*Republic of the Philippines*
**PHILIPPINE HEALTH INSURANCE CORPORATION**
Citystate Centre, 709 Shaw Boulevard, Pasig City
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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

**Case No. _____**

**Annex "E1 – TOF"**

| | | |
|---|---|---|
| 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 OR REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 1)
### Tetralogy of Fallot – Elective TOF Repair

Place a check mark (✓)

| **Requirements** | **YES** |
|---|---|
| 1. Checklist of Requirements for Reimbursement (Annex E1-TOF) | |
| 2. Photocopy of approved Pre –Authorization Checklist & Request (Annex A-TOF) | |
| 3. Photocopy of completed ME FORM (Annex B) | |
| 4. *Properly accomplished* PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2 | |
| 5. Signed Checklist of Mandatory and Other Services (Annex C1-TOF) | |
| 6. Photocopy of completed and signed Z Satisfaction Questionnaire (Annex D) | |
| 7. *Photocopy of* accomplished surgical operative report | |
| 8. *Photocopy of* accomplished anesthesia report | |

| | |
|---|---|
| Certified correct by: | Certified correct by: |
| (Printed name and signature)<br>Attending *Pediatric Cardiologist* | (Printed name and signature)<br>Executive Director/Chief of Hospital/<br>Medical Director/ Medical Center Chief |
| PhilHealth Accreditation No. ☐☐☐☐☐-☐☐☐☐☐☐-☐ | PhilHealth Accreditation No. ☐☐☐☐☐-☐☐☐☐☐☐-☐ |
| Date signed (mm/dd/yyyy) | Date signed (mm/dd/yyyy) |

| | |
|---|---|
| Documents received by: | Conforme by: |
| (Printed name and signature)<br>Z Benefits Coordinator | (Printed name and signature)<br>Parent/Guardian |
| Date signed (mm/dd/yyyy) | Date signed (mm/dd/yyyy) |