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

PHILHEALTH CIRCULAR
No. 2025 - 0007

TO : **ALL FILIPINOS, ACCREDITED HEALTH CARE INSTITUTIONS/ PROVIDERS, PHILHEALTH REGIONAL OFFICES, BRANCHES, LOCAL HEALTH INSURANCE OFFICES AND ALL OTHERS CONCERNED**

SUBJECT : **PhilHealth Benefit Package for Optometric Services for Children 0 to 15 Years Old**

I. RATIONALE

The 2018 Philippine Eye Disease Study found that 1.98% of Filipinos have visual impairments, mainly due to cataracts, uncorrected refractive errors, glaucoma, and maculopathy. PhilHealth's mandate is to provide financial access to essential health services. Under the Universal Health Care Act, "every Filipino shall be granted immediate eligibility and access to preventive, promotive, curative, rehabilitative, and palliative care for medical, dental, mental, and emergency health services" for which PhilHealth aims to develop a comprehensive outpatient benefit.

The National Vision Screening Act (Republic Act No. 11358) established a program to screen the vision of kindergarten pupils and mandated PhilHealth to create a benefit package for children's eye disease treatment. Currently, PhilHealth covers some eye diseases but not common vision problems like refractive errors.

In line with the principle of Universal Health Care, no one is left behind. While the current vision screening of the government is only focused to kindergarten pupils, other children with error of refraction and other eye problems need early intervention to improve their vision. Clear vision is vital in the child's health development. Moreover, improving the child's vision will have a positive effect on his/her social and emotional well-being and literacy and learning.

Hence, PhilHealth Board through PhilHealth Board Resolution No. 2970 s.2024 approved the Benefit Package for Optometric Services covering assessments and prescription glasses for children 0 to 15 years of age.

II. OBJECTIVES

This PhilHealth Circular has the following objectives:

A. Provide a mechanism for children 0 to 15 years old to have financial access to vision assessment and prescription eyeglasses;

B. Expand the coverage of PhilHealth outpatient benefits to cover optometric services towards comprehensive outpatient benefits; and

C. Provide policy on the implementation of the PhilHealth Optometry Benefit Package for Children 0 to 15 years old.

III. SCOPE

This PhilHealth Circular covers PhilHealth beneficiaries 0 to 15 years old, and all PhilHealth-accredited facilities and professionals, and other health care providers with capability to provide optometric services.

IV. DEFINITION OF TERMS

A. Age-appropriate Vision Screening Tests – tests to screen eye problems which are conducted based on the age of the patient.

B. Designer Frames – eyeglasses frames that were made by high-end fashion, designer, or luxury brands. The branding and exclusivity made them more costly than the regular frames.

C. First Patient Encounter (FPE) – initial episode of patient contact for the year whereby a primary care provider takes and/or updates the basic health data of an eligible beneficiary to identify their health risks. The FPE is not considered a consultation.

D. Health Care Professionals – physicians/medical doctors, nurses, midwives, dentists, or other allied professionals or practitioners duly licensed to practice in the Philippines.

E. Health Facilities – places or establishments, which are devoted primarily to the provision of services for health promotion, prevention, diagnosis, treatment, rehabilitation, and palliation of individuals suffering from illness, disease, injury, disability, or deformity, or those in need of obstetrical or other medical and nursing care.

F. Ophthalmologists – physicians who specialize in the diagnosis, treatment, and study of eye diseases and vision conditions. They are licensed as physicians by the Philippine Regulation Commission (PRC) and certified as diplomate by the Philippine Board of Ophthalmology (PBO). For the purpose of this PhilHealth Circular, licensed physicians who completed the residency training in a training institution accredited by the Philippine Academy of Ophthalmology (PAO), are also considered ophthalmologists.

G. Optometric Clinics – health facilities where eye and vision examinations are conducted; and ophthalmic medical devices such as prescription eyeglasses, low vision devices, contact lenses, and solutions are prescribed and dispensed. In some facilities, an optometric clinic may be a part of the health services (e.g., diagnostics, ambulatory surgeries) that they are providing.

