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UNIVERSAL HEALTH CARE
KATIUSUGAN AT KALINGA PARA SA LAHAT

PHILHEALTH CIRCULAR
No. 2023 - 0005

TO : **ALL CONTRACTED HEALTH FACILITIES *FOR THE Z BENEFITS FOR COLON AND RECTAL CANCER,* AND ALL OTHERS CONCERNED**

SUBJECT : **Z Benefits Package for Colon and *Rectal* Cancers *(Revision 1)***

I. RATIONALE

Recent estimates indicate cancers of the colon and *rectal* combined rank *3rd* for both sexes, *2nd* among males, and *3rd* among females, in the Philippines (Globocan, 2018). The incidence rates begin to rise steeply at *the* age *of* 50 in both males and females. *However, recent findings show that cases of colon and rectal cancers are increasing in younger patients under the age of 40.*

The earlier the cancer is detected, the better the survival rates; screening with *a* fecal occult blood test and colonoscopy can detect early cancer *and* precancerous lesions. Once diagnosed with cancer, prompt and proper treatment must be given *that is* specific *for the* cancer stage.

The Z Benefits will provide *state-of-the-art* treatment for early stage up to stage III colon and *rectal* cancers that can up the survival rate from this disease. Surgery is the primary mode of treatment for colorectal cancer and can be curative in *its* early stages. Chemotherapy is the primary treatment *modality* after *colon cancer* surgery; chemo-radiotherapy is used in *rectal* cancer *before* surgery for T3-4N0M0/any TN1-2M0. *Treating* colon and *rectal* cancers, as in any cancer, must be *done* via a multidisciplinary team.

In the context of quality healthcare and continuous quality improvement, the goal of the Z Benefits *is* to serve as *a* rational intervention to standardize care and improve the system of delivery of services for colon and *rectal* cancers in the country. Thus, PhilHealth, experts *on* colon and *rectal* cancers, contracted health *facilities (HFs),* and key stakeholders are partners in the development, implementation, and future enhancements of the Z Benefits to achieve better health outcomes *for* patients with colorectal cancer for them to go back to society as productive citizens and to contribute to the economic growth of the country.

MASTER COPY DC: Date: 2/7/23

II. OBJECTIVES

This PhilHealth Circular aims to define the policies and procedures for implementing the Z Benefits package for colon and rectal cancers and ensure quality service delivery by contracted health facilities (HFs).

III. SCOPE

This PhilHealth Circular shall apply to all contracted HFs to deliver the defined mandatory services for the Z Benefits package for colon and rectal cancers and all relevant stakeholders involved in its implementation.

IV. DEFINITION OF TERMS

A. *Electronic medical record (EMR)* *or electronic health record (HER) - is a digital collection of medical information about a person helpful in making clinical recommendations or decisions and providing data on episodes of care that could indicate resource intensity use and information pertinent to healthcare costs.*

B. *Lost to Follow-up* *–In the context of colorectal cancer, lost to follow-up means that the patient has not come back as advised for the immediate next treatment visit or within 12 weeks from the last patient attended clinic visit. Visiting the clinic for more than 12 weeks from the advised scheduled treatment visit renders the patient lost to follow-up. For chemoradiation, a patient may be declared lost to follow-up if the patient has missed at least one session.*

C. *Member Empowerment (ME) Form* *– is a document showing that the patient is fully informed of their Z Benefit package, treatment options, treatment schedule and follow-up visits, roles, and responsibilities. The ME Form also documents that the contracted health facility provided education, counseling, and other pertinent courses of action. The beneficiary or their guardian or representative and the attending healthcare provider in charge jointly sign the ME form.*

D. *Multidisciplinary-Interdisciplinary Team (MDT) Approach* *– an approach to patient care involving team members from different professional backgrounds or work disciplines, with each member providing specific services while working collaboratively together to provide the best care to the patient.*

E. *Pre-authorization* *– is an approval process of PhilHealth that gives the contracted HF the information that the patient fits the definition for the minimum selection criteria for the availment of the Z Benefits.*

F. *Total Mesorectal Excision (TME)* *– is the gold standard of surgery for rectal cancer, offering patients a better prognosis and quality of life.*

V. POLICY STATEMENTS

A. Patient Assessment

1. *Contracted HFs should develop an efficient process for assessing all their colon and rectal cancer patients for qualification for the Z Benefits. These patients should be entitled to the Z Benefits package if they fit the clinical definition or selection criteria for pre-authorization.*

2. *Contracted HFs should refer all confirmed colon and rectal cancer patients enrolled in the Z Benefits to the MDT. This team is* composed of, at the minimum, a colorectal surgeon *and* a medical oncologist, *while for rectal cancer, the MDT is composed of, at the minimum, a colorectal surgeon, a medical oncologist,* and a radio-oncologist. *Together, the members of the MDT shall* discuss a consensus management plan for the patient prior to the provision of services.

3. In the absence of a colorectal surgeon in the contracted *HF*, a surgical oncologist or a general surgeon with completed training in TME, *certified by the Philippine Society of Colon and Rectal Surgeons (PSCRS),* may be considered *a* member of the MDT. *Therefore,* it is the responsibility and accountability of the contracted *HF* to ensure that these surgeons are credentialed to manage patients with *rectal* cancer, *which* shall be stipulated in the contract with PhilHealth.

4. In *rectal* cancer, MDT planning must be done *before any treatment modality is performed.* As such, *a photocopy of* the MDT plan shall be attached to the tranche requirements for reimbursement.

5. MDT approach to patient care is a mandatory requirement in all Z Benefits. *In addition, it* is a non-negotiable requirement *to renew* all future contracts with PhilHealth. All contracted *HFs* should practice *the* MDT approach to colon and *rectal* cancer management regardless of patient social classification (i.e., "pay" or "charity/service" category) in the contracted *HF.*

6. Patients with *a* diagnosis of colorectal cancer who fulfill the *selection* criteria (*Sections V.AA and V.BB of this PhilHealth Circular*) shall be covered under the Z Benefits for colon and *rectal* cancers. The *selection* criteria are *the* current standards validated by *colorectal cancer* experts and adopted by PhilHealth during benefits development. These standards are clinical and updated during regular policy *reviews* with stakeholders based on *recent* evidence in the medical literature and data gathered during implementation.

B. ***Pre-authorization Process***

1. *Enrolment into the Z Benefits shall require pre-authorization from PhilHealth based on the selection criteria before providing services. The* contracted *HF shall completely and properly accomplish all requests for preauthorization* by filling out the pre-authorization checklist and request *form* (Annex A) and submitted by a designated liaison of the contracted *HF* to the Local Health Insurance Office (LHIO) or to the office of the Head of the PhilHealth Benefits Administration Section (BAS) in the region for approval.

2. *The contracted HF* may *apply the patient* for pre-authorization for any of the treatment phases (refer to tables 4, 5, 10, 11, and 12). An approved pre-authorization entitles the patient *to* the services covering the *entire* cycle of care *for the Z Benefits.*

3. The approved Pre-authorization Checklist and Request (Annex "A") shall be valid for 60 calendar days from the date of approval by PhilHealth. All contracted *HFs* are responsible for tracking the validity of their approved pre-authorization. *Therefore,* they shall inform PhilHealth immediately if pre-authorization requests *lapse.* They can, however, submit a new pre-authorization checklist and request, if needed.

4. *In case of fortuitous events and other natural calamities, PhilHealth shall accord an extension of sixty (60) days reckoned from the date of approval of the preauthorization.*

5. While the *original copy of the* pre-authorization *checklist and* request *(Annex A)* is submitted manually, *it shall be submitted with the photocopy and* properly accomplished Member Empowerment Form or ME Form (Annex B) *and a photocopy of the MDT Plan. The documents may also be scanned and emailed to the*

respective PROs for approval. In addition, PhilHealth will generate a unique case number for every pre-authorization request submitted once the pre-authorization system is developed and fully functioning.

6. The ME Form shall be accomplished together by the attending health care professional/s in the contracted *HFs* and the patient *for enrolment* in the Z Benefits for colon and *rectal* cancers. The ME Form aims to support patients to be active participants in health care *decision-making* by being educated and informed of the conditions *and* management options. Further, the ME Form *encourages* the attending health care professionals in the contracted *HFs* to dedicate adequate time to discuss with patients to achieve better health outcomes and patient satisfaction.

7. PhilHealth members and their qualified dependents must be eligible to avail of PhilHealth benefits at the time of pre-authorization *approval.*

C. ***Patient Management and Standards***

1. *The management of the patient shall proceed based on the consensus and recommendation of the MDT as reflected in the MDT plan submitted during the application for pre-authorization.*

2. *If there will be a deviation from the treatment plan, the HF shall attach a certification of the change in treatment plan to be signed by the attending physician when filing the claims for reimbursement.*

3. The minimum standards of care for *managing* colon and *rectal* cancers under the Z Benefits cover the entire course of treatment for colon and *rectal* cancer stages I to III. These are based on current standards of practice and may be updated as needed during regular policy reviews in collaboration with pertinent stakeholders.

