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February 14, 2018

PHILHEALTH CIRCULAR
No. 2018 - 0011

TO : ALL PHILHEALTH MEMBERS, ACCREDITED AND CONTRACTED HEALTH CARE PROVIDERS, PHILHEALTH REGIONAL OFFICES AND ALL OTHERS CONCERNED

SUBJECT : **Z Benefits for Children with Hearing Impairment**

I. RATIONALE

Loss of hearing can be disabling. For children younger than 14 years old, this means hearing loss that is greater than 30 decibels, while it is hearing loss greater than 40 decibels for children aged 15 to less than 18 years, in the better hearing ear (WHO, 2015). Hearing loss can be mild, moderate, severe or profound. It could affect one ear or both. Hearing loss can result from either congenital or acquired conditions.

Timely recognition of hearing impairment is very important among children primarily due to its impact on the development of their communication abilities (WHO, 2015). Delays in language development can happen when the disability is not addressed. It could spell the difference on the chance of children to participate in education activities, and eventually on opportunities to gain meaningful employment. It is estimated that hearing impairment is the fifth highest cause of years lost due to disability for both genders and across all ages (IHME, 2013).

The WHO estimates the overall prevalence of hearing impairment in the Philippines ranging from 3.43% to 6.13% (WHO, 2013). A local estimate through modeling suggests that there are 1.5 M of less than 19 years of age who have hearing impairment (PFP, 2016 [unpublished]).

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Hearing impairment can be confirmed with a diagnostic test. Children fitted with hearing devices and provided with habilitative / rehabilitative speech therapy can gain functionality in hearing and communication. There is evidence that when interventions for hearing loss are provided at an early age, speech and language development improve (McPherson, 2012). However, access to specialized care and hearing aid is costly, often prohibiting access among the poor (WHO, 2001). Failure to address the unmet need for hearing aid could lead to more of these children not being able to complete school and participate meaningfully in the society (UN, 2005; as cited in Olusanya et al., 2007).

In 2009, the country legislated Republic Act 9709 "Universal Newborn Hearing Screening and Intervention Act of 2009." This mandated the provision of universal access to hearing screening at birth, and possible referral. The Philippine Health Insurance Corporation (PhilHealth) benefit Newborn Care Package covers for this screening. However, there is no further support for follow-up and access to hearing aid device when warranted.

PhilHealth is mandated to ensure financial risk protection, with provisions towards persons with disabilities. Thus, the PhilHealth Board, per Board Resolution 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. Z benefits, in particular, are designed to prevent catastrophic spending among the marginalized that are enrolled in the program while ensuring the provision of quality healthcare services.

This Circular describes the benefit package for children with hearing impairment, covering services from assessment, provision of appropriate devices and habilitation/rehabilitation, such that hearing can be preserved and rehabilitated. A previously issued Circular on benefits for children with disability (PhilHealth Circular **2016-032**) provides an overarching guidance in the implementation of this policy.

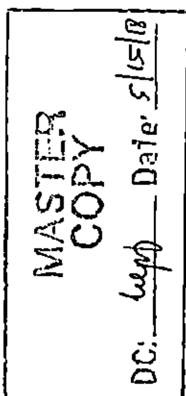
II. OBJECTIVES

This Circular aims to establish the guiding principles and define the policies and procedures in the delivery of quality of health service for children with hearing impairment under the Z Benefits.

III. SCOPE

This Circular shall apply to all health care institutions (HCIs) that are contracted to provide the Z Benefits for children with hearing impairment, and other relevant stakeholders involved in the implementation of the Z Benefits.

IV. DEFINITION OF TERMS



A. **Assessment** - process of examination, interaction, and observation of a child with potential or actual health conditions, and the degree of limitations in function, activity and participation. Assessments are required for the provision of the assistive device and rehabilitation services. This also refers to the process of diagnosing the degree of hearing loss in a child presenting delay in auditory milestones and/or communication issues, and sensorineural hearing loss.

B. **Assistive Device** - any device that is designed, made and adapted to help a child ~~to~~ perform tasks such device may include those used in aural rehabilitation of

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children with hearing impairment. For this policy, the assistive device specifically refers to the hearing aid.

C. **Aural habilitation** - refers to the provision of a hearing aid and speech therapy services, which aims to assist children in their development of age appropriate speech and language skills. With optimal amplification and auditory skills as pre-requisite to the development of speech and language, verification and validation of hearing aid fitting is an essential component.

D. **Contracted Health Care Institution** – a health facility that is PhilHealth-accredited and enters into a contract for care with PhilHealth.

E. **Hearing aid fitting verification** – refers to the process of determining if amplification or hearing aids meet a set of standardized measured that include basic electroacoustics, comfortable fit, and real-ear electroacoustic performance with reference to evidence-based fitting prescription most suitable for pediatric cases.

F. **Hearing impairment** - refers to a child with hearing loss with greater than 30 decibels, while it is hearing loss greater than 40 decibels for children aged 15 to less than 18 years, in the better hearing ear. Hearing impairment, is a result of either congenital or acquired conditions, and can be categorized into mild, moderate, severe or profound.

G. **Lost to follow-up** – means the patient has not come back as advised for immediate next visit: (a) For audiological follow-up, this means that the patient has not come back for follow-up within two months from the scheduled appointment; (b) for speech therapy, this means that the patient has not come back for follow-up within one month from the scheduled appointment.

H. **Pre-authorization** – a decision from PhilHealth that determines if the patient has passed the eligibility and minimum clinical selections criteria required for availment of the Z Benefits.

I. **Speech therapy** – refers to services provided by a Speech and Language Pathologists to assist in the acquisition of auditory skills and the development of speech and language appropriate.

J. **Z Benefits** – benefit packages that focus on providing relevant financial risk protection against illnesses perceived as medically and economically catastrophic.

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V. CONTRACTING HCIs AS PROVIDERS FOR THE Z BENEFIT FOR CHILDREN WITH HEARING IMPAIRMENT

With the mandate of PhilHealth to provide financial risk protection against catastrophic illness and to pay for quality health care services, the Corporation has the prerogative to negotiate and enter into contracts with HCIs and professionals. This is to define the terms of pricing and benefit package delivery that is of quality, in behalf of its members.

In this regard, PhilHealth shall initially engage with identified tertiary government HCIs for the provision of specialized multi- and interdisciplinary health care delivery for this Z benefit. Subsequent contracting of other capable government and private HCIs shall be done to expand benefit utilization and improve implementation efficiency. **PhilHealth Circular 2015-014** provides guidance on the contracting process.