H. Optometrists – health professionals who have been certified by the Board of Optometry and registered with the Professional Regulation Commission (PRC) as being qualified to practice optometry in the Philippines.

I. **Optometry** – a science and art of examining the human eye, analyzing the ocular function, prescribing, and dispensing ophthalmic lenses, prisms, contact lenses, and their accessories.

J. **Prescription Glasses** – eyeglasses or spectacles made specifically for a person specifically to match the wearer's defects of vision. They were made based on an order or prescription made by an optometrist or ophthalmologist.

K. **Regular Frames** – eyeglasses frames that have no brand or were made by less-known manufacturers with focus on basic styles, functionality, and safety rather than aesthetics and trends.

V. POLICY STATEMENTS

A. The PhilHealth Optometry Benefit Package

1. PhilHealth shall cover the following optometric services:

   a. Vision assessment including refraction;

   b. Prescription eyeglasses (including frames and lenses); and

   c. Follow-up, for children 0 to 15 years of age.

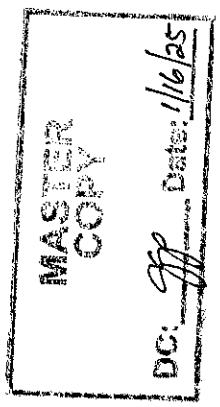
2. The PhilHealth Optometry Benefit Package rate is two thousand five hundred pesos (Php 2,500.00) per case, inclusive of facility and professional/consultation fees. The benefit may be availed of once a year subject to the evaluation of health care provider if indicated.

3. PhilHealth beneficiaries with age 0 to 15 years old, assessed and diagnosed by qualified health professionals to have errors of refraction and other eye conditions that can be corrected by prescription glasses are eligible to avail the benefits.

4. Vision screening and assessment shall be based on the current standards of care and clinical practice guidelines.

5. There shall be no co-payment for the services including regular frames and appropriate lenses (regardless of materials used, including polycarbonate) covered by the Package.

6. However the use of designer frames is subject to out of pocket expense, provided that the beneficiaries are properly informed and have consented.



B. Health Care Provider Engagement and Participation

1. PhilHealth shall accredit health care facilities and professionals as providers of the Benefit Package.

2. Health facilities/optometric clinics (such as optical clinics and ambulatory surgical clinics) that have a Food and Drug Administration (FDA) License to Operate (LTO) as retailers of medical devices (eyeglasses) are qualified to apply as providers of the Benefit Package.

a. They shall submit documentary requirements for accreditation (Annex A: Documentary Requirements for Accreditation of Health Facilities for Optometry Benefit Package) to the nearest PhilHealth Office.

b. They shall pay an accreditation fee of one thousand pesos (Php 1,000).

c. Health facilities that are already PhilHealth-accredited for other services (e.g., ambulatory surgical clinics) may also apply through re-accreditation in accordance with PhilHealth Circular No. 2023-0012 Omnibus Guidelines on the Accreditation of Health Facilities (HFs) to the National Health Insurance Program.

d. Health facilities shall have a memorandum of agreement or service level agreement with PhilHealth Konsulta Package Provider or schools conducting vision screening (based on Republic Act No. 11358: National Vision Screening Act) as referral facilities for optometric services.

3. Health professionals may be the following:

a. Optometrists with an updated license from the PRC.

a.1. They shall submit documentary requirements for PhilHealth Accreditation (Annex B: Documentary Requirements for Accreditation of Health Professionals for Optometry Benefit Package).

a.2. The process of accreditation shall be based on PhilHealth Circular No. 2023-0024: Accreditation of Health Care Professionals, and its subsequent amendments.

b. Ophthalmologists with an updated license as physicians from the PRC.

b.1. These physicians who are certified by the Philippine Board of Ophthalmology or have completed training in a PAO-accredited training institution are qualified to perform eye examinations and vision assessments.

b.2. PhilHealth already accredits ophthalmologists as physicians. There shall be no separate accreditation guidelines for this Benefit Package. Provider engagement and accreditation shall be based on PhilHealth Circular No. 2023-0024: Accreditation of Health Care Professionals.