4. *Contracted HF should strictly monitor patients enrolled in the Z Benefits. The Z Benefits do not cover additional services required by patients with disease progression to stage IV. PhilHealth will reimburse the contracted HF only for the tranche of mandatory services delivered before the disease progression to stage IV. Additional services or changes in the treatment protocol may be considered out-of-pocket. Thus, for quality improvement, contracted HFs are expected to conduct the appropriate study and analysis of all their enrolled patients in the Z Benefits.*

5. *The mandatory services for* the Z Benefits for colon and *rectal* cancers are the *minimum standards of care covered by PhilHealth* (Tables 1, 2, 6, 7 and 8) that *all contracted HFs shall deliver to all patients enrolled in the Z Benefits. Therefore, the mandatory services provided to the patients shall be the basis of PhilHealth reimbursement.*

6. *The mandatory or* minimum outpatient diagnostics for colon cancer *diagnosis* are colonoscopy, biopsy with histopathology, *chest CT or chest x-ray,* and abdominal CT scan, preferably with contrast.

7. The *mandatory or* minimum outpatient diagnostics *for rectal cancer diagnosis* are chest CT scan *and abdominal CT scan, preferably with contrast.*

8. *The results of colonoscopy*, chest x-ray, *CT scan* and abdominal ultrasound *are valid up to* 60 calendar days before the date of submission of the pre-authorization checklist and request to PhilHealth.

9. *CT scan results, whether done in the contracted hospital or another facility, shall be required by the MDT and should be attached to the patient's medical chart.*

10. *Linear* accelerator shall be the mode for delivering radiotherapy procedure*s* to patients with *rectal* cancer. *Therefore, a*ll contracted *HFs* shall exert effort to capacitate their facility to be able to provide linear accelerator services *for* their *rectal cancer* patients.

11. *Weekly* portal films or electronic portals are required for the standard course radiotherapy, while daily portal films or electronic portals are required for the short course radiotherapy.

D. Contracted *HFs* for the Z Benefits on colon and *rectal* cancers are required to have a medical record of all their patients, preferably *an* electronic medical record (EMR). For standardization, the contents of the EMR shall be set by PhilHealth in collaboration with experts *on* colon and *rectal* cancers and pertinent stakeholders. It should contain the necessary quality indicators that PhilHealth shall require for monitoring, policy research, and quality improvement.

E. *PhilHealth shall establish q*uality standards and indicators *(Annex F)* in collaboration with *the contracted reference HF,* clinical experts *on* colon and *rectal* cancers, and other pertinent stakeholders. All contracted *HFs* for the Z Benefits for colon and *rectal* cancers shall comply with these quality standards and indicators, which shall have a bearing on the renewal of all future contracts with PhilHealth. These quality standards and indicators shall be updated, as needed, based on current evidence and standards of practice.

F. *PhilHealth strongly encourages* coordination and collaboration *between* the reference *HF* and *other* contracted *HFs* for colon and *rectal* cancers. *This is vital* for quality improvement, *policy implementation, benchmarking,* training, patient audits, *coordinated* referrals, patient tracking *or monitoring, and* procurement of medicines and supplies.

G. *Contracted HFs implementing the Z Benefits for colon and rectal cancers are encouraged to develop a registry system or any system that will be useful for monitoring, quality improvement, and policy research.*

H. The contracted *HFs* shall ensure at all times the availability in their pharmacy of needed medicines and supplies for their patients and the proper inventory of these medicines and supplies to prevent stock-outs.

I. Patients enrolled in the Z Benefits for colon and *rectal* cancers shall be deducted a maximum of five (5) days from the 45 days annual benefit limit regardless of the *patient's* length of stay in the contracted *HF* in a calendar year. *PhilHealth* shall *deduct the five (5) days in* the current year when the pre-authorization is approved. In cases where the remaining annual benefit limit is less than five (5) days but at least one (1) day at the time of pre-authorization, the member shall remain eligible to avail of the Z Benefits. Contracted *HFs* should *regularly* remind these patients *to update their member profiles and premium contributions, as applicable, to ensure continuous coverage under the Z Benefits.*

J. The contracted HF should thoroughly discuss the co-payment with the patient during the administration of the ME form to inform them of any additional charges covering the share for amenities or any extra or upgrade of services not covered by the Z Benefits package for colon and rectal cancers.

K. *The co-payment shall have a fixed limit or cap not to exceed the corresponding rate of the Z Benefit package. The co-payment of patients shall be indicated in the respective contracts of the HFs.*

L. *Patients admitted in basic or ward accommodation are excluded from co-payment. However, if they would opt for amenities, such as an upgrade of room accommodation or additional services not covered by PhilHealth's Z Benefits, contracted HFs can charge a co-payment that should not exceed the package rate. The ME Form is the documentation of the agreement on co-payment between the patient and the contracted HF.*

M. Hospital confinements secondary to other conditions or co-morbidities *unrelated* to the primary condition of colon and *rectal* cancers shall be covered under other applicable benefits of PhilHealth.

N. *The contracted HF shall file a*ll claims for the Z Benefits for colon and *rectal* cancers according to the schedules set by PhilHealth.

O. The *contracted HF shall file* claims within 60 calendar days from the last day of the period covered specified in the *treatment phases* in Tables 4, 5, 10, 11, and 12.

P. *PhilHealth shall reimburse contracted HFs based on the pre-authorization diagnosis of colorectal cancer stages I to III.*

Q. *PhilHealth* shall not deny submitted claims with a final diagnosis of stage IV colon and *rectal* cancers. *Payment to contracted HF will be for the mandatory services given to patients covered in the specific treatment phase before disease progression to stage IV.*

R. *A patient who previously availed of the Z Benefits for colorectal cancer but developed a metachronous colorectal tumor, stage I to III, may still avail of the same Z Benefits package at the 6th month from the end of the last treatment for colorectal cancer, provided that the patient fits the required selection criteria.*

S. *Contracted HFs should properly document patients lost to follow-up and conduct the appropriate study and analysis in the context of quality healthcare.*

T. *Patients who are not yet declared lost to follow-up may still avail of the Z Benefits under the following conditions:*

1. *Colon and rectal cancer patients, stages II to III, who refused to undergo chemotherapy after surgery, but returned for treatment two (2) months after the contemplated date of the first chemotherapy session and without evidence of disease progression, may undergo chemotherapy that will be covered by the Z Benefits.*

2. *For patients who underwent neoadjuvant chemotherapy and returned within 16 weeks after neoadjuvant chemotherapy and present with no disease progression, the patient may opt to continue surgery that shall be covered by the Z Benefits. Beyond 16 weeks, the patient is no longer eligible to avail of the Z Benefits.*

U. In cases when the patient expires or is lost to follow-up *anytime during service provision, PhilHealth will only reimburse the corresponding tranche for the specific phase as long as the patient received the scheduled services. After that, however, PhilHealth will not pay the subsequent tranches.*

If the patient expires during the course of treatment, a photocopy of the death certificate or a notarized sworn declaration issued by authorized government agencies shall be required.

V. Contracted *HFs* shall submit to PhilHealth a sworn declaration that a patient is lost to follow-up when filing the claim for the specific treatment phase.

Contracted *HFs* shall submit to PhilHealth the "List of Quality Indicators for the Z Benefits for Colon and *Rectal* Cancers" (Annex F) for all deaths and lost to follow-up patients based on the *Outcomes Report Form for colon and rectal cancers (Annex I).*

W. The professional fees under the Z Benefits for colon and *rectal* cancers shall be 20% of the package rate.

X. Rules on pooling of professional fees for government *HF* shall apply.

Y. Package rates are considered net of mandatory discounts.

Z. **Z Benefits Coordinator for Colon and *Rectal* Cancers**

Contracted *HFs* shall be required to designate at least one (1) **Z Benefits Coordinator** *for the Z Benefits for colon and rectal cancers*, whose responsibilities may include, but are not limited to the following, as may be deemed necessary by the contracted *HF*:

1. *Guide and navigate* Z patients by facilitating timely access to the services required for the Z Benefits. Guiding Z patients enrolled in the program aims to overcome healthcare barriers in the availment of the said benefits to ensure patient adherence to agreed treatment plans to achieve good clinical outcomes and ultimate patient satisfaction.

2. Coordinate with PhilHealth *on* matters pertinent to the Z Benefits availment of candidate patients, such as filling out forms and *assessing* eligibility requirements *before* pre-authorization and *providing* feedback and other inputs required by PhilHealth.

3. Encode pertinent *clinical* information *and other data* (*e.g.*, demographics, etc.) of all patients diagnosed with colon and rectal cancers, whether or not the patient fulfills the selection criteria for pre-authorization.

   Once the Z Benefits and Information Tracking System (ZBITS) is in place, the Z Benefits coordinator shall enter pertinent data elements of all patients with approved Pre-authorization Checklist and Request in the required fields of the ZBITS Module *in* the *HF* Portal. *PhilHealth* shall determine *the data elements in collaboration with the contracted reference HF*, experts *on* colon and *rectal* cancers, and other stakeholders. Contracted *HFs shall* train their respective Z Benefits coordinator/s.

4. Other duties and responsibilities *are* ensuring completeness and accuracy of all *document* attachments *required* for pre-authorization *and* claims *application for* reimbursement *and coordination with PhilHealth, which* shall facilitate the implementation of the Z Benefits.

AA. **Colon Cancer: *Mandatory or the* Minimum Standards of Care, Package Rate, and Criteria for Inclusion in the Z Benefits**

1. The following are the selection criteria:

   a. Clinical and TNM Staging: Colon cancer from stages I to III (clinically *Tis*-T4, N0-2, M0)

   b. Pre-operative physical risk classification:
      b.1. ASA I – normal healthy patient, OR
      b.2. ASA II – patient with mild systemic disease

   c. ECOG Performance Status
      c.1. 0 – Fully active, able to carry on all pre-disease performance without restriction, OR
      c.2. 1 – Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work, OR
      c.3. 2 – Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours.