The prescribed minimum standards of care of HCI as providers for children with hearing impairment are provided for as Annex VI in this Circular.

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Coordination and collaboration with the contracted HCIs for the Z Benefits for children with hearing impairment shall be required for quality improvement and operational purposes, such as, but not limited to, pertinent training, regular patient audits, patient referrals, patient tracking, and pooled procurement of supplies, etc.

The contracted HCI shall designate at least one Z Benefits Coordinator to perform the tasks specified in PhilHealth Circular 2015-35 Section V, providing guidance and navigation services to patients, coordination with PhilHealth, and encoding of patient information.

VI. MINIMUM STANDARDS OF CARE

The Z Benefits for children with hearing impairment shall include the following healthcare services (Table 1) to be rendered by the multi- interdisciplinary team.

Table 1. Mandatory and other services for Z Benefits for children with hearing impairment

Mandatory Services	Other services
A. Diagnostic audiologic assessment* 1. Otoacoustic Emission (OAE) Test and Auditory Brainstem Response (ABR) for 0 to less than 3 years old 2. Age appropriate Behavioral Audiometry by an Audiologist for age 3 to less than 6 years	

Mandatory Services	Other services
old 3. Diagnostic Pure Tone Audiometry by an Audiologist or Audiometrist or PRC - Licensed Otolaryngologist with valid certification of good standing from the Philippine Society of Otolaryngology – Head and Neck Surgery for ages 6 to less than 18 years old, only for moderate hearing loss	
B. For moderate and severe to profound hearing loss: 1. Hearing aid fitting and verification 2. Hearing aid device, batteries and ear mold 3. Ear mold refitting	When warranted, and only after five (5) years from last hearing aid fitting, replacement of hearing aid can be prescribed by an Audiologist, endorsed by a PRC -Licensed Otolaryngologist with valid certification of good standing from the Philippine Society of Otolaryngology – Head and Neck Surgery and implemented by an Audiologist (for ages 0 to 5 years old) or Audiometrist (for ages 6 to less than 18 years old) or Philippine Board of – Head and Neck Surgery certified-physician. The signatures need to be affixed.
C. Speech Therapy**	

* The diagnostic audiologic assessment should be verified by a PRC -Licensed Otolaryngologist with valid certification of good standing from the Philippine Society of Otolaryngology – Head and Neck Surgery.

** Eligible children with hearing impairment can only avail of a maximum of two sets of therapies per fiscal year for moderate hearing loss and six sets for severe to profound hearing loss, respectively. Each set of therapies has a maximum of 26 sessions.

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VII. GUIDELINES ON AVAILMENT OF THE Z BENEFIT FOR CHILDREN WITH HEARING IMPAIRMENT

A. Assessment of patients

1. The provision of services for the Z Benefits for hearing impairment shall cover only those cases that fulfill the following selections criteria:

    a. Age must be 0 to 17 years and 364 days old

b. The child must have undergone professional assessment and is deemed to have <u>all of the following</u>:

i. Presence of delay on auditory milestones and / or communication issues at home / school

ii. Sensorineural hearing loss presenting with <u>either moderate or severe to profound hearing loss</u> described as:

a) Moderate hearing loss - three frequency (500Hz, 1000Hz, 2000Hz) average threshold between 41 dBHL to 60 dBHL
b) Severe to profound hearing loss - three frequency (500Hz, 1000Hz, 2000Hz) average threshold greater than or equal to 61 dBHL

iii. Absence of signs and symptoms of an active ear infection (e.g. otalgia, otorrhea, fever, tenderness)

2. In order to qualify for the Z Benefits, children with hearing impairment shall be assessed by appropriate health care providers at the contracted HCIs. If qualified, these children shall be enrolled in this program.

3. These children with hearing impairment must be eligible to avail of PhilHealth benefits at the time of pre-authorization.

4. Contracted HCIs shall be responsible for developing an efficient process for assessing Z Benefits patients that is applicable in their local setting.

B. Application for Pre-authorization

1. A pre-authorization from PhilHealth based on the approved selections criteria shall be required to avail of the Z Benefits. All requests for pre-authorization shall be completely and properly accomplished by the contracted HCI by filling out the Pre-authorization Checklist and Request (Annex A) and submitted by a designated liaison of the contracted HCIs to the Local Health Insurance Office (LHIO) or to the office of the Head of the PhilHealth Benefits Administration Section (BAS) in the region for approval.

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2. Contracted HCIs shall follow the prescribed process of seeking approval for the pre-authorization as described in PhilHealth Circular 2015-035 Section VII.

3. The approved Pre-Authorization Checklist and Request shall be valid for one fiscal year from the date of approval by PhilHealth provided that the child has

not turned 18 years of age. All contracted HCIs are responsible in tracking the validity of their approved pre-authorizations. The contracted HCI shall inform PhilHealth in cases when the validity has lapsed. When needed, a new Pre-Authorization Checklist and Request may be submitted if services were not provided at the end of the validity period of the prior request and if the child is still below 18 years old.

4. The member or the dependent should have at least one day remaining from the 45-day annual benefit limit prior to submission of the Pre-authorization Checklist and Request. Five days shall be deducted from the 45-day annual benefit limit upon approval of the application for pre-authorization.

5. An approved Pre-authorization Checklist and Request guarantees payment of the initial tranche of the Z benefits provided that mandatory services for the specified treatment phase are given to the patient and all other PhilHealth requirements are complied with.

6. While the Pre-authorization Checklist and Request is submitted manually, it shall be submitted together with the properly accomplished Member Empowerment Form or ME form (Annex B).

7. The ME Form shall be discussed by the attending health professional/s and accomplished together with the parent/guardian or patient to be enrolled in the Z Benefits. The ME Form aims to support parent/guardian or patients to become active participants in health care decision making by being educated and informed of the conditions and all management options. Further, the ME Form aims to encourage the attending health care professionals in the contracted HCIs to dedicate adequate time to discuss with patients. The overall goal is to achieve better health outcomes and patient satisfaction.