4. Accredited health care providers shall follow the current patient care pathway, quality policies, and other PhilHealth and DOH-issued patient care guidelines and standards. They shall perform age-appropriate vision tests and provide the appropriate prescription glasses.

C. Benefit Availment

1. PhilHealth Konsulta Package Providers (KPPs) shall perform vision screening among their clients (0 to 15 years old) as part of the First Patient

Encounter or during subsequent consultations. The screening is already covered by the capitation payment under PhilHealth Konsulta. The KPPs shall refer children who failed in screening to PhilHealth-accredited facilities for Optometry Package (Annex C: Referral Form for Optometric Services) for complete eye examination and vision assessment, and possible provision of prescription glasses.

2. Schools that are conducting vision screening (as provided in Republic Act No. 11358: National Vision Screening Act) and PhilHealth-accredited health facilities that attend to and perform health screening/examination among children may also refer their pupils or patients (who failed in the vision screening) to PhilHealth-accredited optometric clinics (Annex C: Referral Form for Optometric Services).

3. The PhilHealth-accredited optometric clinics through their PhilHealth-accredited health professionals shall perform a thorough vision assessment appropriate for the child's age and shall determine the need for eyeglasses and write/order the appropriate prescription to correct the vision.

4. Children whose vision cannot be corrected to 20/20 (or 6/6 in metric system) despite the lenses, shall be referred first to ophthalmologists for further examination.

5. Children with other vision or eye problems (e.g. problems in the cornea or retina) shall be referred to ophthalmologists.

6. The eyeglasses shall be dispensed according to the prescription. The types of lenses and frames shall be the recommended materials and types (i.e., polycarbonate lens for younger children) that is appropriate and safe for the child's age.

7. There shall be follow-up for the fitting of eyeglasses, and advice for eye care and eyeglasses care.

8. The attending health professionals shall accomplish and update, as necessary, the health record of the child and shall provide feedback to the referring facility.

D. Provider Payment and Claims Filing

1. Accredited health facilities that directly provided the service shall submit claims to PhilHealth through PhilHealth-certified/-provided claims submission system or application within 60 days after dispensing the eyeglasses. (Annex D: Claim Form for PhilHealth Optometry Benefit Package). Direct filing is not encouraged.

2. If applicable, the health care providers shall indicate the out of pocket or copayment in the appropriated section of the Claim Form. This shall be used as reference for the monitoring and review of the Benefit.

3. In order to facilitate the processing of claims, health facilities shall use the following code (Table 1):

Package Code	Description	Covered Services	Package Rate
OPT01	Optometry Benefit Package for Children (0-15 years old)	Assessment of eye and vision Prescription glasses (lens and frame) Follow-up	Php 2,500.00*
*subject to tax			

Table 1: Package Code and Description of PhilHealth Optometry Benefit Package

4. PhilHealth shall process and pay the claims within 60 days after receipt.

5. PhilHealth shall pay directly to the health facility that provided the service through auto credit payment system (ACPS).

6. PhilHealth shall not prescribe or differentiate facility and professional fees, and the sharing among health care workers, in accordance with Section 18(b) of Republic Act No. 11223, Universal Health Care Act.

E. Monitoring and Review

1. Healthcare providers shall maintain a patient record (Annex E: Template of Optometry Patient Record) in the facility and shall submit relevant information to PhilHealth regularly and when necessary.

2. PhilHealth shall monitor health care providers in accordance with PhilHealth Circular No. 2018 – 0019: Health Care Provider Performance Assessment System (HCPPAS) Revision 2.