Stage I to II (low risk) *Colon Cancer*	Mandatory Services *(Minimum Standards of Care)*	Other Services
Procedures	Colonoscopy[a] Histopathology Surgery (definitive)	Surgery for closure of colostomy/ileostomy, if needed[b]
Diagnostics	Chest CT or Chest x-ray (PA-L)[a] CT scan of whole abdomen *preferably with contrast*[a, c] Fasting blood sugar (FBS) Carcinoembryonic antigen (CEA), as baseline Complete blood count Blood typing Albumin Creatinine	ECG CP clearance SGPT Prothrombin time Alkaline phosphatase CEA (for monitoring, as needed) SGPT (for monitoring, as needed) Creatinine (for monitoring, as needed)
Medicines		*Antimicrobials*, as indicated Pain relievers, as indicated
Others		Blood support, such as cross-matching, screening, and processing, as needed

Table 1: Mandatory and Other Services for the Z Benefits for Colon Cancer

[a] *Should be done within 60 calendar days before the date of submission of the pre-authorization checklist and request to PhilHealth*
[b] Shall be covered under the Z Benefits within two (2) years from the date of surgery; *patients may be charged co-payment within the allowable limit as indicated in the contract of the HF*
[c] PET scan *is acceptable* in place of a CT scan

Stage II (high risk)[d] to III *Colon Cancer*	Mandatory Services *(Minimum Standards of Care)*	Other Services
Procedures	Colonoscopy[a] *Biopsy with* histopathology Surgery (definitive)	Surgery for closure of colostomy/ileostomy, if needed[b]
Diagnostics	*Chest CT or Chest x-ray (PA-L)*[c] CT scan of whole abdomen *preferably with contrast*[a, c] Fasting blood sugar (FBS) Carcinoembryonic antigen (CEA), as baseline Complete blood count Blood typing Albumin Creatinine	ECG CP clearance SGPT Prothrombin time Alkaline phosphatase Bilirubin CEA (for monitoring, as needed) SGPT (for monitoring, as needed) Creatinine (for monitoring, as needed) 2D Echocardiogram (as needed)
Medicines	Systemic chemotherapy with any of the following, as indicated: • Capecitabine-Oxaliplatin (CapeOX) • Capecitabine • Fluorouracil-Folinic acid-Oxaliplatin (FOLFOX4) • Fluorouracil-Folinic acid-Oxaliplatin (mFOLFOX 6) • Fluorouracil-Folinic acid (FU-FA)	When indicated: Antiemetics *Antimicrobials* Pain relievers
Others		Blood support, as needed

Table 2: Mandatory and Other Services for the Z Benefits for Colon Cancer (Stage II [high risk] to III)

[a] *Should be done within 60 calendar days before the date of submission of the pre-authorization checklist and request to PhilHealth*
[b] Shall be covered under the Z Benefits within two (2) years from the date of surgery; *patients may be charged co-payment within the allowable limit as indicated in the contract of the HF*
[c] PET scan *is acceptable* in place of *a* CT scan
[d] risk for early recurrence or distant metastasis

2. The following post-op and post-chemotherapy monitoring are not covered *under the Z Benefits*:
   a. PET scan
   b. CT scan
   c. Ultrasound
   d. Blood chemistry

3. The package code for the Z benefits for colon cancer is **Z013**.

Stage	Package Rate (Php)
I to II (low risk)	150,000
II (high risk) to III	300,000

Table 3: Package rates for the course of treatment for colon cancer

4. The mode of payment for this package shall be given in tranches, based on the MDT plan, with the corresponding amounts and filing schedule as follows:

Package Code	Treatment phase	Amount (Php)	Filing Schedule
Z0131-A	Surgery	150,000	Within 60 calendar days after discharge from surgery

Table 4: Package code, treatment phase, amount per tranche and filing schedule for colon cancer (Stage I to II, low risk)

Package Code	Treatment phase	Amount (Php)	Filing Schedule
Z0131-B	Surgery	150,000	Within 60 calendar days after discharge from surgery
Z0132-B	Chemotherapy	150,000	Within 60 calendar days after the last cycle of chemotherapy

Table 5: Package code, treatment phase, amount per tranche and filing schedule for colon cancer (Stage II, high risk) to III

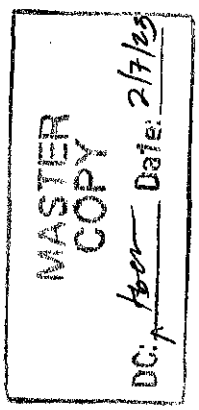
BB. **Rectal Cancer: *Mandatory or the* Minimum Standards of Care, Package Rate, and Criteria for Inclusion in the *Z* Benefits**

1. The following are the selection criteria:

   a. Clinical and TNM Staging: *Rectal* cancer from stages I to III (clinically T1-4, N0-2, M0)

   b. Pre-operative physical risk classification:
      b.1. ASA I – normal healthy patient, OR
      b.2. ASA II – patient with mild systemic disease

   c. ECOG Performance Status
      c.1. 0 - Fully active, able to carry on all pre-disease performance without restriction, OR
      c.2. 1 - Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work, OR
      c.3. 2 - Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours.



Stage I *Rectal Cancer* (Clinical and Pathologic Stage)	Mandatory Services ***(Minimum Standards of Care)***	Other Services
Procedure	Colonoscopy[a] *Biopsy with* histopathology Surgery (definitive)	Surgery for closure of colostomy/ileostomy, if needed[b] *Proctoscopy*
Diagnostics	*Chest CT or Chest x-ray (PA-L)*[c] Pelvic MRI or endorectal ultrasound CT scan of whole abdomen *preferably with contrast*[a, c] Fasting blood sugar (FBS) Carcinoembryonic antigen (CEA), as baseline Complete blood count Blood typing Albumin Creatinine	ECG 2D echocardiogram CP clearance SGPT Prothrombin time Alkaline phosphatase Bilirubin CEA (for monitoring, as needed) SGPT (for monitoring, as needed) Creatinine (for monitoring, as needed)
Medicines		*Antimicrobials*, as indicated Pain relievers, as indicated
Others		Blood support, as needed

Table 6: Mandatory and other services for the Z Benefits for *rectal* cancer Stage I (Clinical and Pathologic Stage)

[a] *Should be done within 60 calendar days before the date of submission of the pre-authorization checklist and request to PhilHealth*

[b] Shall be covered under the Z Benefits within two (2) years from the date of surgery; *patients may be charged co-payment within the allowable limit as indicated in the contract of the HF*

[c] PET scan *is acceptable* in place of *a* CT scan

Pre-operative clinical stage I but with post-operative pathologic stage II – III *Rectal Cancer*	Mandatory Services ***(Minimum Standards of Care)***	Other Services
Procedure	Colonoscopy[a] *Biopsy with* histopathology Surgery (definitive)	Surgery for closure of colostomy/ileostomy, if needed[b] *Proctoscopy*
Diagnostics	Chest CT or Chest x-ray (PA-L)[c] Pelvic MRI or endorectal ultrasound CT scan of whole abdomen *preferably with contrast*[a c] Fasting blood sugar (FBS) Carcinoembryonic antigen (CEA), as baseline Complete blood count Blood typing Albumin Creatinine	ECG CP clearance SGPT Prothrombin time Alkaline phosphatase Bilirubin CEA (for monitoring, as needed) SGPT (for monitoring, as needed) Creatinine (for monitoring, as needed)
Chemotherapy (adjuvant followed by radiotherapy or concurrent with radiotherapy followed by adjuvant chemotherapy)	Any of the following protocols: • Fluorouracil-Folinic acid (FU-FA) • Capecitabine • Capecitabine-Oxaliplatin (CapeOX) • Fluorouracil-Folinic acid-Oxaliplatin (FOLFOX 4) • Fluorouracil-Folinic acid-Oxaliplatin (mFOLFOX 6)	
Radiotherapy (concurrent with chemotherapy)	Standard or short course • Linear accelerator Weekly (for standard course) and daily (for short course) portal films or electronic portals	
Other medicines		When indicated: Antiemetics *Antimicrobials* Pain relievers
Others		Blood support, as needed

Table 7: Mandatory and other services for the Z Benefits for *rectal* cancer with pre-operative clinical stage I but with post-operative pathologic stage II - III

[a] *Should be done within 60 calendar days before the date of submission of the pre-authorization checklist and request to PhilHealth*

[b] Shall be covered under the Z Benefits within two (2) years from the date of surgery; *patients may be charged co-payment within the allowable limit as indicated in the contract of the HF*

[c] PET scan *is acceptable* in place of *a* CT scan

Stage II to III *Rectal Cancer*	Mandatory Services ***(Minimum Standards of Care)***	Other Services
Procedures	Colonoscopy[a] *Biopsy with* histopathology *Histopathology (post-operative)* *Radiotherapy (linear accelerator)* Surgery (definitive)	Surgery for diversion, if needed Surgery for closure of colostomy/ileostomy[b] Proctoscopy
Diagnostics	*Chest CT* or Chest x-ray (PA-L)[c] Pelvic MRI or Endorectal Ultrasound CT scan of whole abdomen *preferably with contrast*[a, c] Fasting blood sugar (FBS) Carcinoembryonic antigen (CEA), as baseline Complete blood count Blood typing Albumin Creatinine	CP Clearance SGPT Prothrombin time Alkaline phosphatase Bilirubin CEA (for monitoring, as needed) SGPT (for monitoring, as needed) Creatinine (for monitoring, as needed) ECG
Chemotherapy (adjuvant followed by radiotherapy or concurrent with radiotherapy followed by adjuvant chemotherapy)	Any of the following protocols: • Fluorouracil-Folinic acid (FU-FA) • Capecitabine • Capecitabine-Oxaliplatin (CapeOX) • Fluorouracil-Folinic acid-Oxaliplatin (FOLFOX 4) • Fluorouracil-Folinic acid-Oxaliplatin (mFOLFOX 6)	
Radiotherapy (concurrent with chemotherapy)	Standard or short course • Linear accelerator Weekly (for standard course) and daily (for short course) portal films or electronic portals	
Other medicines		When indicated: Antiemetics *Antimicrobials* Pain relievers
Others		Blood support, as needed

