.ph

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Date signed (mm/dd/yyyy)



Annex F.2: Checklist of Requirements for Reimbursement – Developmental and Functional Assessment (Tranche 2)



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Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number - -	
B. MEMBER	☐ Same as patient (Answer the following only if the patient is a dependent)	
	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number - -	

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex F.2)	
2. Properly accomplished PhilHealth Claim Form 2	
3. Properly accomplished Checklist of Mandatory Services (Annex E.1 or E.2)	
4. Photocopy of completed Z Satisfaction Questionnaire (Annex G)	
DATE COMPLETED:	
DATE FILED:	

Certified correct by:										Certified correct by:									
(Printed name and signature) Attending <i>Medical Specialist</i>										(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief/ Head of <i>Health Facility</i>									
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)

MASTER COPY

DC: gfp Date: 9/7/26



Annex F.3: Checklist of Requirements for Reimbursement – Rehabilitation Therapy



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 📱 PhilHealthOfficial ✉ teamphilhealth

Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number -	
B. MEMBER	☐ Same as patient (Answer the following only if the patient is a dependent)	
	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number -	

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex F.3)	
2. Properly accomplished PhilHealth Claim Form 2	
3. Properly accomplished Checklist of Mandatory Services (Annexes E.3.1 - E.3.4)	☐ Physical Therapist ☐ Occupational Therapist ☐ Speech and Language Pathologist/ Speech Therapist ☐ Psychological Services
4. Photocopy of completed Z Satisfaction Questionnaire (Annex G)	
DATE COMPLETED:	
DATE FILED:	

Certified correct by: (Printed name and signature) Attending Medical Specialist	Certified correct by: (Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief/ Head of Health Facility
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

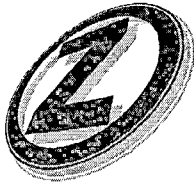
Date signed (mm/dd/yyyy)

MASTER COPY

DC: 9726 Date: 9/7/26



PhilHealth



Benefits

Share your opinion with us!

We would like to know how you feel about the services that pertain to the Z Benefit Package in order that we can improve and meet your needs. This survey will only take a few minutes. Please read the items carefully. If you need to clarify items or ask questions, you may approach your friendly health facility or you may contact PhilHealth call center at 8662-2588. Your responses will be kept confidential and anonymous.

For items 1 to 3, please tick on the appropriate box.

1. Z benefit package availed is for:

☐ Acute lymphoblastic leukemia	☐ Peritoneal dialysis
☐ Breast cancer	☐ Colorectal cancer
☐ Prostate cancer	☐ Prevention of preterm delivery
☐ Kidney transplantation	☐ Preterm and small baby
☐ Cervical cancer	☐ Children with developmental impairment and disability
☐ Coronary artery bypass surgery	☐ Children with mobility impairment
☐ Surgery for Tetralogy of Fallot	
☐ Orthopedic implants	☐ Children with visual disability
☐ Surgery for ventricular septal defect	☐ Children with hearing impairment
☐ ZMORPH/Expanded ZMORPH	☐ Heart valve repair and/or replacement
☐ Post kidney transplantation services	
2. Respondent's age is:
 - ☐ 19 years old & below
 - ☐ between 20 to 35
 - ☐ between 36 to 45
 - ☐ between 46 to 55
 - ☐ between 56 to 65
 - ☐ above 65 years old
3. Sex of respondent
 - ☐ male
 - ☐ female

For items 4 to 8, please select the one best response by ticking the appropriate box.

4. How would you rate the services received from the health facility (HF) in terms of availability of medicines or supplies needed for the treatment of your condition?
 - ☐ adequate
 - ☐ inadequate
 - ☐ don't know