C. Guidelines on Reimbursement

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1. The package codes and corresponding rates per laterality of the Z Benefits for children with hearing impairment are specified in the following tables:

Table 2. Description for assessment and hearing aid provision of children 0 to less than 3 years old at the time of approval of pre-authorization

Z Code	Description	RATE (PhP)
Z020.1	**Assessment and hearing aid provision, with moderate hearing loss** a. Assessment: OAE Screening and ABR b. Hearing aid fitting, hearing aid device, batteries good for five years, ear mold and hearing aid verification c. Ear mold refitting every six months for five years	53,460.00
Z020.2	**Assessment and hearing aid provision, with severe to profound hearing loss** a. Assessment: OAE Screening and ABR b. Hearing aid fitting, hearing aid device, batteries good for five years, ear mold and hearing aid verification c. Ear mold refitting every four months for five years	67,100.00

Table 3. Description for assessment and habilitation of children 3 to less than 6 years old at the time of approval of pre-authorization

Z Code	Description	RATE (PhP)
Z020.3	**Assessment and hearing aid provision, with moderate hearing loss** a. Assessment: Age Appropriate Behavioral Audiometry b. Hearing aid fitting, hearing aid device, batteries good for five years, ear mold and hearing aid verification c. Ear mold refitting once a year for five years	45,400.00
Z020.4	**Assessment and hearing aid provision, with severe to profound hearing loss** a. Assessment: Age Appropriate Behavioral Audiometry	54,100.00

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	b. Hearing aid fitting, hearing aid device, batteries good for five years, ear mold and hearing aid verification c. Ear mold refitting once a year for five years	

Table 4. Description for assessment and habilitation for children 6 to less than 18 years old at the time of approval of pre-authorization

Z Code	Description	RATE (PhP)
Z020.5	**Assessment and hearing aid provision, with moderate hearing loss** a. Assessment: Diagnostic Pure Tone Audiometry b. Hearing aid fitting, hearing aid device, batteries good for five years, ear mold and hearing aid verification c. Ear mold refitting once a year for three years	43,880.00

Table 5. Description for speech therapy assessment and sessions

Z Code	Description	RATE (PhP)
Z020.6	**Speech therapy assessment and sessions for moderate hearing loss** Includes speech evaluation, speech therapy sessions, and counseling	22,100.00
Z020.7	**Speech therapy for severe to profound hearing loss** Includes speech evaluations, speech therapy sessions, and counseling	63,420.00

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Table 6. Description for hearing aid replacement*

Z Code	Description	RATE (PhP)
Z020.8	**Replacement of hearing aid for moderate hearing loss, 5 to less than 18 years old**	43,670.00

	Includes hearing aid fitting, hearing aid, batteries good for five years, ear mold and hearing aid verification	
Z020.9	**Replacement of hearing aid for severe to profound hearing loss, 5 to less than 18 years old** a. This is only available to those who have been enrolled prior to the age of six years old b. Includes hearing aid fitting, hearing aid, batteries good for five years, ear mold and hearing aid verification	48,670.00

* Replacements of hearing aids will be available to those who have been enrolled prior to the age of six years old and availed of the hearing aid under the Z Benefits. This will require a new application for pre-authorization.

2. The above rates are inclusive of applicable government taxes. Discounts for persons with disabilities will be governed by specific terms espoused in Republic Act 10754 "An Act Expanding the Benefits and Privileges of Persons with Disabilities (Amending RA 7277)".

3. The rates cover the hearing aid, its prescription, fitting, and fitting evaluation for one ear only. In cases where hearing loss is asymmetric, the ear to fit will depend on the configuration of hearing loss for both ears. When one ear has moderate hearing loss and other ear is severe or profound, the ear to fit is the side with severe or profound hearing loss. When one ear is severe and the other is profound, the ear with severe loss is fitted.

4. There shall be no out-of-pocket expenses for the availment of the Z Benefits for hearing impairment for all member categories of PhilHealth, except for upgrades of services. This shall be reflected as co-payment arrangements will be arranged with the contracted HCIs and shall be stipulated in the individual contracts of HCIs.

5. HCIs shall establish their own guidelines on the administration of reimbursement funds including how professional fees will be dispensed. Monies in excess of the amount needed to deliver the services will be utilized to develop the hearing clinic/ facility.

6. Rules on pooling of professional fees in government hospitals apply.

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D. Claims Filing and Reimbursement

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

2. The claim application filed by the contracted HCI shall include the following documentation:

   a. Transmittal Form of claims for the Z Benefit Package (Annex H) to be used by the contracted HCI per claim or per batch of claims;

   b. Photocopy of the approved Pre-authorization Checklist and Request (Annex A) signed by the patient or the parent or guardian, and the health care providers who are members of the multi- and interdisciplinary team managing the patient, as applicable, for the first tranche;

   c. PhilHealth Benefit Eligibility Form printout or its equivalent (e.g. Claim Form or CF1) attached as proof of eligibility during the pre-authorization process;

   d. Photocopy of the properly accomplished ME Form (Annex B) for the first tranche;

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

   e. Properly accomplished PhilHealth CF2 for all tranches;

   f. Checklist of Mandatory Services (Annex C) for the corresponding tranches;

   g. Corresponding Checklist of Requirements for Reimbursements (Annex E); and

   h. Photocopy of the accomplished Z Satisfaction Questionnaire (Annex D);

   i. Photocopy of the ABR waveform tracing;

   j. Certificate of completed hearing aid verification (Annex J) signed by the Audiologist;

   k. Certificate of completed speech therapy sessions (Annex K);

   l. Photocopy of hearing test result for hearing aid replacement

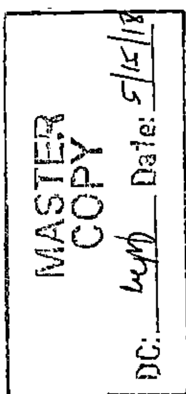
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Table 7. Summary of forms to be utilized in claims filing and reimbursement

Benefit package	Forms Required
I. Assessment and hearing aid provision	
Tranche 1: Assessment	a. Checklist of Requirements for Reimbursement (Annex E1) b. Pre-authorization Checklist and Request (photocopy) (Annex A) c. ME Form (photocopy) (Annex B) d. PhilHealth Benefit Eligibility Form or equivalent (e.g. PhilHealth CF 1) e. PhilHealth CF2 f. Checklist of Mandatory Services (Annex C1) g. Z Satisfaction Questionnaire (photocopy) (Annex D) h. Photocopy of the ABR waveform tracing or applicable hearing test result
Tranche 2: Hearing aid provision	a. Checklist of Requirements for Reimbursement (Annex E2.1) b. PhilHealth CF2 c. Checklist of Mandatory Services (Annex C2) d. Z Satisfaction Questionnaire (photocopy) (Annex D) e. Certificate of completed hearing aid verification (Annex J)
Tranche payments for ear-mold refitting	a. Checklist of Requirements for Reimbursement (Annex E3.1) b. PhilHealth CF2 c. Checklist of Mandatory Services (Annex C3) d. Z Satisfaction Questionnaire (photocopy) (Annex D)
II. Speech Therapy	
Speech Therapy	a. Checklist of Requirements for Reimbursement (Annex E-Speech Therapy) b. PhilHealth CF2 c. Z Satisfaction Questionnaire (photocopy) (Annex D) d. Certificate of completion of speech therapy sessions (Annex K)
III. Replacement	
Replacement of assistive device	a. Checklist of Requirements for Reimbursement (Annex E-Hearing Aid Replacement) b. Pre-authorization Checklist and Request (photocopy) (Annex A) c. ME Form (photocopy) (Annex B) d. PhilHealth Benefit Eligibility Form or equivalent (e.g. PhilHealth CF1) e. PhilHealth CF2 f. Checklist of Mandatory Services (Annex C-Hearing Aid Replacement) g. Z Satisfaction Questionnaire (photocopy) (Annex D) h. Photocopy of the hearing test result

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3. Patients should keep their used or replaced devices and are discouraged to sell or donate them.