Table 8: Mandatory and other services for the Z benefit for *rectal* cancer Stage II-III

[a] *Should be done within 60 calendar days before the date of submission of the pre-authorization checklist and request to PhilHealth*
[b] Shall be covered under the Z Benefits within two (2) years from the date of surgery; *patients may be charged co-payment within the allowable limit as indicated in the contract of the HF*
[c] PET scan *is acceptable* in place of *a* CT scan

2. The following post-operative and post-chemotherapy monitoring *are* not covered *under* the Z Benefits:
   a. PET scan
   b. CT scan
   c. Ultrasound
   d. Blood chemistry

3. The package code for the Z benefits for *rectal* cancer is **Z014.**

Stage	Package Rate (Php)
Stage I (clinical and pathologic)	150,000
Pre-operative clinical stage I but with post-operative pathologic stage II – III	400,000
Stage II - III	400,000

Table 9: Package rates for the course of treatment for *rectal* cancer

4. The mode of payment for this package shall be given in tranches based on the MDT plan with the corresponding amounts and filing schedule as follows (Refer to Tables *10, 11 and 12*):

Package Code	Treatment phase	Amount (Php)	Filing Schedule
Z0141-A	Surgery	150,000	Within 60 calendar days after discharge surgery

Table 10: Package code, treatment phase, amount per tranche and filing schedule for *rectal* stage I (Clinical and Pathologic *Stage*)

Package Code	Treatment phase	Amount (Php)	Filing Schedule
Z0141-B	Surgery	150,000	Within 60 calendar days after discharge surgery
Z0142-B	Chemo-radiotherapy	100,000 (using linear accelerator)	Within 60 calendar days after completion of chemo-radiotherapy
Z0143-B	Chemotherapy	150,000	Within 60 calendar days after the last cycle of chemotherapy

Table 11: Package code, treatment phase, amount per tranche and filing schedule for *rectal* cancer with pre-operative clinical stage I but with post-operative pathologic stage of II – III

PhilHealth shall reimburse the tranche amount corresponding to the *mandatory services provided by the contracted HF* specific *to the* treatment phase.

Package Code	Treatment phase	Amount (Php)	Filing Schedule
Z0141-C	Chemo-radiotherapy	100,000 (using linear accelerator)	Within 60 calendar days after completion of chemo-radiotherapy
Z0142-C	Surgery	150,000	Within 60 calendar days after discharge from surgery
Z0143-C	Chemotherapy	150,000	Within 60 calendar days after the last cycle of chemotherapy

Table 12: Package code, treatment phase, amount per tranche and filing schedule for rectal cancer, stage II – III

CC. **Claims *Filing***

1. *Contracted HFs* shall file claims according to *current* PhilHealth *policies.*

2. *Contracted HFs shall file claims on* behalf of patients. There shall be no direct filing by members.

3. *Contracted HFs* shall submit claim applications per completed *treatment phase.*

4. *As per MDT consensus, colon cancer patients may have completed neoadjuvant chemotherapy before surgery, which is a possible scenario. Therefore, filing of claims for chemotherapy may may precede submission claims for surgery.*

5. Contracted *HFs* are required to submit to PhilHealth photocopies of the final pathologic report of their patients during the filing of the *claims for reimbursement.*

6. For the claim application, the following shall be attached:
   a. Transmittal Form (Annex H) of all claims for the Z Benefits for colon and *rectal* cancers for submission to PhilHealth, per claim or per batch of claims;
   b. *Photocopy* of the approved Pre-authorization Checklist and Request;
   c. *Photocopy* of the properly accomplished ME Form;
   d. PhilHealth Benefit Eligibility Form (PBEF) printout during the pre-authorization application.

      A PBEF *with a* "YES" *indication is sufficient to mean that the patient is eligible. Submission of other documents, such as Member Data Record (MDR) and PhilHealth Claim Form 1 (CF1) shall NO longer be required.*

      A "NO" indication on the PBEF should prompt the contracted HF to coordinate with the PhilHealth CARES assigned in their facility to validate the eligibility of the patient or present proof of contributions or duly accomplished CF1.

   e. Properly accomplished Claim Form 2;
   f. Checklist of Mandatory and Other Services (Annex C) for the corresponding tranches;
   g. Photocopy of completely accomplished Z Satisfaction Questionnaire (Annex D);
   h. Tranche Requirements Checklist (Annex E);
   i. *Photocopy of the MDT Plan; and*
   j. *Original or certified true copy (CTC) of the Statement of Account (SOA). PhilHealth shall disseminate a separate issuance of the guidelines for the submission of the SOA for the Z Benefits.*

7. *PhilHealth shall require the photocopy* of the final *histopathologic* report when filing the claim for rectal cancer with pre-operative clinical stage I but with pathologic stage II – III.

8. *Photocopy of the accomplished surgical operative report, for the applicable treatment phase.*

9. *Photocopy of the accomplished anesthesia report, for the applicable treatment phase.*

10. *Photocopy of the chemotherapy treatment summary form, for applicable treatment phase.*

11. *Photocopy of the radiation treatment summary form, for applicable treatment phase.*

12. List of quality indicators for the Z Benefits for colon and rectal cancers based on the *Outcomes Report Form for colon and rectal cancers* (Annex I) for all deaths and lost to follow-up patients.

13. Sworn declaration for all lost to follow-up patients or photocopy of death certificate *of* expired patients.

14. The Z Satisfaction Questionnaire (Annex D) shall be administered to all Z patients *before* patient discharge from the contracted *HF*. These are validated during field monitoring and *processed accordingly as input to the policy review.*

15. Rules on late filing *of claims* shall apply.

16. If the delay in claims *filing* is due to natural calamities or fortuitous events, *the existing guidelines of PhilHealth on the provision of special privileges to those affected by fortuitous events shall apply.*

DD. ***Claims Payment***

1. *The coverage of the Z Benefits for colon cancer for the complete course of first-line surgical and standard anti-cancer drug care excludes radiotherapy. As such, radiotherapy shall be covered under a different PhilHealth benefit. However, all contracted HFs shall facilitate radiotherapy services for their Z patients by coordinated referrals to other PhilHealth-accredited facilities.*

2. *PhilHealth shall reimburse the corresponding tranche payment for the mandatory services provided that is specific to the treatment phase when the patient does not complete the required number of cycles of chemotherapy under the following circumstances:*
   a. *Lost to follow up;*
   b. *Progression of disease to stage IV;*
   c. *Comorbidities that will forbid the patient to complete the treatment; and*
   d. *Death*

   The HF shall attach a certification to be signed by the attending physician *in such circumstances.*

EE. ***Monitoring***

1. Utilization and Compliance

Monitoring of the implementation of the Z Benefits package for colon and rectal cancers shall be conducted by PhilHealth as provided in the current guiding principles of the Z Benefits.

The performance indicators and measures to monitor compliance with the policies of this PhilHealth Circular shall be established in collaboration with relevant stakeholders and experts. These shall be incorporated into the relevant monitoring policies of the Corporation.

2. Policy Review

In consultation and collaboration with relevant stakeholders, experts, and technical staff representatives from the Corporation, PhilHealth shall conduct a regular policy review of the Z Benefits for colon and rectal cancers.

FF. ***Marketing and Promotion***

PhilHealth shall educate the general public, increase awareness of the Z Benefits, and promote informed decision-making among patients, and participation of healthcare professionals, health facilities, and other stakeholders following the integrated marketing and communication plan of PhilHealth.

GG. **Annexes (Posted on official PhilHealth website)**

1. Annex A: Pre-authorization checklist
   a. Annex A1: Colon Cancer
   b. Annex A2: Rectal Cancer

2. Annex B: Member Empowerment Form or ME Form

3. Annex C: Checklist of Mandatory and Other Services

   a. Annex C1.1: Colon Cancer Stage I to II (low risk) – Post-surgery
   b. Annex C1.2: Colon Cancer Stage II (high risk) to III – Post-surgery
   c. Annex C1.3: Colon Cancer Stage II (high risk) to III – After last cycle of Chemotherapy
   d. Annex C2.1: Rectal Cancer Stage I (clinical and pathologic stage) – Post-surgery
   e. Annex C3.1: Rectal Cancer Pre-Operative Clinical Stage I with Post-Operative Pathologic Stage II to III – Post-surgery
   f. Annex C3.2: Rectal Cancer Pre-Operative Clinical Stage I with Post-operative Pathologic Stage II to III – After completion of Chemoradiotherapy
   g. Annex C3.3: Rectal Cancer Pre-Operative Clinical Stage I with Post-operative Pathologic Stage II to III – After last cycle of Chemotherapy
   h. Annex C4.1: Rectal Cancer Pre-treatment Clinical Stage II to III – After completion of Chemoradiotherapy
   i. Annex C4.2: Rectal Cancer Pre-treatment Clinical Stage II to III – Post-surgery
   j. Annex C4.3: Rectal Cancer Pre-treatment Clinical Stage II to III – After last cycle of Chemotherapy

