Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center: (02) 8441-7442 | Trunkline: (02) 8441-7444
www.philhealth.gov.ph

UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "C – Prostate CA"

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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF MANDATORY AND OTHER SERVICES
Prostate Cancer

Place a (✓) in the appropriate tick box.

MANDATORY SERVICES	OTHER SERVICES as needed/as indicated
Surgery done (any of the following): ☐ open radical prostatectomy ☐ laparoscopic radical prostatectomy	☐ CP Clearance
	☐ Chest X-ray
	☐ ECG
☐ Core needle biopsy or TURP specimen	☐ Abdominal ultrasound
☐ Prostate specific antigen (PSA)	☐ Bone scan
	☐ CT scan/MRI of pelvis and/or abdomen
	☐ PET Scan
	☐ Creatinine
	☐ FBS
	☐ CBC
	☐ Electrolytes
	☐ Urinalysis
	☐ Medicines, specify:

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