4. Rules on late filing shall apply.

5. If the delay in the filing of claims is due to natural calamities or other fortuitous events, the contracted HCI shall be accorded an extension period of 60 calendar days as stipulated in Section 47 of the Implementing Rules and Regulations (IRR) of the National Health Insurance Act of 2013 (Republic Act 7875, as amended).

6. There shall be no direct filing of claims by members.

7. The claims shall be evaluated according to the process stipulated in PhilHealth Circular 2015-035 Section IX.
8. Terms of claims payment described in PhilHealth Circular 2015-035 Section X applies.

9. The description of services, tranche payment, amount, schedule of filing of tranches and the frequency of availment of the benefit packages for children with hearing impairment are described in the following tables (Table 8 to 12):

Table 8. Description of services, tranche payments, amounts, filing schedule and maximum availment for the Z Benefits for children with hearing impairment, age 0 to less than 3 years, for assessment and appropriate assistive device

Description	Tranche	Code	Amount (PhP)	Filing Schedule	Maximum Availment
I. Moderate Hearing Loss					
Assessment	1	Z020.11	1,250.00	Within 30 calendar days after verification of assessment results by an Audiologist and recommendations by a PRC - Licensed Otolaryngologist with valid certification of good standing from the Philippine Society of Otolaryngology – Head and Neck Surgery	Once upon enrollment
Hearing aid fitting, hearing	2	Z020.12	39,010.00	Within 30 calendar days upon	Once upon enrollment

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Description	Tranche	Code	Amount (PhP)	Filing Schedule	Maximum Availment
aid package (hearing aid and batteries good for 5 years), verification, ear mold				certification of completion of hearing aid verification	
Ear mold refitting	Eleven (11) tranches as needed	Z020.13 Z020.14 Z020.15 Z020.16 Z020.17 Z020.18 Z020.19 Z020.110 Z020.111 Z020.112 Z020.113	1,200 per tranche	Within 30 days after ear mold refitting	Eleven (11) ear mold refitting every six months after provision of hearing aid device, within five years
II. Severe to Profound Hearing Loss					
Assessment	1	Z020.21	1,250.00	Within 30 calendar days after verification of assessment results by an Audiologist and recommendations by a PRC - Licensed Otolaryngologist with valid certification of good standing from the Philippine Society of Otolaryngology – Head and Neck Surgery	Once upon enrollment
Hearing aid fitting, hearing aid package (hearing aid and batteries good for 5 years), verification, ear mold	2	Z020.22	45,450.00	Within 30 calendar days upon certification of completion of hearing aid verification	Once upon enrollment
Ear mold	Seventeen	Z020.23 Z020.24	1,200 per tranche	Within 30 days after	Seventeen

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Description	Tranche	Code	Amount (PhP)	Filing Schedule	Maximum Availment
refitting	(17) tranches as needed	Z020.25 Z020.26 Z020.27 Z020.28 Z020.29 Z020.210 Z020.211 Z020.212 Z020.213 Z020.214 Z020.215 Z020.216 Z020.217 Z020.218 Z020.219		ear mold refitting	(17) ear mold refitting every four months within five years after provision of hearing aid device

Table 9. Description of services, tranche payment, amounts, filing schedule and maximum availment for the Z Benefits for children with hearing impairment, age 3 to less than 6 years, for assessment and appropriate assistive device

Description	Tranche	Code	Amount (PhP)	Filing Schedule	Maximum Availment
I. Moderate Hearing Loss					
Assessment	1	Z020.31	600.00	Within 30 calendar days after verification of assessment results by an Audiologist and recommendations by a PRC - Licensed Otolaryngologist with valid certification of good standing from the Philippine Society of Otolaryngology – Head and Neck Surgery	Once upon enrollment
Hearing aid fitting, hearing aid package (hearing aid and batteries good for 5 years), verification, ear	2	Z020.32	38,800.00	Within 30 calendar days upon certification of completion of hearing aid verification	Once upon enrollment

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Description	Tranche	Code	Amount (PhP)	Filing Schedule	Maximum Availment
mold					
Ear mold refitting	Five tranches as needed	Z020.33 Z020.34 Z020.35 Z020.36 Z020.37	1,200 per tranche	Within 30 days after ear mold refitting	Five refitting once a year within five years after provision of hearing aid device
II. Severe to Profound Hearing Loss					
Assessment	1	Z020.41	600.00	Within 30 calendar days after verification of assessment results by an Audiologist & recommendations by a PRC - Licensed Otolaryngologist with valid certification of good standing from the Philippine Society of Otolaryngology – Head and Neck Surgery	Once upon enrollment
Hearing aid fitting, hearing aid package (hearing aid and batteries good for 5 years), verification, ear mold	2	Z020.42	47,500.00	Within 30 calendar days upon certification of completion of hearing aid verification	Once upon enrollment
Ear mold refitting	Five tranches as needed	Z020.43 Z020.44 Z020.45 Z020.46 Z020.47	1,200 per tranche	Within 30 days after ear mold refitting	Five refitting once a year within five years after provision of hearing aid device

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Table 10. Description of services, tranche payment, amounts, filing schedule and maximum availment for the Z Benefits for children with hearing impairment, age 6 to less than 18 years

Description	Tranche	Code	Amount (PhP)	Filing Schedule	Maximum Availment
Moderate Hearing Loss					
Assessment	1	Z020.51	600.00	Within 30 calendar days after verification of assessment results by an Audiologist or Audiometrist, and recommendations by a PRC - Licensed Otolaryngologist with valid certification of good standing from the Philippine Society of Otolaryngology – Head and Neck Surgery	Once upon enrollment
Hearing aid fitting, hearing aid package (hearing aid and batteries good for 5 years), verification, ear mold	2	Z020.52	39,680.00	Within 30 calendar days upon certification of completion of hearing aid verification	Once upon enrollment
Ear mold refitting	Three tranches as needed	Z020.53 Z020.54 Z020.55	1,200 per tranche	Within 30 days after ear mold refitting	Three refitting once a year within five years after provision of hearing aid device

