

## Annex G: Checklist for Patient Transfer



Republic of the Philippines  
**PHILIPPINE HEALTH INSURANCE CORPORATION**  
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Case No. \_\_\_\_\_

HEALTH FACILITY (HF)		
ADDRESS OF HF		
<b>A. PATIENT</b>	1. Last Name, First Name, Middle Name, Suffix	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
	2. PhilHealth ID Number <input type="text"/> - <input type="text"/> - <input type="text"/>	
<b>B. MEMBER</b>	<b>(Answer only if the patient is a dependent; otherwise, write, "same as above")</b>	
	1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number <input type="text"/> - <input type="text"/> - <input type="text"/>	

### CHECKLIST FOR PATIENT TRANSFER Z Benefits Package for Breast Cancer

For breast cancer patients enrolled in the Z benefits who will be transferred to a referral contracted HF, the following checklist shall be accomplished:

NAME OF REFERRAL CONTRACTED HF:
ADDRESS OF REFERRAL CONTRACTED HF:

Requirements	YES OR NO (tick appropriate box)	Signature of Responsible Person
1. Updated Medical Abstract	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ Name and Signature Attending Physician
2. Letter of Referral from the Attending Physician	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Certified true copy of the breast cancer treatment passport	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ Name and Signature Z Benefits Coordinator
4. Letter of Intent from the patient requesting for transfer to a referral contracted HF (Annex I)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ Name and Signature Patient/Parent/Guardian

Certified complete by: _____ Printed name and signature Z Benefits Coordinator	Conformed by: _____ Printed name and signature Patient/Parent/Guardian
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