3. PhilHealth shall institute fraud prevention measures and act in line with the applicable laws and regulations.

F. Annexes

1. Annex A: Documentary Requirements for Accreditation of Health Facilities for Optometry Benefit Package

2. Annex B: Documentary Requirements for Accreditation of Health Professionals for Optometry Benefit Package

3. Annex C: Referral Form for Optometric Services

4. Annex D: Claim Form for PhilHealth Optometry Benefit Package

5. Annex E: Template of Optometry Patient Record

6. Annex F: Claims Summary Form for PhilHealth Optometry Benefit Package

VI. PENALTY CLAUSE

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

VII. TRANSITORY CLAUSE

A. Health facilities shall maintain a paper-based record of the clients. For the initial implementation in CY 2025, services rendered within this year may be claimed within 180 days after the provision of services.

B. PhilHealth shall make available an interim electronic reporting and claims submission system in the first three years of implementation.

C. For the first 180 days of implementation, PhilHealth shall allow manual submission of claims. To facilitate the submission of claims, the health care providers shall use the prescribed claims summary form (Annex F: Claims Summary Form for PhilHealth Optometry Benefit Package).

VIII. SEPARABILITY CLAUSE

In the event that a section or a provision of this policy is declared unconstitutional or invalid by a court of law or competent authority, provisions not affected by such declaration shall remain in full force and in effect.

IX. REPEALING CLAUSE

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

X. DATE OF EFFECTIVITY

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

EMMANUEL R. LEDESMA, JR.
President and Chief Executive Officer

Date signed: 01/15/25

Annex A: Documentary Requirements for Accreditation of Health Facilities for Optometry Benefit Package

Documentary Requirements for Accreditation Health Facilities

Health Facility	Provider's Data Record	Notarized Performance Commitment	Payment of Accreditation Fee	FD- LTO	Memorandum of Agreement or Service Level Agreement with a PhilHealth Konsulta Package Provider	OTHERS
Optometry Clinics	✓	✓	✓	✓	✓	Additional requirement: Memorandum of Agreement/Service Level Agreement with PhilHealth KPP or schools as referral facility for optometric services
PhilHealth-Accedited Konsulta Package Provider	✓ (updated)	✓ (updated)	N/A	✓	N/A	N/A
Other PhilHealth-accredited health facilities	✓ (updated)	✓ (updated)	N/A	✓	✓	Additional requirement: Memorandum of Agreement/Service Level Agreement with PhilHealth KPP or schools as referral facility for optometric services

The Provider Data Record (PDR) and the Performance Commitment (PC) can be downloaded from the PhilHealth website through this link: https://www.philhealth.gov.ph/downloads under the "Accreditation Documents" section.

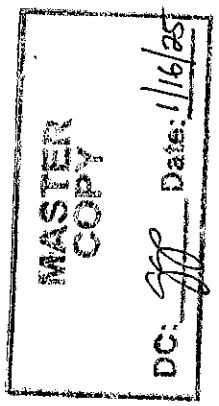
Please ensure that the accreditation of the healthcare professional (HCProf) serving as the head of facility (HoF), i.e. medical director, chief of hospital, or medical center chief, is valid during the accreditation period being applied for by the facility. If the HoF's accreditation is near expiration, please ensure that an application of renewal is also submitted in the soonest possible time. All HCProfs may submit their application for renewal of their accreditation 120 to 20 days before its expiration

Annex B: Documentary Requirements for Accreditation of Health Professionals for Optometry Benefit Package

Documentary Requirements for Accreditation of Health Professionals

Health Professionals	Updated PRC License	Provider Data Record	Notarized Performance Commitment	Certificate of Good Standing	OTHERS
Optometrists	✓	✓	✓	✓ (Copy of CGS submitted during PRC license renewal is acceptable)	
Physicians (Ophthalmologists)	✓	✓	✓	✓	Additional requirement: Certificate as Diplomate from the Philippine Board of Ophthalmology OR Certificate of completed residency training in Ophthalmology from an institution accredited by the Philippine Academy of Ophthalmology

The Provider Data Record (PDR) and the Performance Commitment (PC) can be downloaded from the PhilHealth website through this link: https://www.philhealth.gov.ph/downloads under the "Accreditation Documents" section.