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Table 11. Description of speech therapy services, amount of payment, filing schedule and maximum availment for the Z Benefits for children with hearing impairment

Description	Tranche	Code	Amount (PhP)	Filing Schedule	Maximum Availment

Description	Tranche	Code	Amount (PhP)	Filing Schedule	Maximum Availment
I. Moderate Hearing Loss					
Speech Therapy**	Two tranches for one year (as needed)	Z020.61 Z020.62	11,050.00 per tranche	Within 30 days after the last session for one set of therapies completed	Two sets of therapies starting from the date of initial speech therapy
II. Severe to Profound Hearing Loss					
Speech Therapy**	Six tranches within three years (as needed)	Z020.71 Z020.72 Z020.73 Z020.74 Z020.75 Z020.76	10,570.00 per tranche	Within 30 days after the last session for one set of therapies completed	Six sets of therapies starting from the date of initial speech therapy to be availed for a maximum of three years

** Eligible children with hearing impairment can only avail of a maximum of two sets of therapies for moderate hearing loss and six sets for severe to profound hearing loss, respectively. Each set of therapies has a maximum of 26 sessions.

Table 12. Description of replacement service, amount of payment, filing schedule and maximum availment for the Z Benefits for children with hearing impairment, for children 5 years to less than 18 years old

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Description	Tranche	Code	Amount (PhP)	Filing Schedule	Maximum Availment
Replacement of hearing aid for moderate hearing loss: 5 years to less than 18 years old	1	Z020.8	43,670.00	Within 30 calendar days upon submission of assessment and plan	No less than 5 years from the last fitting, within the age of eligibility
Replacement of hearing aid for severe to profound hearing loss: 5	1	Z020.9	48,670.00	Within 30 calendar days upon submission of assessment	No less than 5 years from the last fitting, within the age of eligibility

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Description	Tranche	Code	Amount (PhP)	Filing Schedule	Maximum Availment
years to less than 18 years old				and plan	

Note: Replacements of hearing aids will be available to those who have been enrolled in Z Benefits prior to the age of six years old and have previously availed of the hearing aid under the Z Benefits. Availment of this benefit will require a new application for pre-authorization from PhilHealth.

10. A patient is enrolled to the Z Benefits for Children with Hearing Impairment at time of diagnosis and fitting of hearing aids.

    a. For diagnostic evaluation with ABR, Conditioned Play Audiometry, and Pure Tone Audiometry, payment is given as first tranche upon confirming a diagnosis of either moderate or severe and profound hearing loss. Diagnostic evaluation can only be filed once the ear and frequency specific thresholds are obtained from the patient.

    b. Succeeding tranches cover for aural habilitation with hearing aids for moderate or those with severe and profound hearing loss. The 2nd tranche covers the device, its prescription, fitting, and fitting verification. Batteries and ear mold corresponding to five years from time of issuance is included with device sticker attached as proof of regulated device use.

    c. Speech therapy services is covered for a maximum of 52 sessions per year or per cycle of care. One cycle of care can be availed of once for moderate hearing loss and three times for severe to profound hearing loss.

    d. For replacement of hearing aid on those with moderate or severe to profound hearing loss, availment should be no less than 5 - year interval from the time of last fitting (e.g. during enrolment). The amount covers the device, its prescription, fitting, and fitting verification. Batteries and ear mold corresponding to five years from the time of issuance is included with device sticker attached as proof of regulated device use. Replacements of hearing aids will be available to those who have been enrolled prior to the age of six years old and availed of the hearing aid under the Z Benefits. This will require a new application for pre-authorization.

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11. In the event that the patient expires or is declared "lost to follow-up" in the course of the rehabilitation therapy, the contracted HCI may still file claims for the payment of services rendered to PhilHealth. The contracted HCI

should submit a sworn declaration (e.g. notarized) for all "lost to follow-up" patients and for those who expired.

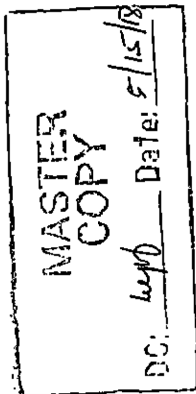
"Lost to follow-up" means the patient has not come back as advised for immediate next visit. For audiological follow-up, this means that the patient has not come back for follow-up within two months from the scheduled appointment. For speech therapy, this means that the patient has not come back for follow-up within one month from the scheduled appointment.

For speech therapy sessions, at least 20 of the 26 recommended sessions per tranche should have been completed for the treatment to be eligible for claims reimbursement.

12. In instances that these patients who were declared "lost to follow-up" by the contracted HCI were provided rehabilitation services in other HCIs, claims for the succeeding rehabilitation services for this particular Z Benefit package shall be denied.

VIII. MONITORING AND POLICY REVIEW

Benefit package implementation shall be monitored. Contracted HCIs shall comply with PhilHealth guidance in establishing the HCI Portal that will facilitate efficient tracking and reporting of patient outcomes through the ZBITS.



Field monitoring of service provision by contracted HCI shall also be conducted. It shall follow the guidelines, tools and consent forms provided in PhilHealth Circular 2015-035 Section XI. The performance indicators and measures to monitor compliance to the policies of this Circular shall be established in collaboration with relevant stakeholders and experts. This shall be incorporated in the Health Care Provider Performance Assessment System that is governed by another policy issuance.

Results of reports and monitoring visits shall inform the regular policy review described in PhilHealth Circular 2015-035 Section XII.

IX. MARKETING, PROMOTION AND PATIENT EMPOWERMENT

The implementation of the benefit package shall promote the role of patients and their caregivers as active participants in health care decision-making. PhilHealth Circular 2015-035 Section XIII specifies guidance to this end.

X. REPEALING CLAUSE

Provisions of previous issuances inconsistent with this Circular are hereby amended, modified or repealed accordingly. Those that are consistent shall remain valid and binding.

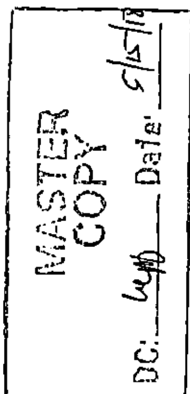
XI. EFFECTIVITY

This circular shall take effect after fifteen (15) days of complete publication in a newspaper of general circulation and shall therefore be deposited with the National Administrative Register, University of the Philippines Law Center.

