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

Case No. _____

Annex "E2.1 – Visual Disability"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2)
Visual Disability, Category 1

Requirements	**Please Check**
1. Checklist of Requirements for Reimbursement (Annex E2.1)	
2. PhilHealth Claim Form2 (CF2)	
3. Checklist of Mandatory Service for Visual Disabilities (Tranche 2) (Annex C2.1)	
4. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
5. Proof of device use	
DATE COMPLETED :	
DATE FILED :	

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

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