MASTER
COPY

DC: *zff* Date: *9/7/26*

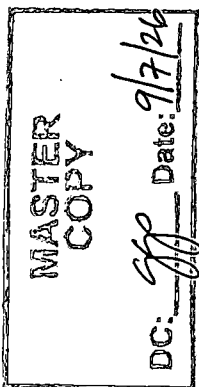


5. How would you rate the patient's or family's involvement in the care in terms of patient empowerment? (You may refer to your Member Empowerment Form)
- ☐ excellent
 - ☐ satisfactory
 - ☐ unsatisfactory
 - ☐ don't know
6. In general, how would you rate the health care professionals that provided the services for the Z benefit package in terms of doctor-patient relationship?
- ☐ excellent
 - ☐ satisfactory
 - ☐ unsatisfactory
 - ☐ don't know
7. In your opinion, by how much has your HF expenses been lessened by availing of the Z benefit package?
- ☐ less than half
 - ☐ by half
 - ☐ more than half
 - ☐ don't know
8. Overall patient satisfaction (PS mark) is:
- ☐ excellent
 - ☐ satisfactory
 - ☐ unsatisfactory
 - ☐ don't know
9. If you have other comments, please share them below:

Thank you. Your feedback is important to us!

Signature of Patient/ Parent/ Guardian

Date accomplished: _____



Annex H: Certificate from Medical Specialist/s and Rehabilitation Therapist/s and Recommendations



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Case No. _____

Last Name, First Name, Suffix, Middle Name	Age
Address	
Contact Number	

CERTIFICATE OF ASSESSMENT AND RECOMMENDATIONS

I. Nature of Client Visit:

☐ Initial consult/assessment

☐ Follow-up consult/assessment

Date of previous assessment: (mm/dd/yyyy) ____/____/____

Outcome of previous assessment (Please include standard test score if applicable):

II. Summary for Present Consult/Assessment

Date completed: (mm/dd/yyyy) ____/____/____

Nature of consult/assessment and standard test done, if applicable:

☐ Medical, Developmental Pediatrics

☐ Medical, Rehabilitation Medicine

☐ Medical, *Neurodevelopmental Pediatrics*

☐ Medical, *Pediatric Neurologist*

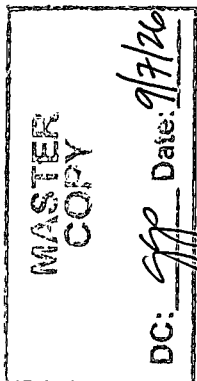
☐ Medical, *Child and Adolescent Psychiatrist*

☐ Physical therapy

☐ Occupational therapy

☐ Speech therapy

☐ Psychological Services



Assessment Results:

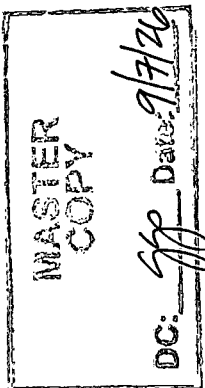
If applicable: Previous test score: _____ Current test score: _____

Assessment Summary:

1. Developmental *impairment and disability*
 - ☐ Mental
 - ☐ Intellectual
 - ☐ Learning
 - ☐ Speech, language and communication
 - ☐ Physical
2. Functional disability
 - ☐ Home care and management of children with disability (CWD)
 - ☐ Activities of daily living
 - ☐ Learning, applying knowledge &/or undertaking tasks
 - ☐ Domestic life, relationships and interactions
 - ☐ Mobility and safety
 - ☐ Education/employment/community/social and or civic life
 - ☐ Contextual (environmental and personal) barriers
3. Others: Please specify

III. Recommendation:

- ☐ Refer to medical specialist, please specify _____
- ☐ Refer to other services
 - ☐ SPED & other school systems
 - ☐ Psychological
 - ☐ Social service
 - ☐ Placement
 - ☐ Community-based rehabilitation service
 - ☐ Others, please specify _____
- ☐ For assessment/reassessment by a rehabilitation therapist
 - ☐ Physical therapist, specify number of sessions: _____
 - ☐ Speech therapist, specify number of sessions: _____
 - ☐ Occupational therapist, specify number of sessions: _____
- ☐ For temporary discharge with follow-up visit on: _____
- ☐ For final discharge
- ☐ Other Z Benefits for CWDs
 - ☐ Mobility
 - ☐ Visual
 - ☐ Hearing