XII. ANNEXES (These annexes shall be uploaded in the PhilHealth website)

A. Pre-authorization Checklist and Request (Annex A)
B. ME Form (Annex B)
C. Checklist of Mandatory Services (Annex C)
D. Z Satisfaction Questionnaire (Annex D)
E. Checklists for Requirements for Reimbursement (Annex E)
F. HCI Standards as Providers for Children with Hearing Impairment (Annex F)
G. General process flow for the provision of care for a child with hearing impairment (Annex G)
H. Transmittal Form for the Z Benefits (Annex H)
I. Sample CF2 (Annex I)
J. Certificate of completed hearing aid verification (Annex J)
K. Certificate of completion of speech therapy sessions (Annex K)

DR. CELESTINA MA. JUDE P. DE LA SERNA
Interim/OIC President and CEO
Date Signed: 05/9/18



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Case No. ___________

Annex "A – Hearing Impairment"

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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

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 HEARING IMPAIRMENT

Place a (✓) in the status column if yes

	General Qualifications	Status
1.	The child's age is 0 to 17 years and 364 days old	
2.	The child must have undergone professional assessment and was diagnosed to have **all of the following**: ☐ Presence of delay on auditory milestones and/or communication issues at home/school ☐ Sensorineural hearing loss presenting with either moderate or severe to profound hearing loss (Tick one) ☐ Moderate hearing loss ☐ Severe - Profound hearing loss ☐ No signs and symptoms of an active ear infection	

Conforme by Patient/Parent/Guardian:

____
Printed name and signature

Attested by Attending Otolaryngologist

____
Printed name and signature

PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐ - ☐

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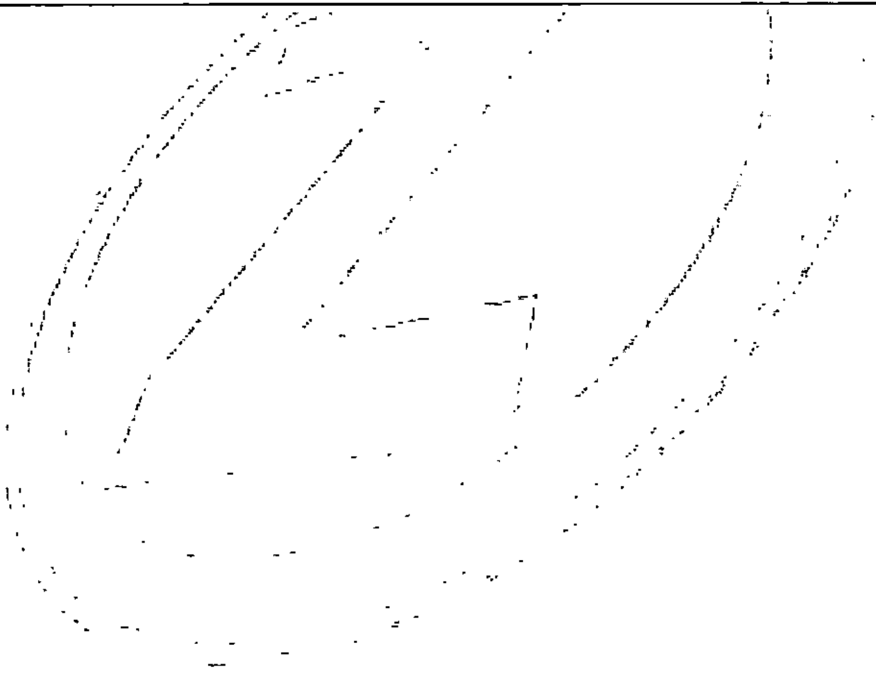
Note:
Once approved, the contracted hospital shall print the approved pre-authorization form and have this signed by the patient, parent or guardian and health care providers, as applicable. This form shall be submitted to the Local Health Insurance Office (LHIO) or the PhilHealth Regional Office (PRO) when filing the first tranche.
There is no need to attach assessment/diagnostic 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.



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PRE-AUTHORIZATION REQUEST
Z BENEFITS FOR CHILDREN WITH HEARING IMPAIRMENT

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z benefit package for
_________________________ in _________________________
(NAME OF PATIENT) (NAME OF HOSPITAL)
under the terms and conditions as agreed for availment of the Z Benefit Package.

The patient belongs to the following category (please tick appropriate box):

☐ No Balance Billing (NBB)
☐ Co-pay

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Otolaryngologist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
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)
Authorized Personnel, Benefits Administration Section (BAS)

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INITIAL APPLICATION			COMPLIANCE TO REQUIREMENTS		
Activity	**Initial**	**Date**	☐ APPROVED ☐ DISAPPROVED (State reason/s)		
Received by LHIO/BAS:					
Endorsed to BAS (if received by LHIO):					
☐ Approved ☐ Disapproved			**Activity**	**Initial**	**Date**
Released to HCI:			Received by BAS:		
This pre-authorization is valid for one (1) fiscal year from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to HCI:		

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Annex "C – Hearing Aid Replacement"

CHECKLIST OF MANDATORY SERVICES
Z BENEFITS FOR HEARING IMPAIRMENT

HEARING AID REPLACEMENT

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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

Place a check (✓) on the appropriate boxes

Place a (✓) on the box for the age group, category of hearing impairment and mandatory service rendered to the child:

Age Group at Pre-authorization	Category of Hearing Impairment	Mandatory Service
☐ Age 5 to less than 18 years old	☐ Moderate hearing loss ☐ Severe to profound hearing loss	☐ Hearing aid fitting ☐ Hearing aid replacement ☐ Hearing aid verification ☐ Batteries ☐ Ear mold

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Otolaryngologist	(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)

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Annex "C1 – Hearing Impairment"

CHECKLIST OF MANDATORY SERVICES
Z BENEFITS FOR HEARING IMPAIRMENT

ASSESSMENT (TRANCHE 1)

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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

Place a check (✓) on the appropriate boxes

Place a (✓) on the box for the appropriate assessment/evaluation that was given to the child according to the category of hearing impairment:

Age Group at Pre-authorization	Assessment Done	Category of Hearing Impairment
☐ Age 0 to less than 3 years old	☐ Otoacoustic emission test (OAE) ☐ Auditory brainstem response (ABR)	☐ Moderate hearing loss ☐ Severe to profound hearing loss
☐ Age 3 to less than 6 years old	☐ Age Appropriate Behavioral Audiometry Specify, _______________	☐ Moderate hearing loss ☐ Severe to profound hearing loss
☐ Age 6 to less than 18 years old	☐ Diagnostic pure tone audiometry	☐ Moderate hearing loss