Annex C: Referral Form for Optometric Services

Referral

Date of Referral	
Name of Client	
Age/Sex	
Referring Facility	
PAN of Referring Facility	
Referral Facility	
PAN of Referral Facility	
Reason for Referral	☐ Optometric Services ☐ Others ____
Vision Screening Result	☐ Normal ☐ Abnormal ☐ Others____
Referral Transaction Code	

Respectfully referring patient: _____

For: _____

Additional patient information if any: _____

Thank you.

Name and Signature
Designation

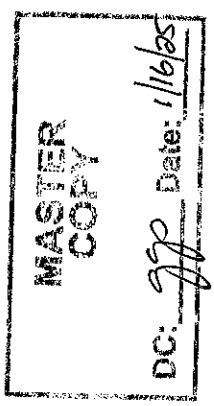
_____

Feeback

Services Rendered to the Client	Date Done	Remarks

Accomplished by:

Name and Signature
Designation



Annex D: Claim Form for PhilHealth Optometry Benefit Package

PhilHealth
Your Partner in Health

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
email: actioncenter@philhealth.gov.ph

Series #

Part I -Member Information

1. PhilHealth Identification Number (PIN) of Member: ☐☐-☐☐☐☐☐☐☐☐-☐

2. Name of Member:

Last Name | First Name | Name Extension (JR/SR/III) | Middle Name (ex: DELA CRUZ JUAN JR SIPAG)

3. Date of Birth: ☐☐-☐☐-☐☐☐☐ (month-day-year)

4. Mailing Address:

Unit/Room No./Floor | Building Name | Lot/Blk/House/Bldg.No | Street | Subdivision/Village

Barangay | City/Municipality | Province | Country | Zip Code

5. Sex: ☐ Male ☐ Female

6. Contact Information:

Landline No. (Area Code + Tel. No.) | Mobile No. | Email Address

7. Patient is the member? ☐ Yes, Proceed to Part III ☐ No, Proceed to Part II

Part II – Patient/Client Information

1. PhilHealth Identification Number (PIN) of Dependent ☐☐-☐☐☐☐☐☐☐☐-☐

2. Name of Patient:

Last Name | First Name | Name Extension (JR/SR/III) | Middle Name (ex: DELA CRUZ JUAN JR SIPAG)

3. Date of Birth: ☐☐-☐☐-☐☐☐☐ (month-day-year)

4. Relationship to Member: ☐ Child ☐ Parent ☐ Spouse

5. Sex: ☐ Male ☐ Female

Part III – Health Care Institution/Facility (HCI) Information

1. PhilHealth Accreditation Number (PAN) of Health Care Institution: ☐☐☐☐☐☐☐☐☐

2. Name of Health Care Institution/Facility: _____

3. Address: _____ (Building Number and Street Name) _____ (City/Municipality) _____ (Province)

Part IV. Health Care Professional Information and Signature

1. Name of Professional Provider

Last Name | First Name | Name Extension(JR/SR/III) | Middle Name
(ex: DELA CRUZ JUAN JR SIPAG)

Accreditation Number ☐☐☐☐-☐☐☐☐☐☐☐☐-☐

Signature _____ (Signature Over Printed Name)

Date Signed: ☐☐-☐☐-☐☐☐☐ (month-day-year)

Part V Patient/Client Information on Service/s Availed

1. Was the patient/client referred by another Health Care Institution/Facility (HCI)?

☐ No ☐ Yes Name of HCI

PAN of Referring HCI

Date of Referral ☐☐-☐☐-☐☐☐☐ Month Day Year

2. Was the patient/client referred by other institution?

☐ No ☐ Yes Name of Institution

Type of Institution

3. Date Provision of Service/s ☐☐-☐☐-☐☐☐☐ month day year

4. Patient/Client Disposition ☐ a. Improved ☐ b. Recovered ☐ c. Discharged against medical advice ☐ d. Absconded ☐ e. transferred/referred to _____