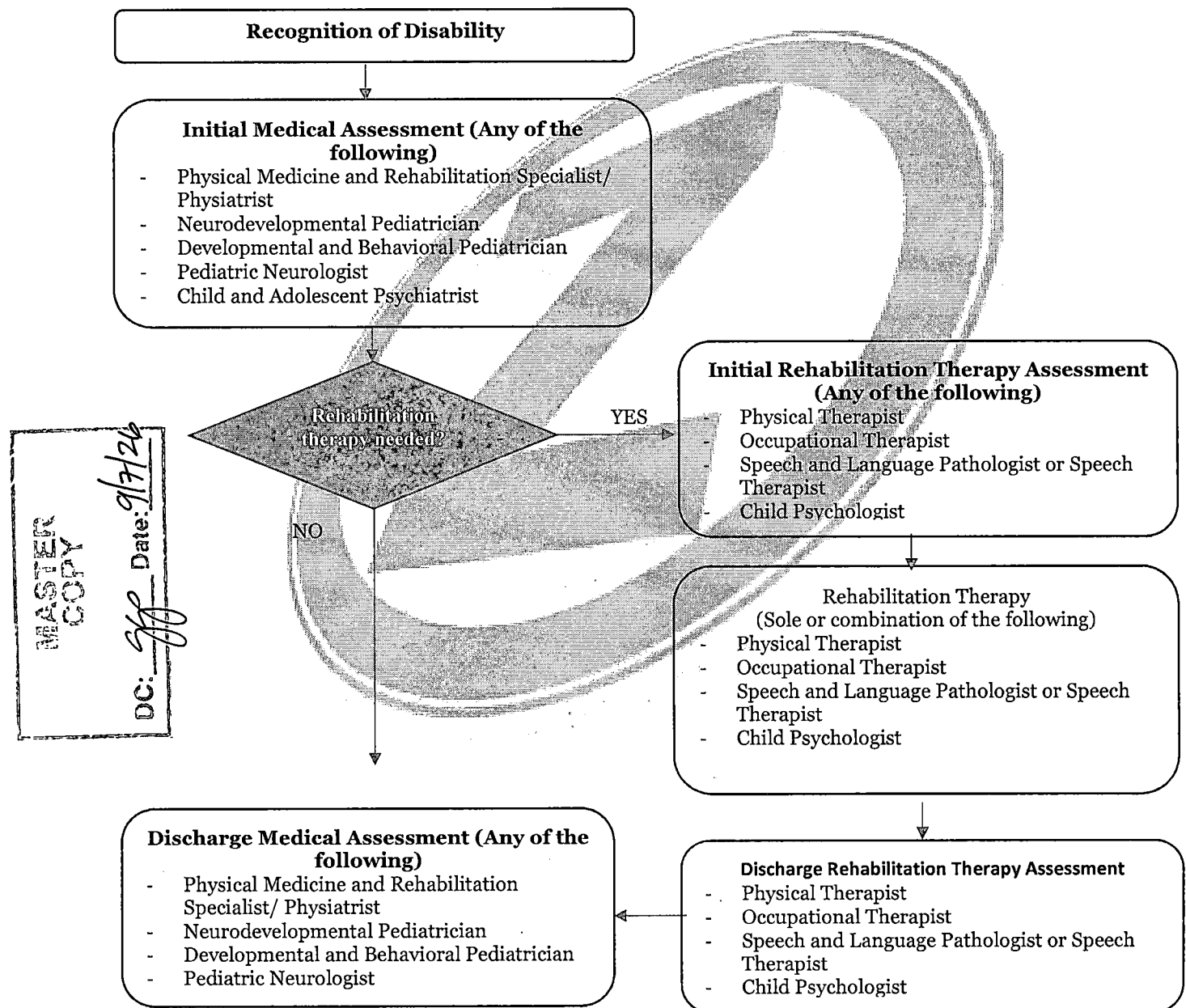


Annex I: Process Flow – General Process Flow for the Provision of Care for a Child with Neurodevelopmental Disorder or Developmental Impairments and Disability



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General Process Flow for the Provision of Care for a Child with Neurodevelopmental Disorder or *Developmental Impairment and Disability*



Annex J: Developmental Disability

SAMPLE CLAIM FORM 2 FOR DEVELOPMENTAL DISABILITY (TRANCHE 1)



This form may be reproduced and is NOT FOR SALE

CF2

(Claim Form 2)
revised November 2013

Series # _____

IMPORTANT REMINDERS:

PLEASE WRITE IN CAPITAL LETTERS AND CHECK THE APPROPRIATE BOXES.
This form together with other supporting documents should be filed within sixty (60) calendar days from date of discharge.
All information, fields and tick boxes required in this form are necessary. Claim forms with incomplete information shall not be processed.
FALSE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CRIMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.