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Otolaryngologist	(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)

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Annex "C2 – Hearing Impairment"

CHECKLIST OF MANDATORY SERVICES
Z BENEFITS FOR HEARING IMPAIRMENT

HEARING AID PROVISION (TRANCHE 2)

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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

Place a (✓) on the box for the appropriate age group, category of hearing impairment and services that were rendered to the child:

Age Group at Pre-authorization	Category of Hearing Impairment	Mandatory Services
☐ Age 0 to less than 3 years old	☐ Moderate hearing loss ☐ Severe to profound hearing loss	☐ Hearing aid fitting ☐ Hearing aid device ☐ Hearing aid verification ☐ Batteries ☐ Ear mold
☐ Age 3 to less than 6 years old	☐ Moderate hearing loss ☐ Severe to profound hearing loss	
☐ Age 6 to less than 18 years old	☐ Moderate hearing loss	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Otolaryngologist	(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)

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Annex "C3 – Hearing Impairment"

CHECKLIST OF MANDATORY SERVICES
Z BENEFITS FOR HEARING IMPAIRMENT

EAR-MOLD REFITTING (TRANCHE No. ____)

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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

Age Group at Pre-authorization	Category of Hearing Impairment	Mandatory Service
☐ Age 0 to less than 3 years old	☐ Moderate hearing loss	☐ Ear mold refitting every six months for five years
	☐ Severe to profound hearing loss	☐ Ear mold refitting every four months for five years
☐ Age 3 to less than 6 years old	☐ Moderate hearing loss ☐ Severe to profound hearing loss	☐ Ear mold refitting once a year for five years
☐ Age 6 to less than 18 years old	☐ Moderate hearing loss	☐ Ear mold refitting once a year for three years

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Otolaryngologist	(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)

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Annex "E– Hearing Aid Replacement"

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

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E)Hearing Aid Replacement)	
2. Photocopy of Pre-authorization Checklist and Request (Annex A)	
3. Photocopy ME Form (Annex B)	
4. PhilHealth Benefit Eligibility Form or equivalent or Claim Form1 (CF1)	
5. PhilHealth Claim Form2 (CF2)	
6. Checklist of Mandatory Services (Annex C -Hearing Aid Replacement)	
7. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
8. Photocopy of hearing test result	
DATE COMPLETED :	
DATE FILED :	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Otolaryngologist	(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)

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Annex "E- Speech Therapy"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT SPEECH THERAPY

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E)	
2. PhilHealth Claim Form2 (CF2)	
3. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
4. Certificate of Completed Speech Therapy Sessions (Annex K)	
DATE COMPLETED :	
DATE FILED :	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Otolaryngologist	(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)

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Annex "E1 – Hearing Impairment"

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 1) ASSESSMENT

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E1)	
2. Photocopy of approved Pre–Authorization Checklist & Request (Annex A)	
3. Photocopy of completely accomplished ME FORM (Annex B)	
4. Completed PhilHealth Claim Form (CF1) or PhilHealth Benefit Eligibility Form (PBEF)	
5. PhilHealth Claim Form 2	
6. Checklist of Mandatory Service for Hearing Impairment (Annex C1)	
7. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
8. Photocopy of the ABR waveform tracing or applicable hearing test result	
DATE COMPLETED :	
DATE FILED:	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Otolaryngologist	(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)

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Annex "E2.1 – Hearing Impairment"

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) HEARING AID PROVISION

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E2.1)	
2. PhilHealth Claim Form2 (CF2)	
3. Checklist of Mandatory Service for Hearing Impairment (Tranche 2) (Annex C2)	
4. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
5. Certificate of completed hearing aid verification (Annex J)	
DATE COMPLETED :	
DATE FILED :	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Otolaryngologist	(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)

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Annex "E3.1 – Hearing Impairment"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT-FOR EAR MOLD REFITTING

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E3.1)	
2. PhilHealth Claim Form2 (CF2)	
3. Checklist of Mandatory Service for Hearing Impairment (Annex C3)	
4. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
DATE COMPLETED :	
DATE FILED :	

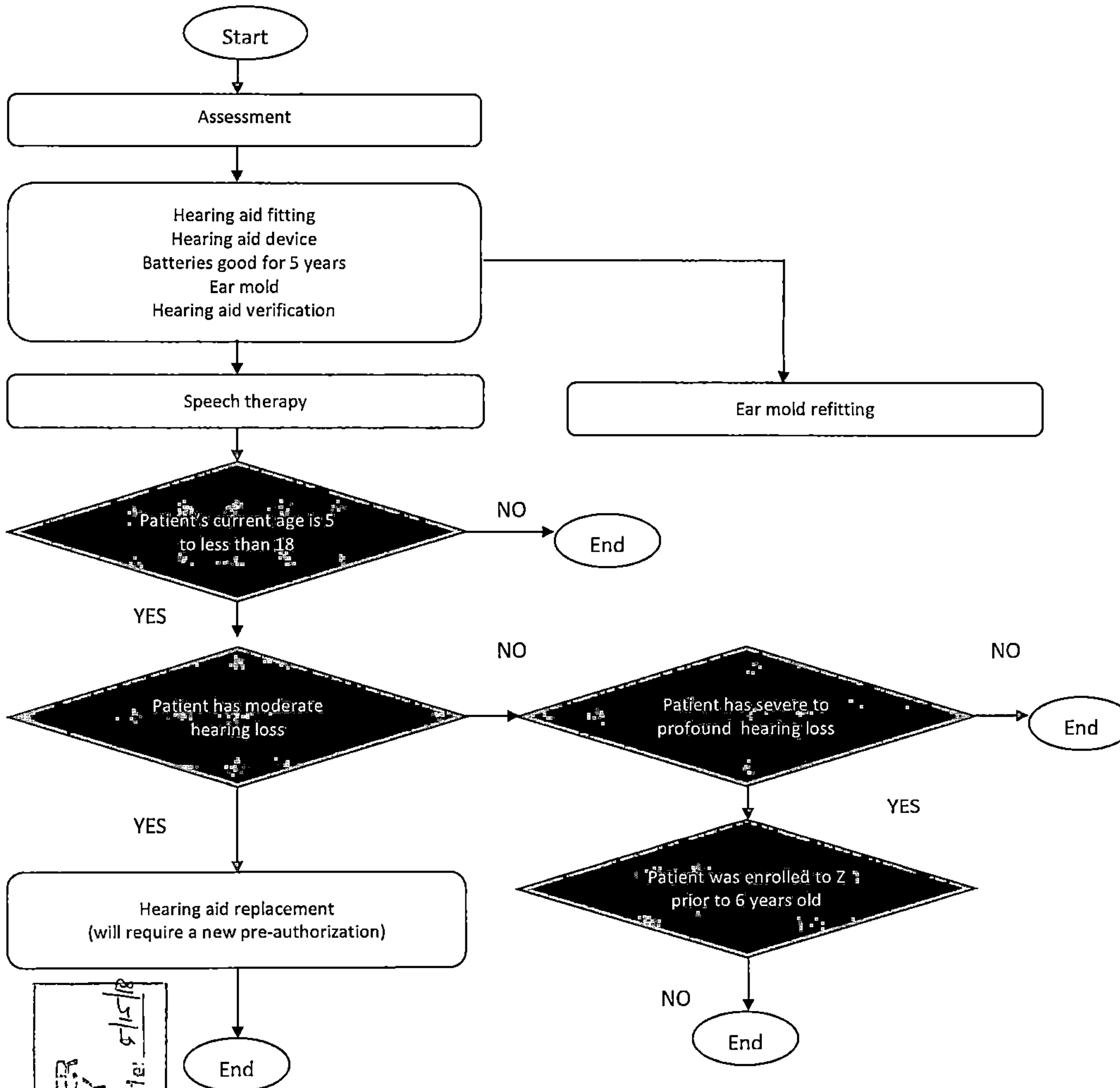
Certified correct by:	Certified correct by:
(Printed name and signature) Attending Otolaryngologist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐	PhilHealth Accreditation No. ☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐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

