**Case No. _______________**

**Annex "E1.1 – Cervical CA"**

| HEALTHCARE *PROVIDER (HCP)* | | |
|---|---|---|
| ADDRESS OF *HCP* | | |
| A. PATIENT | 1. Last Name, First Name, Suffix Middle Name | *SEX* ☐ *Male* ☐ *Female* |
| | 2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐ | |
| B. MEMBER | ☐ *Same as patient* *(Answer the following only if the patient is a dependent)*<br>1. Last Name, First Name, Suffix, Middle Name | |
| | 2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐ | |

## CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT
### Surgery for Cervical Cancer Stage IA1, IA2-IIA1

| Requirements | Please Check |
|---|---|
| 1. Checklist of Requirements for Reimbursement (Annex E1.1-Cervical CA) | |
| 2. Photocopy of approved Pre –Authorization Checklist & Request (Annex A-Cervical CA) | |
| 3. Photocopy of completely accomplished ME FORM (Annex B) | |
| 4. *Properly accomplished* PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2 | |
| 5. Checklist of Mandatory and Other Services (Annex C1.1-Cervical CA) | |
| 6. Photocopy of completed Z Satisfaction Questionnaire (Annex D) | |
| 7. *Photocopy of accomplished operative surgical report* | |
| 8. *Photocopy of accomplished anesthetic report* | |
| 9. *Original copy of* medical certificate of the out-patient follow up consultation (within 2 weeks post-op) with written request for outpatient pap smear 3 months from surgery | |
| 10. *Photocopy of* histopathology result (definitive surgery) | |

| Certified correct by: | Conforme by: |
|---|---|
| (Printed name and signature)<br>Gynecologic Oncologist | (Printed name and signature)<br>Patient |
| PhilHealth Accreditation No. ☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐ | Date signed (mm/dd/yyyy) |
| Date signed (mm/dd/yyyy) | |