Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

Citystate Centre Building, 709 Shaw Boulevard, Pasig City
Healthline 441-7444 www.philhealth.gov.ph

TETRALOGY OF FALLOT – ELECTIVE TOF REPAIR

Name: _____ Age: ____Sex ____ PhilHealth No. _____
Address: _____ Date of Birth:_____
_____
Date of Admission: _____
Date of Discharge: _____ :

TRANCHE 1 REQUIREMENTS CHECKLIST

I. First Tranche Payment	Please Check
1. Copy of Completed ME FORM	
2. Copy of Approved Pre –Authorization Checklist & Request	
3. Confirmatory Preoperative Laboratory Exams 2Decho	
4. Complete Surgical Operative Report	
5. Complete Anaesthesia Report	
6. Intraoperative TEE Report/ Transthoracic within 3days post op (Attach Result)	
7. MANDATORY CHECKLIST OF SERVICES SIGNED	
8. CLINICAL ABSTRACT Signed by Attending Physician	
9. Completed Z Satisfaction Questionnaire Signed	
10. VSD DATA BASE ENCODED	
11. Completed and signed Philhealth CF2	
DATE COMPLETED : DATE FILED :	

CONFORME:

_____ Relation to Patient: _____
Patient/ Guardian
Printed Name and Signature

Documents Reviewed by:

_____
Printed Name & Signature
PHILHEALTH Z MANAGER

Attested by:

_____ _____
Printed Name & Signature Printed Name & Signature
Attending Physician Executive Director/Medical Center Chief

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Name: _____ Age: ____Sex ____ PhilHealth No. _____
Address: _____ Date of Birth: _____
_____
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TRANCHE 2 REQUIREMENTS CHECKLIST

II. Second Tranche Payment	Please check
1. Completed PHC- Pediatric Cardiac Rehab Form with 4 sessions Exercise program	
2. Medical certificate of OPD consultation	
3. Postoperative 2Decho result attached	
DATE COMPLETED : DATE FILED :	

CONFORME:

_____ Relation to Patient: _____
Patient/ Guardian
Printed Name and Signature

Documents Reviewed by:

_____
Printed Name & Signature
PHILHEALTH Z MANAGER

Attested by :

_____ _____
Printed Name and Signature Printed Name and Signature
Attending Physician Executive Director/Medical Center Chief