Reason for referral/transfer _____

5. Working Diagnosis/es

6. Final Diagnosis/es ICD 10 Code/s

7. Procedure/s Done RVS/Package Code/s

8. Special Considerations

For Optometric Benefit Package (Details)

	PD	S	C	AX	ADD
OS (LE)					N/A
OD (RE)					N/A

9. PhilHealth Benefit Claim **RVS/ Package Code/s** 1._____

Part VI Details of Copayment and Consent to Access Patient Records

1. Certification of No Copayment/Copayment

☐ No copayment ☐ with copayment Amount of Copayment PHP _____

2. Details of Copayment

Total Charges (HCI and Professional Fees)	Mandatory Discounts (e.g., Senior Citizens, PWDs)	PhilHealth Benefit	Copayment
PHP	PHP	PHP	PHP

3. Consent to Access Patient Records

I hereby consent to the submission and examination of the patient's pertinent medical records for the purpose of verifying the veracity of this claim to effect efficient processing of benefit payment.

I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all legal 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

MASTER COPY 1/16/25

PART VI Certification of Consumption of Health Care Institution/Facility

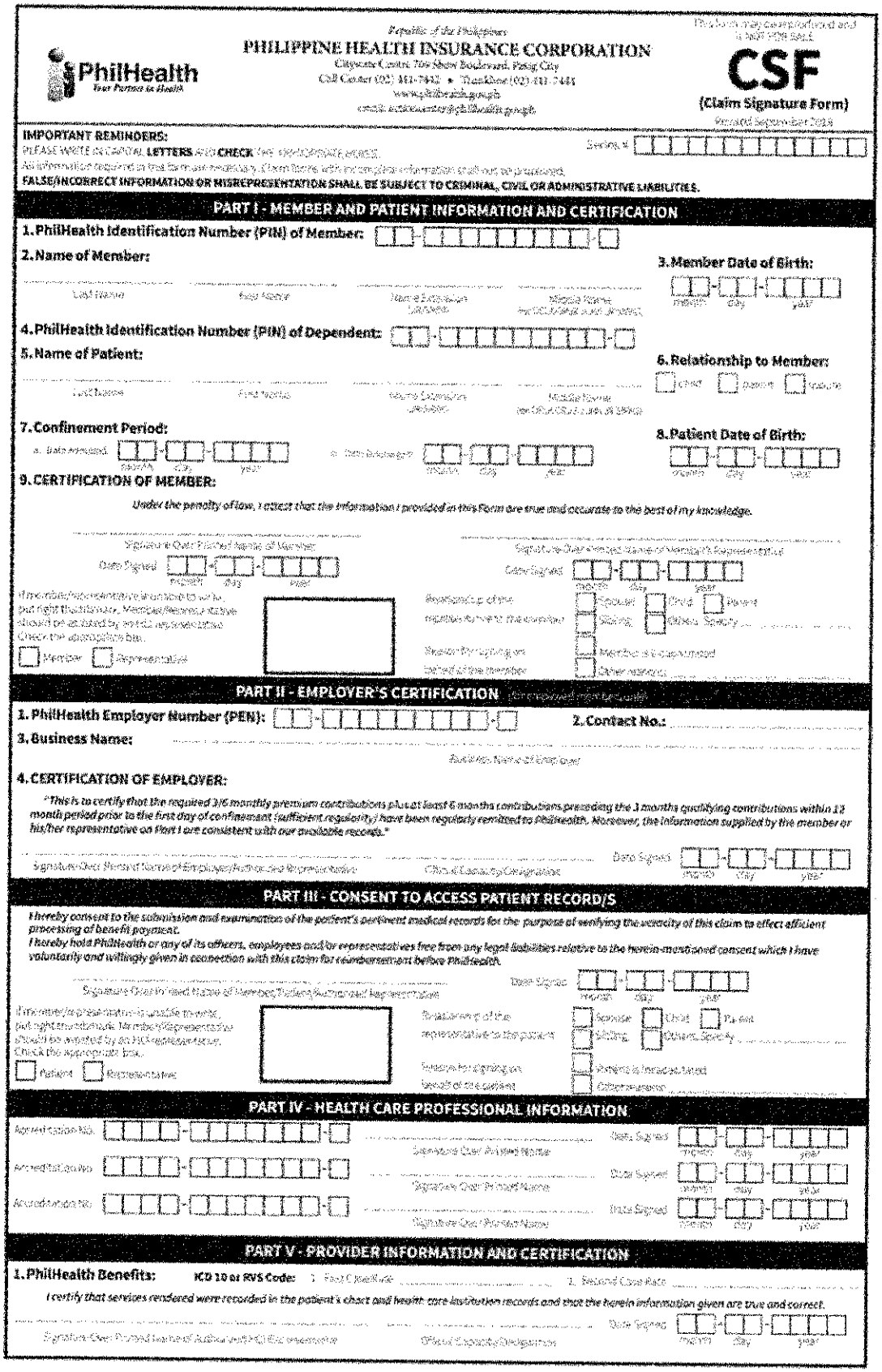
"I certify that services rendered were recorded in the patient's chart and health care institution records and that the herein information given are true and correct.

