Annex E.2: Checklist of Requirements for Reimbursement – Surgery

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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PhilHealthOfficial teamphilhealth

Case No. _____

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT
Breast Cancer – Surgical Procedure

Place a (✔) in the appropriate tick box.

Requirements	Please Check
1. Checklist of Requirements for Reimbursement - Surgery (Annex E.2)	
2. Properly accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)	
3. Properly accomplished PhilHealth Claim Form (CF) 2	
4. Photocopy of approved Pre-authorization Checklist and Request (Annex A.2)	
5. Photocopy of Member Empowerment Form (Annex B)	
6. Checklist of Mandatory and Other Services (Annex C.2)	
7. Completed Z Satisfaction Questionnaire (Annex D)	
8. Transmittal Form (Annex H)	
9. Photocopy of multidisciplinary – interdisciplinary team (MDT) plan	
10. Original or certified true copy (CTC) of the Statement of Account (SOA) or its equivalent	
11. Photocopy of accomplished surgical operative report	
12. Photocopy of accomplished anesthesia report	
13. Photocopy of histopathology report	
DATE COMPLETED (mm/dd/yyyy):	
DATE FILED (mm/dd/yyyy):	

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