Annex E.5.2: Checklist of Requirements for Reimbursement – Targeted Therapy Tranche 2

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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(02) 8662-2588 www.philhealth.gov.ph
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 – Targeted Therapy (Tranche 2)

Place a (✓) in the appropriate tick box.

Requirements	Please Check
1. Checklist of Requirements for Reimbursement – Targeted Therapy (Annex E.5.2)	
2. Photocopy of approved Pre-authorization Checklist and Request (Annex A.2)	
3. Properly accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)	
4. Properly accomplished PhilHealth Claim Form (CF) 2	
5. Photocopy of Member Empowerment Form (Annex B)	
6. Checklist of Mandatory and Other Services (Annex C.5.2)	
7. Completed Z Satisfaction Questionnaire (Annex D)	
8. Breast Cancer Treatment Passport (Annex F)	
9. Transmittal Form (Annex H)	
10. Photocopy of the multidisciplinary – interdisciplinary team (MDT) plan	
11. Original or certified true copy (CTC) of the Statement of Account (SOA) or its equivalent	
DATE COMPLETED (mm/dd/yyyy):	
DATE FILED (mm/dd/yyyy):	

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