4. Annex D: Z Benefits Satisfaction Questionnaire

5. Annex E: Tranche Requirements Checklist

   a. Annex E1.1: Colon Cancer Stage I to II (low risk) – Post-surgery
   b. Annex E1.2: Colon Cancer Post-Surgery Stage II (high risk) to III – Post-surgery
   c. Annex E1.3: Colon Cancer Stage II (high risk) to III – After completion of Chemotherapy
   d. Annex E2.1: Rectal Cancer Stage I (clinical and pathologic stage): Post-surgery
   e. Annex E3.1: Rectal Cancer Pre-Operative Clinical Stage I with Post-Operative Pathologic Stage II to III – Post-surgery

f. Annex E3.2: Rectal Cancer Pre-Operative Clinical Stage I with Post-operative Pathologic Stage II to III: After completion of Chemoradiotherapy

g. Annex E3.3: Rectal Cancer Pre-Operative Clinical Stage I with Post-operative Pathologic Stage II to III: After last cycle of Chemotherapy

h. Annex E4.1: Rectal Cancer Pre-treatment Clinical Stage II to III: After completion of Chemoradiotherapy

i. Annex E4.2: Rectal Cancer Pre-treatment Clinical Stage II to III: Post-surgery

j. Annex E4.3: Rectal Cancer Pre-treatment Clinical Stage II to III: After last cycle of Chemotherapy

6. Annex F: Quality Indicators for the Z Benefits for *colorectal* cancer

7. Annex G: Pathway for the Z Benefits for colon and *rectal* cancers

8. Annex H: Transmittal Form of Claims for the Z Benefits

9. Annex I: Outcomes Report Form for colon and rectal cancers

The complete list of annexes of the Z Benefits can be found in PhilHealth Circular 2021-0022 "Guiding Principles of the Z Benefits (Revision 1)."

VI. PENALTY CLAUSE

Any violation of this PhilHealth Circular shall be dealt with and penalized in accordance with the pertinent provisions of RA 11223, other relevant laws, and RA 7875, as amended by RA 9241 and 10606, and their respective Implementing Rules and Regulations.

VII. TRANSITORY CLAUSE

A. *Upon publication of this PhilHealth Circular, PhilHealth shall disseminate information to contracted HFs, ensure the availability of revised forms on the PhilHealth website and the deployment of necessary enhancements in the claims system.*

B. *Claims filed with approved pre-authorizations prior to the date of effectivity of this PhilHealth Circular shall follow the provisions of PhilHealth Circular No. 2021-0022 "The Guiding Principles (Revision 1) and PhilHealth Circular No. 028 – 2015 "The Z Benefits for Colon and Rectum Cancers."*

VIII. SEPARABILITY CLAUSE

If any provision of this PhilHealth Circular shall be declared invalid, unconstitutional, or unenforceable, the validity of the remaining parts or provisions not affected shall remain in full force and enforceable.

IX. REPEALING CLAUSE

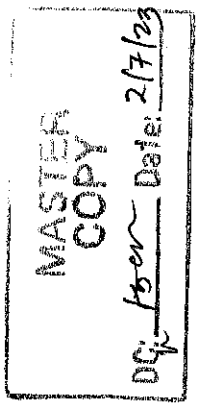
This policy repeals PhilHealth Circular No. 028-2015 titled the Z Benefits for Colon and Rectum Cancers. All circulars, issuances, rules, and regulations or parts thereof that are contrary to and inconsistent with this PhilHealth Circular are hereby repealed, amended, or modified accordingly.

X. *DATE OF EFFECTIVITY*

This PhilHealth Circular shall take effect after fifteen (15) days following the completion of its publication in any newspaper of general circulation or in the Official Gazette. A copy shall thereafter be deposited to the Office of the National Administrative Register (ONAR) at the University of the Philippines Law Center.

EMMANUEL R. LEDESMA, JR.
Acting President and Chief Executive Officer (APCEO)

Date signed: 01/30/13



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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")*** 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

Fulfilled selections criteria ☐ **Yes** If yes, proceed to pre-authorization application
☐ **No** If no, specify reason/s _____

PRE-AUTHORIZATION CHECKLIST
Colon Cancer
Stages I to III (clinically *Tis-T4*, N0-2, M0)

Place a check mark (✓)

QUALIFICATIONS	**Yes**
Colon cancer stages I to III (clinically *Tis-T4*, N0-2, M0)	
No evidence of systemic metastasis from chest x-ray and abdominal ultrasound or CT scan of whole abdomen	

SITE OF CANCER (check applicable site)
☐ cecum ☐ ascending colon ☐ hepatic flexure ☐ transverse colon
☐ splenic flexure ☐ descending colon ☐ sigmoid
☐ for synchronous tumor, specify sites _____

CLINICAL STAGE (Choose one stage)
☐ Stage I ☐ Stage II ☐ Stage III

OTHER QUALIFICATIONS	**Yes**
1. Normal or with mild systemic disease (ASA I or II)	
2. Fully active, able to carry on all pre-disease performance without restriction, OR restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g. light house work, office work, OR ambulatory and *capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours.* (ECOG Performances 0-2)	

MASTER COPY
DC: Date: 2/7/23

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")***	
	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

Certified correct by Attending Surgeon:	Certified correct by Attending Medical Oncologist:	Conforme by Patient:
Printed name and signature	Printed name and signature	Printed name and signature
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	

Note:
Once approved, the contracted *HF* shall print the approved pre-authorization form from the HCI Portal and have this signed by the patient, parent or guardian and health care providers, as applicable. This form shall be submitted to the Local Health Insurance Office (LHIO) or the PhilHealth Regional Office (PRO) when filing the first tranche.

There is no need to attach laboratory results. However, these should be included in the patient's chart and may be checked during the field monitoring of the Z Benefits. Please do not leave any item blank.

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

PRE-AUTHORIZATION REQUEST
Colon Cancer

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z benefit package for _____ in _____
(Patient's *last, first, suffix, middle name*) (Name of *HCI*)
under the terms and conditions as agreed for availment of the Z Benefit Package.

The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the benefit package (please tick appropriate box):
☐ *Without co-payment*
☐ *With co-payment, for the purpose of:* _____

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No.	PhilHealth Accreditation No.

Conforme by:	Certified correct by:
(Printed name and signature) Patient	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
	PhilHealth Accreditation No.

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

_____
(Printed name and signature)
Head or authorized representative, Benefits Administration Section (BAS)

INITIAL APPLICATION		
Activity	**Initial**	**Date**
Received by LHIO/BAS:		
Endorsed to BAS (if received by LHIO):		
☐ Approved ☐ Disapproved		
Released to HCI:		
This pre-authorization is valid for sixty (60) calendar days from date of approval of request.		

COMPLIANCE TO REQUIREMENTS		
☐ APPROVED ☐ DISAPPROVED (State reason/s)		
Activity	**Initial**	**Date**
Received by BAS:		
☐ Approved ☐ Disapproved		
Released to HCI:		

MASTER COPY
DC: hm Date: 2/7/23

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")*** 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

Fulfilled selections criteria ☐ **Yes** If yes, proceed to pre-authorization application
☐ **No** If no, specify reason/s _____

PRE-AUTHORIZATION CHECKLIST
Rectal Cancer
Stages I to III (clinically *T1-T4*, N0-2, M0)

Place a check mark (✓)

QUALIFICATIONS	Yes
Biopsy proven tissue diagnosis of rectal cancer	
No evidence of systemic metastasis from chest x-ray and abdominal ultrasound or CT scan of whole abdomen	
No previous pelvic radiation	

SITE OF CANCER (check applicable site)
☐ cecum ☐ ascending colon ☐ hepatic flexure ☐ transverse colon
☐ splenic flexure ☐ descending colon ☐ sigmoid
☐ for synchronous tumor, specify sites _____

CLINICAL STAGE (Choose one stage)
☐ Stage I ☐ Stage II ☐ Stage III

OTHER QUALIFICATIONS	Yes
1. Normal or with mild systemic disease (ASA I or II)	
2. Fully active, able to carry on all pre-disease performance without restriction, OR restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g. light house work, office work, OR ambulatory and *capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours.* (ECOG Performances 0-2)	

MASTER COPY Date: 2/7/23 DC: _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")***	
	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

Certified correct by Attending Surgeon:	Certified correct by Attending Medical Oncologist:	Conforme by Patient:
Printed name and signature	Printed name and signature	Printed name and signature
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	

Note:
Once approved, the contracted *HF* shall print the approved pre-authorization form from the HCI Portal and have this signed by the patient, parent or guardian and health care providers, as applicable. This form shall be submitted to the Local Health Insurance Office (LHIO) or the PhilHealth Regional Office (PRO) when filing the first tranche.

There is no need to attach laboratory results. However, these should be included in the patient's chart and may be checked during the field monitoring of the Z Benefits. Please do not leave any item blank.

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PRE-AUTHORIZATION REQUEST
Rectal Cancer

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z benefit package for

_____ in _____
(Patient's *last, first, suffix, middle name*) (Name of *HF*)
under the terms and conditions as agreed for availment of the Z Benefit Package.

The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the benefit package (please tick appropriate box):
☐ *Without co-payment*
☐ *With co-payment, for the purpose of:* _____

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No.	PhilHealth Accreditation No.

Conforme by:	Certified correct by:
(Printed name and signature) Patient	(Printed name and signature) Executive Director/ Chief of Hospital/ Medical Director/ Medical Center Chief
	PhilHealth Accreditation No.