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

MASTER COPY
DC: [signature] Date: 5/15/18

Annex "G – Hearing Impairment"

General Process Flow for the Provision of Care for Children with Hearing Impairment



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SAMPLE CLAIM FORM 2 FOR HEARING IMPAIRMENT (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 (Building Number and Street Name) QUEZON CITY (City/Municipality) Province

PART II - PATIENT CONFINEMENT INFORMATION

1. Name of Patient: DELA CRUZ (Last Name) JUAN (First Name) JR. (Name Extension (JR/SR/III)) MASIPAG (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: 1 0 - 0 1 - 2 0 1 7 (month / day / year) b. Time Admitted: __:__ (hour / min) ☐AM ☐PM
   c. Date Discharged: 1 0 - 1 5 - 2 0 1 7 (month / day / year) d. Time Discharged: __:__ (hour / min) ☐AM ☐PM
   OUTPATIENT
4. Patient Disposition: (select only 1)
   ✓ a. Improved
   ☐ b. Recovered
   ☐ c. Home/Discharged Against Medical Advise
   ☐ d. Absconded
   ☐ e. Expired, Date: month - day - year Time: hour : min ☐AM ☐PM
   ☐ f. Transferred/Referred ______ (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

MASTER COPY DC: Date:

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: Z020.11 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 assessment

Date of verification of assessment results

Write OUTPATIENT in lieu of time admitted & discharged

Tick YES if the patient was referred by another HCI

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

Indicate the laterality

Indicate the diagnosis

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

This is not required

10. Professional Fees / Charges (Use additional CF2 if necessary):

Accreditation Number / Name of Accredited Health Care Professional / Date Signed	Details
Accreditation No.: 1234-5678901-2 JUANA DELA CRUZ, MD Signature Over Printed Name Date Signed: __ - __ - ____ (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: __ - __ - ____ (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: __ - __ - ____ (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 no additional Professional fee

Tick this box if patient paid an additional Professional fee, indicate amount

PART III - CERTIFICATION OF CONSUMPTION OF BENEFITS AND CONSENT TO ACCESS PATIENT RECORD/S

NOTE: Member/Patient should sign only after the applicable charges have been filled-out

A. CERTIFICATION OF CONSUMPTION OF BENEFITS

☑ PhilHealth benefit is enough to cover HCI and PF charges.
No purchases of drugs/medicines, supplies, diagnostics, and co-pay for professional fees by the member/patient.

	Total Actual Charges*
Total Health Care Institution Fees	1,250.00
Total Professional Fees	
Grand Total	1,250.00

Tick this box if patient has NO out of pocket payment

☐ The benefit of the member/patient was completely consumed prior to co-pay OR the benefit of the member/patient is not completely consumed BUT with purchases/expenses for drugs/medicines, supplies, diagnostics and others.

Tick this box if patient has an out of pocket payment

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				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.)

b.) Purchases/Expenses NOT included in the Health Care Institution Charges

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)*

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DC: ____ Date: 5/15/18

B. CONSENT TO ACCESS PATIENT RECORD/S

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.

JUAN MASIPAG DELA CRUZ, JR.
Signature Over Printed Name of Member/Patient/Authorized Representative

Affix signature of patient

Date Signed: __ - __ - ____ (month, day, year)

Indicate date signed

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

PART IV - CERTIFICATION OF HEALTH CARE INSTITUTION

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.

MIGUEL DELOS SANTOS
Signature Over Printed Name of Authorized HCI Representative

RECORDS OFFICER
Official Capacity / Designation

Date Signed: 10-19-2017 (month, day, year)

Affix signature of HCI representative

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 "J– Hearing impairment"

Z BENEFITS FOR CHILDREN WITH HEARING IMPAIRMENT

PATIENT (Last name, First name, Middle name, Suffix)	BIRTHDAY (mm/dd/yyyy)
ADDRESS	
CONTACT NUMBER	

CERTIFICATE OF HEARING AID VERIFICATION

This certifies that patient ______________________________, has completed the hearing aid verification.

Remarks (if any): ____

____

Conforme by Patient/Parent/Guardian:

____
Printed name and signature

Certified by:

____
Printed name and signature
Attending Audiologist

teamphilhealth www.facebook.com/PhilHealth www.youtube.com/teamphilhealth actioncenter@philhealth.gov.ph

MASTER COPY
DC: ____ Date: 5/15/18

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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www.philhealth.gov.ph

Case No. ______________

Annex "K– Hearing impairment"

Z BENEFITS FOR CHILDREN WITH HEARING IMPAIRMENT

PATIENT (Last name, First name, Middle name, Suffix)	BIRTHDAY (mm/dd/yyyy)
ADDRESS	
CONTACT NUMBER	

CERTIFICATE OF COMPLETED SPEECH THERAPY SESSIONS

This certifies that patient ______________________________, has completed the speech therapy sessions on the specified dates

Remarks (if any): ______________________________

____

Conforme by Patient/Parent/Guardian:

____
Printed name and signature

Certified by:

____
Printed name and signature
Attending Speech Therapist/Pathologist

MASTER COPY DC: ______ Date: 5/15/18