PART I - HEALTH CARE INSTITUTION (HCI) INFORMATION

1. PhilHealth Accreditation Number (PAN) of Health Care Institution: H 9 3 0 0 5 9 4 3
2. Name of Health Care Institution: UNIVERSITY OF THE EAST RAMON MAGSAYSAY MEMORIAL MEDICAL CENTER
3. Address: 64 AURORA BLVD QUEZON CITY
Building Number and Street Name City/Municipality Province

PART II - PATIENT CONFINEMENT INFORMATION

1. Name of Patient: DELA CRUZ JUAN JR. MASIPAG
Last Name First Name Name Extension (JR/SR/III) Middle Name (example: DELA CRUZ JUAN JR SIPAG)
2. Was patient referred by another Health Care Institution (HCI)?
☒ NO ☐ YES
Name of Referring Health Care Institution Building Number and Street Name City/Municipality Province Zip Code
3. Confinement Period: a. Date Admitted: 0 9 0 1 2 0 2 6 b. Time Admitted: _____ AM _____ PM
month day year hour min
c. Date Discharged: 0 9 0 1 2 0 2 6 d. Time Discharged: _____ AM _____ PM
month day year hour min
4. Patient Disposition: (select only 1)
☒ a. Improved ☐ e. Expired, Date: _____ Time: _____ AM _____ PM
☐ b. Recovered ☐ f. Transferred/Referred
☐ c. Home/Discharged Against Medical Advise
☐ d. Absconded
Name of Referral Health Care Institution Building Number and Street Name City/Municipality Province Zip Code
Reason/s for referral/transfer:

5. Type of Accommodation: ☐ Private ☐ Non-Private (Charity/Service)

6. Admission Diagnosis/es:

Indicate the diagnosis of the child

7. Discharge Diagnosis/es (Use additional CF2 if necessary):

Diagnosis	ICD-10 Code/s	Related Procedure/s (if there's any)	RVS Code	Date of Procedure	Laterality (check applicable boxes)
a.	I.				☐ Left ☐ Right ☐ Both
	ii.				☐ Left ☐ Right ☐ Both
	iii.				☐ Left ☐ Right ☐ Both
b.	I.				☐ Left ☐ Right ☐ Both
	ii.				☐ Left ☐ Right ☐ Both
	iii.				☐ Left ☐ Right ☐ Both
c.	I.				☐ Left ☐ Right ☐ Both
	ii.				☐ Left ☐ Right ☐ Both
	iii.				☐ Left ☐ Right ☐ Both
d.	I.				☐ Left ☐ Right ☐ Both
	ii.				☐ Left ☐ Right ☐ Both
	iii.				☐ Left ☐ Right ☐ Both

8. Special Considerations:

a. For the following repetitive procedures, check box that applies and enumerate the procedure/session dates [mm-dd-yyyy]. For chemotherapy, see guidelines.

☐ Hemodialysis ☐ Blood Transfusion
☐ Peritoneal Dialysis ☐ Brachytherapy
☐ Radiotherapy (LINAC) ☐ Chemotherapy
☐ Radiotherapy (COBALT) ☐ Simple Debridement

b. For Z-Benefit Package Z-Benefit Package Code: Z017.3 Tranche 1

c. For MCP Package (enumerate four dates [mm-dd-yyyy] of pre-natal check-ups)

1 _____ 2 _____ 3 _____ 4 _____

d. For TB DOTS Package ☐ Intensive Phase ☐ Maintenance Phase

e. For Animal Bite Package (write the dates [mm-dd-yyyy] when the following doses of vaccine were given) **NOTE: Anti Rabies Vaccine (ARV), Rabies Immunoglobulin (RIG)**

Day 0 ARV _____ Day 3 ARV _____ Day 7 ARV _____ RIG _____ Others (Specify) _____

f. For Newborn Care Package ☐ Essential Newborn Care ☐ Newborn Hearing Screening Test ☐ Newborn Screening Test **For Newborn Screening, please attach NBS Filter Sticker here**

For Essential Newborn Care, (check applicable boxes)

☐ Immediate drying of newborn ☐ Timely cord clamping ☐ Weighing of the newborn ☐ BCG vaccination ☐ Hepatitis B vaccination