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

_____
(Printed name and signature)
Head or authorized representative, Benefits Administration Section (BAS)

INITIAL APPLICATION		
Activity	**Initial**	**Date**
Received by LHIO/BAS:		
Endorsed to BAS (if received by LHIO):		
☐ Approved ☐ Disapproved		
Released to *HF*:		
This pre-authorization is valid for sixty (60) calendar days from date of approval of request.		

COMPLIANCE TO REQUIREMENTS		
☐ APPROVED ☐ DISAPPROVED (State reason/s)		
Activity	**Initial**	**Date**
Received by BAS:		
☐ Approved ☐ Disapproved		
Released to *HF*:		

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Numero ng kaso: _____
Case No.

MEMBER EMPOWERMENT FORM
Magpaalám, tumulong, at magbigay kapangyarihan
Inform, Support & Empower

Mga Panuto:
Instructions:

1. Ipaliliwanag at tutulungan ng kinatawan ng ospital ang pasyente sa pagsasagot ng ME form.
   The health care provider shall explain and assist the patient in filling-up the ME form.
2. Isulat nang maayos at malinaw ang mga impormasyon na kinakailangan.
   Legibly print all information provided.
3. Para sa mga katanungang nangangailangan ng sagot na "oo" o "hindi", lagyan ng marka (✓) ang angkop na kahon.
   For items requiring a "yes" or "no" response, tick appropriately with a check mark (✓).
4. Gumamit ng karagdagang papel kung kinakailangan. Lagyan ito ng kaukulang marka at ilakip ito sa ME form.
   Use additional blank sheets if necessary, label properly and attach securely to this ME form.
5. Ang kinontratang ospital na magkakaloob ng dalubhasang pangangalaga sa pagpaparami ng kopya ng ME Form.
   The ME form shall be reproduced by the contracted health facility (HF) providing specialized care.
6. Dalawang kopya ng ME form ang kailangang ibigay ng kinontratang ospital. Ang mga kopyang nabanggit ay ilalaan para sa pasyente at sa ospital.
   Duplicate copies of the ME form shall be made available by the contracted HF—one for the patient and one as file copy of the contracted HF providing the specialized care.
7. **Para sa mga pasyenteng gagamit ng Z Benefit for Mobility Orthoses Rehabilitation Prosthesis Help (ZMORPH), ukol sa pagpapalit ng artipisyal na ibabang bahagi ng hita at binti, o Z Benefits para sa mga batang may kapansanan, isulat ang N/A sa tala B2, B3 at D6. Para naman sa Peritoneal Dialysis (PD) First Z Benefits, isulat ang N/A para sa tala B2 at B3.**
   For patients availing of the Z Mobility Orthoses Rehabilitation Prosthesis Help (ZMORPH) for fitting of the external lower limb prosthesis, or Z Benefits for children with disabilities, write N/A for items B2, B3 and D6 and for PD First Z Benefits, write N/A for items B2 and B3.

PANGALAN NG OSPITAL *HEALTH FACILITY (HF)*
ADRES NG OSPITAL *ADDRESS OF HF*

A. Impormasyon ng Miyembro/ Pasyente
A. Member/Patient Information

PASYENTE (Apelyido, Pangalan, Panggitnang Apelyido, Karagdagan sa Pangalan)
PATIENT (Last name, First name, Middle name, Suffix)

NUMERO NG PHILHEALTH ID NG PASYENTE ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐☐
PHILHEALTH ID NUMBER OF PATIENT

MIYEMBRO (kung ang pasyente ay kalipikadong makikinabang) (Apelyido, Pangalan, Panggitnang Apelyido, Karagdagan sa Pangalan)
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)

NUMERO NG PHILHEALTH ID NG MIYEMBRO ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐☐
PHILHEALTH ID NUMBER OF MEMBER

PERMANENTENG TIRAHAN
PERMANENT ADDRESS

Petsa ng Kapanganakan (Buwan/Araw/Taon) *Birthday (mm/dd/yyyy)*	Edad *Age*	Kasarian *Sex*
Numero ng Telepono *Telephone Number*	Numero ng Cellphone *Mobile Number*	Email Address *Email Address*

Kategorya bilang Miyembro:
Membership Category:

Direct contributor
Direct contributor

- ☐ Empleado ng pribadong sector
  Employed private
- ☐ Empleado ng gobyerno
  Employed government
- ☐ May sariling pinagkakakitaan
  Self earning
  - ☐ Indibidwal
    Individual
  - ☐ Sole proprietor
    Sole proprietor
  - ☐ Group enrollment scheme
    Group enrollment scheme
- ☐ Kasambahay / *Household Help*
- ☐ Tagamaneho ng Pamilya/ *Family driver*
- ☐ Filipinong Manggagawa sa ibang bansa
  Migrant Worker/ OFW
  - ☐ Land-based
    Land-based
  - ☐ Sea-based
    Sea-based
- ☐ Habambuhay na kaanib/ *Lifetime Member*
- ☐ Filipino na may dalawang pagkamamamayan/Nakatira sa ibang bansa
  Filipino with Dual Citizenship/Living abroad
- ☐ Foreign national/*Foreign national*

Indirect contributor
Indirect contributor

- ☐ Listahanan
  Listahanan
- ☐ 4Ps/MCCT
  4Ps /MCCT
- ☐ Nakatatandang mamamayan
  Senior Citizen (RA 10645)
- ☐ PAMANA
  PAMANA
- ☐ KIA/KIPO
  KIA/KIPO
- ☐ Bangsamoro/Normalization
- ☐ Inisponsuran ng LGU
  LGU-sponsored
- ☐ Inisponsuran ng NGA
  NGA-*sponsored*
- ☐ Inisponsuran ng pribadong sector
  Private-sponsored
- ☐ Taong may kapansanan
  Person with disability

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B. Impormasyong Klinikal *B. Clinical Information*	
1. Paglalarawan ng kondisyon ng pasyente *Description of condition*	
2. Napagkasunduang angkop na plano ng gamutan sa ospital *Applicable Treatment Plan agreed upon with healthcare provider*	
3. Napagkasunduang angkop na alternatibong plano ng gamutan sa ospital *Applicable alternative Treatment Plan agreed upon with health care provider*	
C. Talatakdaan ng Gamutan at Kasunod na Konsultasyon ***C. Treatment Schedule and Follow-up Visit/s***	
1. Petsa ng unang pagkakaospital o konsultasyon [a] (buwan/araw/taon) *Date of initial admission to HF or consult[a] (mm/dd/yyyy)* [a] Para sa ZMORPH/ mga batang may kapansanan, ito ay tumutukoy sa pagkonsulta para sa rehabilitasyon ng external lower limb pre-prosthesis/ device. Para naman sa PD First, ito ay ang petsa ng konsultasyon o pagdalaw sa PD provider bago magsimula ang unang PD exchange. *[a] For ZMORPH/children with disabilities (CWDs), this refers to the consult prior to the provision of the device and/or rehabilitation. For PD First, this refers to the date of medical consultation or visit to the PD Provider prior to the start of the first PD exchange.*	
2. Pansamantalang Petsa ng susunod na pagpapa-ospital o konsultasyon[b] (buwan/araw/taon) *Tentative Date/s of succeeding admission to HF or consult[b] (mm/dd/yyyy)* [b] Para sa ZMORPH/ mga batang may kapansanan, ito ay petsa ng paglalapat at pagsasayos ng device. Para naman sa PD First, ito ay ang kasunod na pagbisita sa PD Provider. *[b] For ZMORPH/CWDS, this refers to the measurement, fitting and adjustments of the device. For the PD First, this refers to the next visit to the PD Provider.*	
3. Pansamantalang Petsa ng kasunod na pagbisita [c] (buwan/araw/taon) *Tentative Date/s of follow-up visit/s[c] (mm/dd/yyyy)* [c] Para sa ZMORPH/ mga batang may kapansanan, ito ay tumutukoy sa rehabilitasyon ng external lower limb post-prosthesis. *[c] For ZMORPH/CWD, this refers to the external lower limb post-prosthesis rehabilitation consult.*	

D. Edukasyon ng Miyembro ***D. Member Education***		
Lagyan ng tsek (√) ang angkop na sagot o NA kung hindi naaukol *Put a check mark (√) opposite appropriate answer or N.A. if not applicable.*	OO *YES*	HINDI *NO*
1. Ipinaliwanag ng kinatawan ng ospital ang uri ng aking karamdaman. *My health care provider explained the nature of my condition/ disability.*		
2. Ipinaliwanag ng kinatawan ng ospital ang mga pagpipiliang paraan ng gamutan/interbensyon [d] *My health care provider explained the treatment options/ intervention[d].* [d] Para sa ZMORPH, ito ay ukol sa pangangailangan ng pagbibigay at rehabilitasyon para sa pre at post-device. *[d] For ZMORPH, this refers to the need for pre- and post-device provision and rehabilitation.*		
3. Ipinaliwanag ng kinatawan ng ospital ang mga posibleng mga epekto/ masamang epekto ng gamutan/ interbensyon. *The possible side effects/ adverse effects of treatment/ intervention were explained to me.*		
4. Ipinaliwanag ng kinatawan ng ospital ang kailangang serbisyo para sa gamutan ng aking karamdaman/ interbensyon. *My health care provider explained the mandatory services and other services required for the treatment of my condition/ intervention.*		
5. Lubos akong nasiyahan sa paliwanag na ibinigay ng ospital. *I am satisfied with the explanation given to me by my health care provider*		
6. Naibigay sa akin nang buo ang impormasyon na ako ay mahusay na aalagaan ng mga dalubhasang doktor sa aking piniling kinontratang ospital ng PhilHealth at kung gustuhin ko mang lumipat ng ospital ay hindi ito maka-aapekto sa aking pagpapagamot. *I have been fully informed that I will be cared for by all the pertinent medical and allied specialties, as needed, present in the PhilHealth contracted HF of my choice and that preferring another contracted HF for the said specialized care will not affect my treatment in any way.*		
7. Ipinaliwanag ng kinatawan ng ospital ang kahalagahan ng pagsunod sa panukalang gamutan/interbensyon. Kasama rito ang pagkompleto ng gamutan/interbensyon sa unang ospital kung saan nasimulan ang aking gamutan/interbensyon. *My health care provider explained the importance of adhering to my treatment plan/ intervention. This includes completing the course of treatment/ intervention in the contracted HF where my treatment/ intervention was initiated.* Paalala: Ang hindi pagsunod ng pasyente sa napagkasunduang gamutan/interbensyon sa ospital ay maaaring magresulta sa hindi pagbabayad ng mga kasunod na claims at hindi dapat itong ipasa bilang case rates. *Note: Non-adherence of the patient to the agreed treatment plan/ intervention in the HF may result to denial of filed claims for the succeeding tranches and which should not be filed as case rates.*		