_____

Signature Over Printed Name of Member/Patient/Authorized Representative

Date Signed: ☐☐-☐☐-☐☐☐☐ month day year

Claim Signature Form



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
email: actioncenter@philhealth.gov.ph

PhilHealth
Your Partner in Health

This form may be reproduced and is NOT FOR SALE

CSF
(Claim Signature Form)
Revised September 2018

IMPORTANT REMINDERS:
PLEASE WRITE IN CAPITAL LETTERS AND CHECK (✓) WHERE APPROPRIATE.
All information required in this form must be provided. Claims with incomplete information will not be processed.
FALSE/INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CRIMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.

Serial #

PART I - MEMBER AND PATIENT INFORMATION AND CERTIFICATION

1. PhilHealth Identification Number (PIN) of Member:
2. Name of Member: (Last Name, First Name, Name Extension (Jr./III), Middle Name or Initial (if with middle name or initial))
3. Member Date of Birth: (month / day / year)
4. PhilHealth Identification Number (PIN) of Dependent:
5. Name of Patient: (Last Name, First Name, Name Extension (Jr./III), Middle Name or Initial (if with middle name or initial))
6. Relationship to Member: Child / Spouse / Others
7. Confinement Period: a. Date Admitted (month / day / year) b. Date Discharged (month / day / year)
8. Patient Date of Birth: (month / day / year)
9. CERTIFICATION OF MEMBER:

Under the penalty of law, I attest that the information I provided in this Form are true and accurate to the best of my knowledge.

Signature Over Printed Name of Member
Date Signed (month / day / year)

If member/representative is unable to write, put right thumbmark. Member/Representative should be assisted by an HCI representative. Check the appropriate box.
Member / Representative

Signature Over Printed Name of Member's Representative
Date Signed (month / day / year)
Relationship of the representative to the patient: Spouse / Child / Parent / Sibling / Others, Specify
Reason for signing on behalf of the member: Member is incapacitated / Others, specify

PART II - EMPLOYER'S CERTIFICATION (To be accomplished by Employer)

1. PhilHealth Employer Number (PEN):
2. Contact No.:
3. Business Name: (Business Name of Employer)
4. CERTIFICATION OF EMPLOYER:

"This is to certify that the required 3/6 monthly premium contributions paid at least 6 months contributions preceding the 1 month qualifying contributions within 12 month period prior to the first day of confinement (sufficient regularity) have been regularly remitted to PhilHealth. Moreover, the information supplied by the member or his/her representative on Part I are consistent with our available records."