☐ Early skin-to-skin contact ☐ Eye prophylaxis ☐ Vitamin K administration ☐ Non-separation of mother/baby for early breastfeeding initiation

g. For Outpatient HIV/AIDS Treatment Package Laboratory Number: _____

9. PhilHealth Benefits

ICD 10 or RVS Code: a. First Case Rate _____ b. Second Case Rate _____

Date of initial
consult/
assessment

Date of
completion of
assessment

Write
OUTPATIENT
in lieu of time
admitted &
discharged

Tick YES if
the patient
was referred
by another
HF

This is not
required as
this is done in
an out-
patient
setting

Indicate the
diagnosis
and ICD-10
code

Indicate the
appropriate
"Z benefit
package
code" and
order of
tranche

This is not
required

MASTER
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DC: JP Date: 9/7/26

Accreditation Number / Name of Accredited Health Care Professional / Date Signed	Details
Accreditation No.: <u> 1 </u> <u> 2 </u> <u> 3 </u> <u> 4 </u> - <u> 5 </u> <u> 6 </u> <u> 7 </u> <u> 8 </u> <u> 9 </u> <u> 0 </u> <u> 1 </u> - <u> 2 </u> JUANA DELA CRUZ, <i>*Signature Over Printed Name</i> Date Signed: <u> </u> - <u> </u> - <u> </u> month day year	☐ No co-pay on top of PhilHealth Benefit ☒ With co-pay on top of Philhealth Benefit P _____
Accreditation No.: _____ - ____-_____ Signature Over Printed Name Date Signed: <u> </u> - <u> </u> - <u> </u> month day year	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____
Accreditation No.: _____ - ____-_____ Signature Over Printed Name Date Signed: <u> </u> - <u> </u> - <u> </u> month day year	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____

Tick this box
if patient
paid an
additional
Professional
fee

Tick this box
if patient
has an out
of pocket
payment

A. CERTIFICATION OF CONSUMPTION OF BENEFITS

- | | Total Actual Charges* |
|------------------------------------|-----------------------|
| Total Health Care Institution Fees | 4,726.0 |
| Total Professional Fees | |
| Grand Total | 4,726.0 |

- a.) The total co-pay for the following are:

	Total Actual Charges*	Amount after Application of Discount (i.e., personal discount, Senior Citizen/PWD)	PhilHealth Benefit	Amount after PhilHealth Deduction
Total Health Care Institution Fees	4,726.0		4,726.0	Amount P _____ Paid by (Check all that applies): ☐ Member/Patient ☐ HMO ☐ Others (i.e., PCSO, Promissory note, etc.)
Total Professional Fees (for accredited and non-accredited professionals)				Amount P _____ Paid by (Check all that applies): ☐ Member/Patient ☐ HMO ☐ Others (i.e., PCSO, Promissory note, etc.)

Total cost of purchase/s for drugs/medicines and/or medical supplies bought by the patient/member within/outside the HCI during confinement	☐ None	☐ Total Amount	P	_____
Total cost of diagnostic/laboratory examinations paid for by the patient/member done within/outside the HCI during confinement	☐ None	☐ Total Amount	P	_____

*NOTE: Total Actual Charges should be based on Statement of Account (SoA)

I hereby consent to the examination by PhilHealth of the patient's medical records for the purpose of verifying the veracity of this claim.
I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim for reimbursement before PhilHealth.

Signature Over Printed Name of Member/Patient/Authorized Representative

Date Signed: - -
 month day year

Relationship of the representative to the member/patient: ☐ Spouse ☐ Child ☐ Parent
☐ Sibling ☐ Others, Specify _____

Reason for signing on behalf of the member/patient: ☐ Patient is Incapacitated
☐ Other Reasons:

If patient/representative is unable to write, put right thumbmark. Patient/representative should be assisted by an HCI representative. Check the appropriate box:

☐ Patient ☐ Representative

I certify that services rendered were recorded in the patient's chart and health care institution records and that the herein information given are true and correct.

RECORDS OFFICER

Signature Over Printed Name of Authorized
HCI Representative

Official Capacity / Designation

Date Signed: 09 03 2026
month day year

Affix
signature of
HF
representative

MASTER COPY

DC: JP Date: 9/7/26