Lagyan ng tsek (√) ang angkop na sagot o NA kung hindi nauukol *Put a check mark(√) opposite appropriate answer or NA if not applicable.*	OO *YES*	HINDI *NO*
8. Binigyan ako ng ospital ng talaan ng mga susunod kong pagbisita. *My health care provider gave me the schedule/ s of my follow-up visit/ s.*		
9. Ipinaalam sa akin ng ospital ang impormasyon tungkol sa maaari kong hingan ng tulong pinansiyal o ibang pang suporta, kung kinakailangan. a. Sangay ng pamahalaan (Hal.: PCSO, PMS, LGU, etc.) b. Civil society o non-government organization c. Patient Support Group d. Corporate Foundation e. Iba pa (Hal. Media, Religious Group, Politician, etc.) *My health care provider gave me information where to go for financial and other means of support, when needed.* *a. Government agency (ex. PCSO, PMS, LGU, etc.)* *b. Civil society or non-government organization* *c. Patient Support Group* *d. Corporate Foundation* *e. Others (ex. Media, Religious Group, Politician, etc.)*		
10. Nabigyan ako ng kopya ng listahan ng mga kinontratang ospital para sa karampatang paggagamot ng aking kondisyon o karamdaman. *I have been furnished by my health care provider with a list of other contracted HFs for the specialized care of my condition.*		
11. Nabigyan ako ng sapat na kaalaman hinggil sa benepisyo at tuntunin ng PhilHealth sa pagpapa-miyembro at paggamit ng benepisyong naaayon sa Z benefits: *I have been fully informed by my health care provider of the PhilHealth membership policies and benefit availment on the Z Benefits:* a. Kaalipikado ako sa mga itinakdang batayan para sa aking kondisyon/kapansanan. *I fulfill all selections criteria for my condition/ disability.*		
b. Ipinaliwanag sa akin ang polisiya hinggil sa "No Balance Billing" (NBB) *The "no balance billing" (NBB) policy was explained to me.* Paalala: Ang polisiya ng NBB ay maaaring makamit ng mga sumusunod na miyembro at kanilang kalipikadong makikinabang kapag na-admit sa ward ng ospital: inisponsuran, maralita, kasambahay, senior citizens at miyembro ng iGroup na may kaukulang Group Policy Contract (GPC). *Note: NBB policy is applicable to the following members when admitted in ward accommodation: sponsored, indigent, household help, senior citizens and iGroup members with valid Group Policy Contract (GPC) and their qualified dependents.*		
Para sa inisponsuran, maralita, kasambahay, senior citizens at miyembro ng iGroup na may kaukulang Group Policy Contract (GPC) at kanilang kwalipikadong makikinabang, sagutan ang c, d at e. ***For sponsored, indigent, household help, senior citizens and iGroup members with valid GPC and their qualified dependents, answer c, d and e.*** c. Nauunawaan ko na sakaling hindi ako gumamit ng NBB ay maaari akong magkaroon ng kaukulang gastos na aking babayaran. *I understand that I may choose not to avail of the NBB and may be charged out of pocket expenses*		

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d. Sakaling ako ay nagpalipat sa mas magandang kuwarto ayon sa aking kagustuhan *o tumanggap ng karagdagang serbisyo na hindi kasama sa benepisyo*, nauunawaan ko na hindi na ako maaaring humiling sa pagamutan para makagamit ng pribilehiyong ibinibigay sa mga pasyente na NBB (kapag NBB, wala nang babayaran pa pagkalabas ng pagamutan)
In case I choose to upgrade my room accommodation or avail of additional services that are not included in the benefit package, I understand that I can no longer demand the hospital to grant me the privilege given to NBB patients (that is, no out of pocket payment upon discharge from the hospital)

e. Ninanais ko na lumabas sa polisiyang NBB ang PhilHealth at dahil dito, babayaran ko ang anumang halaga na hindi sakop ng benepisyo sa PhilHealth
I opt out of the NBB policy of PhilHealth and I am willing to pay on top of my PhilHealth benefits

f. Pumapayag akong magbayad ng hanggang sa halagang PHP _____* para sa:
I agree to pay as much as PHP _____ for the following:*

☐ Paglipat ko sa mas magandang kuwarto, o
I choose to upgrade my room accommodation, or

☐ anumang karagdagang serbisyo, tukuyin _____
additional services, specify _____

* Ito ay tinantiyang halaga lamang na gagabay sa pasyente kung magkano ang kanyang babayaran at hindi dapat gawing batayan para sa pagtutuos ng kuwenta ng nagugol na gastusin sa pagkakaospital na babayaran ng PhilHealth.
This is an estimated amount that guides the patient on how much the out of pocket may be and should not be a basis for auditing claims reimbursement.

Ang mga sumusunod na katanungan ay para sa mga miyembro ng formal at informal economy at kanilang mga kalipikadong makikinabang
The following are applicable to formal and informal economy and their qualified dependents

g. Naiintindihan ko na maaari akong magkaroon ng babayaran para sa halagang hindi sakop ng benepisyo sa PhilHealth.
I understand that there may be an additional payment on top of my PhilHealth benefits.

h. Pumapayag akong magbayad ng hanggang sa halagang PHP _____* para sa aking gamutan na hindi sakop ng benepisyo ng PhilHealth.
I agree to pay as much as PHP _____ as additional payment on top of my PhilHealth benefits.*

* Ito ay tinantiyang halaga lamang na gagabay sa pasyente kung magkano ang kanyang babayaran at hindi dapat gawing batayan para sa pagtutuos ng kuwenta ng nagugol na gastusin sa pagkakaospital na babayaran ng PhilHealth.
This is an estimated amount that guides the patient on how much the out of pocket may be and should not be a basis for auditing claims reimbursement.

12. Limang (5) araw lamang ang babawasan mula sa 45 araw na palugit sa benepisyo sa isang taon para sa buong gamutan sa ilalim ng Z benefits.
Only five (5) days shall be deducted from the 45 confinement days benefit limit per year for the duration of my treatment/ intervention under the Z Benefits.

E. Tungkulin at Responsabilidad ng Miyembro ***E. Member Roles and Responsibilities***		
Lagyan ng (√) ang angkop na sagot o NA kung hindi naaukol *Put a (√) opposite appropriate answer or N/A if not applicable*	OO *YES*	HINDI *NO*
1. Nauunawaan ko ang aking tungkulin upang masunod ang nararapat at nakatakda kong gamutan. *I understand that I am responsible for adhering to my treatment schedule.*		
2. Nauunawaan ko na ang pagsunod sa itinakdang gamutan ay mahalaga tungo sa aking paggaling at pangunahing kailangan upang magamit ko nang buo ang Z benefits. *I understand that adherence to my treatment schedule is important in terms of clinical outcomes and a pre-requisite to the full entitlement of the Z benefits.*		
3. Nauunawaan ko na tungkulin kong sumunod sa mga polisiya at patakaran ng PhilHealth at ospital upang magamit ang buong Z benefit package. Kung sakali na hindi ako makasunod sa mga polisiya at patakaran ng PhilHealth at ospital, tinatalikuran ko ang aking pribilehiyong makagamit ng Z benefits. *I understand that it is my responsibility to follow and comply with all the policies and procedures of PhilHealth and the health care provider in order to avail of the full Z benefit package. In the event that I fail to comply with policies and procedures of PhilHealth and the health care provider, I waive the privilege of availing the Z benefits.*		

F. Pangalan, Lagda, Thumb Print at Petsa ***F. Printed Name, Signature, Thumb Print and Date***		
Pangalan at Lagda ng pasyente:* *Printed name and signature of patient** *Para sa mga menor de edad, ang magulang o tagapag-alaga ang pipirma o maglalagay ng thumb print sa ngalan ng pasyente. * *For minors, the parent or guardian affixes their signature or thumb print here on behalf of the patient.*	Thumb Print (kung hindi makakasulat ang pasyente) *(if patient is unable to write)*	Petsa (buwan/ araw/ taon)
Pangalan at lagda ng nangangalagang Doktor: *Printed name and signature of Attending Doctor*		Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*
Mga Saksi: *Witnesses:*		
Pangalan at lagda ng kinatawan ng ospital: *Printed name and signature of HF staff member*		Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*
Pangalan at lagda ng asawa/ magulang / pinakamalapit na kamag-anak/awtorisadong kinatawan *Printed name and signature of spouse/ parent/ next of kin /authorized guardian or representative* ☐ walang kasama/ *no companion*		Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*