Signature Over Printed Name of Employer/Authorized Representative
Date Signed (month / day / year)

PART III - CONSENT TO ACCESS PATIENT RECORD/S

I hereby consent to the submission and examination of the patient's pertinent medical records for the purpose of verifying the veracity of this claim to effect efficient processing of benefit payment.
I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any legal 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)

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

Relationship of the representative to the patient: Spouse / Child / Parent / Sibling / Others, Specify
Reason for signing on behalf of the member: Patient is incapacitated / Others, specify

PART IV - HEALTH CARE PROFESSIONAL INFORMATION

Accreditation No. / Signature Over Printed Name / Date Signed (month / day / year)
Accreditation No. / Signature Over Printed Name / Date Signed (month / day / year)
Accreditation No. / Signature Over Printed Name / Date Signed (month / day / year)

PART V - PROVIDER INFORMATION AND CERTIFICATION

1. PhilHealth Benefits: ICD 10 or RVS Code: 1. Final Diagnosis 2. Related Case Rate
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.

Signature Over Printed Name of Authorized HCI Representative / Official Capacity/Designation
Date Signed (month / day / year)

MASTER COPY
DC: Date: 1/16/25

Annex E: Template of Optometry Patient Record

Eye Chart

Client Information

Name of Client	
Age/Sex	
Birthday	
Address	
Contact Number	
Name of Parent/Guardian	
Contact Number of Guardian	
PhilHealth Konsulta Package Provider (if applicable)	
Referred by:	☐ Konsulta Provider ☐ School _____ ☐ Others _____
Date of First Visit	
Name of Eye Doctor/Optometrists	

General Medical History

Reason for Visit/ Chief Complaint	
Ocular History	
Pertinent Medical History	
Visual Needs	
Previous Prescriptions (if any)	

Eye/Vision Exam

External Eye Exam	
Internal Eye Exam	
Visual Acuity	Date:
Refraction	DC:
Binocular Vision, Ocular Motility, and Accommodation	
Color Vision	If applicable
Ocular and Systemic Health Assessment	If applicable
Supplementary Tests	If applicable

	No correction	With Correction
OU		
OS (LE)		
OD (RE)		

	PD	S	C	AX	ADD
OS (LE)					
OD (RE)					

MASTER COPY 1/16/25

Diagnosis/Assessment

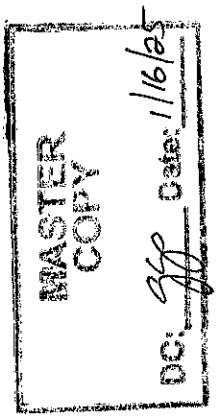
Treatment/Plan

Accomplished by:

Name and Signature of Attending Doctor

Follow-up Visits

Examination Date							
Complaint							
Pertinent History							
Pertinent Eye Exam							
Assessment/Diagnosis							
Treatment/Plan							
Advise							
Name and Signature of Attending Doctor							



Annex F: Claim Summary Form for PhilHealth Optometry Benefit Package

PhilHealth Optometric Package Claims Summary Form

Name of PhilHealth Accredited Facility: _____ Address: _____

PhilHealth Accreditation Number (PAN): _____

No.	Patient Information						Member Information					Details of Benefit Claim						
	PIN	Last Name	First Name	Name Extension	Middle Name	Birthday (mm-dd-yyyy)	PIN	Last Name	First Name	Name Extension	Middle Name	Date of Availment (Dispensing of Eyeglasses) (mm-dd-yyyy)	Package Code	Package Amount	Prescription				
															Eye	Pupillary Distance (D)	Sphere (D)	Cylinder (C)	Axis (AX)
															OD				
															OS				
															OD				
															OS				
															OD				
															OS				
															OD				
															OS				
															OD				
															OS				

MASTER COPY
Date: 1/16/25
DC:

I certify that the services rendered were recorded in the patient's health records and health care provider records and that information herein including the package code are true and correct. We declare that I did not engage in any form of unethical practices such as but not limited to recruitment of patients or engaging with seekers for purposes of claiming reimbursement from PhilHealth.

Prepared by: _____ _____ Approved by: _____ _____

(name over signature and date) (designation) (name over signature and date) (designation)