Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "E2 – ALL"

HEALTH CARE *PROVIDER (HCP)*		
ADDRESS OF *HCP*		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	*SEX* ☐ *Male* ☐ *Female*
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	☐ *Same as patient* *(Answer the following only if the patient is a dependent)* 1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
DATE OF END OF INTENSIFICATION OR RE-INDUCTION PHASE (mm/dd/yyyy)		

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2)
Acute Lymphocytic/Lymphoblastic Leukemia (Standard Risk)
Consolidation, Interim Maintenance and Delayed Intensification Phase

Requirements	**Please Check**
1. Checklist of Requirements for Reimbursement (Tranche 2) (Annex E2-ALL)	
2. *Properly accomplished PhilHealth Claim Form 2*	
3. Checklist of Mandatory and Other Services (Annex C2-ALL)	
4. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
DATE COMPLETED *(mm/dd/yyyy):*	
DATE FILED *(mm/dd/yyyy):*	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physician	(Printed name and signature) Parent/Guardian
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐☐-☐	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	