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G. Detalye ng Tagapag-ugnay ng PhilHealth para sa Z benefits ***G. PhilHealth Z Coordinator Contact Details***		
Pangalan ng Tagapag-ugnay ng PhilHealth para sa Z benefits na nakatalaga sa ospital *Name of PhilHealth Z Coordinator assigned at the HF*		
Numero ng Telepono *Telephone number*	Numero ng CellPhone *Mobile number*	Email Address

H. Numerong maaaring tawagan sa PhilHealth ***H. PhilHealth Contact Details***
Opisinang Panrehiyon ng PhilHealth _____ *PhilHealth Regional Office No.* Numero ng telepono _____ *Hotline Nos.*

I. Pahintulot sa pagsusuri sa talaan ng pasyente ***I. Consent to access patient record***	J. Pahintulot na mailagay ang *medical data* sa Z benefit information and tracking system (ZBITS) ***J. Consent to enter medical data in the Z benefit information & tracking system (ZBITS)***
Ako ay pumapayag na suriin ng PhilHealth ang aking talaang medikal upang mapatunayan ang katotohanan ng Z-claim *I consent to the examination by PhilHealth of my medical records for the sole purpose of verifying the veracity of the Z-claim*	Ako ay pumapayag na mailagay ang aking impormasyong medikal sa ZBITS na kailangan sa Z benefits. Pinahihintulutan ko din ang PhilHealth na maipaalam ang aking personal na impormasyong pangkalusugan sa mga kinontratang ospital. *I consent to have my medical data entered electronically in the ZBITS as a requirement for the Z Benefits. I authorize PhilHealth to disclose my personal health information to its contracted partners*

Ako ay nagpapatunay na walang pananagutan ang PhilHealth o sinumang opisyal, empleyado o kinatawan mula sa pahintulot na nakasaad sa itaas sapagkat kusang-loob ko itong ibinigay upang makagamit ng Z benefits ng PhilHealth.
I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with the Z claim for reimbursement before PhilHealth.

Buong pangalan at lagda ng pasyente* *Printed name and signature of patient** * Para sa mga menor de edad, ang magulang o tagapag-alaga ang pipirma o maglalagay ng thumb print sa ngalan ng pasyente. * *For minors, the parent or guardian affixes their signature or thumb print here on behalf of the patient.*	Thumb print (Kung hindi na makasusulat) *(if patient is unable to write)*	Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*
Buong pangalan at lagda ng kumakatawan sa pasyente *Printed name and signature of patient's representative* ☐ walang kasama/ *no companion*		Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*

Relasyon ng kumakatawan sa pasyente (Lagyan ng tsek ang angkop na kahon)
Relationship of representative to patient (tick appropriate box)

☐ asawa *spouse* ☐ magulang *parent* ☐ anak *child* ☐ kapatid *next of kin* ☐ tagapag-alaga *guardian* ☐ walang kasama *no companion*

Annex C1.1: Colon Cancer Stage I to II (low risk) – Post-surgery

Revised as of December 2022

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. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")***	
	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF MANDATORY AND OTHER SERVICES
Colon Cancer Stage I-II (Low Risk)
Post-Surgery

Place a (✓) in the appropriate tick box if *the service is* done or *given*

MANDATORY SERVICES	OTHER SERVICES as needed/as indicated
Procedure:	
☐ Colonoscopy[a]	☐ Surgery for closure of colostomy/ ileostomy[b]
☐ Histopathology	
☐ Surgery (definitive)	
Diagnostics:	
☐ Chest CT or Chest x-ray (PA-L)[c]	☐ ECG
☐ CT scan of whole abdomen *preferably with contrast*[a, c]	☐ CP clearance
☐ Fasting blood sugar (FBS)	☐ SGPT
☐ Carcinoembryonic antigen (CEA), as baseline	☐ Prothrombin time
	☐ Alkaline phosphatase
☐ Complete blood count	☐ CEA for monitoring
☐ Blood typing	☐ SGPT for monitoring
☐ Albumin	☐ Creatinine for monitoring
☐ Creatinine	Medicine
[a] should be done within 60 calendar days before the date of submission of the pre-authorization checklist and request.to PhilHealth	☐ *Antimicrobials*, specify
[b] shall be covered under the Z Benefits within two (2) years from the date of surgery; patients may be charged co-payment within the allowable limit as indicated in the contract of the HF	☐ Pain relievers, specify
[c] PET scan may be accepted in place of CT scan	Others
	☐ Blood support, such as cross-matching, screening, and processing

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Date: 2/7/23

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	**(Answer only if the patient is a dependent; otherwise, write, "same as above")**	
	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐ - ☐	PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐ - ☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient
Date signed (mm/dd/yyyy)

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Annex C1.2: Colon Cancer Stage II (high risk) to III – Post-surgery

Revised as of December 2022

Republic of the Philippines

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KASIGURAHAN PARA SA LAHAT

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")***	
	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF MANDATORY AND OTHER SERVICES
Colon Cancer Stage II (High Risk) *to* III
Post-Surgery

Place a (✓) in the appropriate tick box if *the service is* done or *given*

MANDATORY SERVICES	OTHER SERVICES as needed/as indicated
Procedure:	
☐ Colonoscopy[a]	☐ Surgery for closure of colostomy/ ileostomy[b]
☐ *Biopsy with* histopathology	
☐ Surgery (definitive)	
Diagnostics:	
☐ Chest CT or chest x-ray (PA-L)[a]	☐ ECG
☐ CT scan of whole abdomen *preferably with contrast*[b,c]	☐ CP clearance
	☐ SGPT
☐ Fasting blood sugar (FBS)	☐ Prothrombin time
☐ Carcinoembryonic antigen (CEA), as baseline	☐ Alkaline phosphatase
	☐ CEA for monitoring
☐ Complete blood count	☐ SGPT for monitoring
☐ Blood typing	☐ Creatinine for monitoring
☐ Albumin	Medicines
☐ Creatinine	☐ *Antimicrobials,* specify
[a] *should be done within 60 calendar days before the date of submission of the pre-authorization checklist and request to PhilHealth*	☐ *Antiemetics,* specify
[b] *shall be covered under the Z Benefits within two (2) years from the date of surgery; patients may be charged co-payment within the allowable limit as indicated in the contract of the HF*	☐ Pain relievers, specify
[c] *PET scan may be accepted in place of CT scan*	Others
	☐ Blood support, such as cross-matching, screening, and processing

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HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")***	
	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐☐ -	PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐☐ -
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient
Date signed (mm/dd/yyyy)

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Annex C1.3: Colon Cancer Stage II (high risk) to III – After last cycle of Chemotherapy

Revised as of December 2022

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	**(Answer only if the patient is a dependent; otherwise, write, "same as above")**	
	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF MANDATORY AND OTHER SERVICES
Colon Cancer Stage II (High Risk) –III
After last cycle of chemotherapy

Place a (✓) if DONE or NA if not applicable in the status column.

MANDATORY SERVICES	*OTHER SERVICES (As indicated)*
Medicines: Any of the following:	
Capecitabine-Oxaliplatin (CapeOX)	
Capecitabine	
Fluorouracil-Folinic acid- Oxaliplatin (FOLFOX 4)	
Fluorouracil-Folinic acid- Oxaliplatin (mFOLFOX 6)	
Fluorouracil-Folinic acid (FU-FA)	
	Anti-emetics, specify _____
	Antimicrobials, specify _____
	Pain relievers, specify _____
	Others:
	Blood support

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Medical Oncologist	(Printed name and signature) Patient
PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐ - ☐	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

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Date: 2/17/23

Annex C2.1: Rectal Cancer Stage I (clinical and pathologic stage) – Post-surgery

Revised as of December 2022

Republic of the Philippines

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KASIGURADUHAN PARA SA LAHAT

Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")*** 1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF MANDATORY AND OTHER SERVICES

***Rectal* Cancer Stage I (clinical and pathologic stage)**
Post Surgery

Specify the following:

Clinical stage prior to initiation of treatment	cT:	N:	M:
Pathologic stage	pT:	N:	M:

Place a (✓) in the appropriate tick box if DONE or GIVEN.

MANDATORY SERVICES	OTHER SERVICES as needed/ as indicated
Procedure	
☐ Colonoscopy[a]	☐ Surgery for closure of colostomy/ileostomy[b]
☐ *Biopsy with* histopathology	☐ *Proctoscopy*
☐ Surgery (definitive)	
Diagnostics	
☐ *Chest CT or Chest x-ray (PA-L)*[c]	☐ ECG
☐ Pelvic MRI or endorectal ultrasound	☐ 2D echocardiogram
☐ CT scan of whole abdomen *preferably with contrast*[a,c]	☐ CP clearance
	☐ SGPT
☐ Fasting blood sugar (FBS)	☐ Prothrombin time
☐ Carcinoembryonic antigen (CEA), as baseline	☐ Alkaline phosphatase
	☐ Bilirubin
☐ Complete blood count	☐ CEA for monitoring
☐ Blood typing	☐ SGPT for monitoring
☐ Albumin	☐ Creatinine for monitoring
☐ Creatinine	

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[a] should be done within 60 calendar days before the date of submission of the pre-authorization checklist and request to PhilHealth
[b] shall be covered under the Z Benefits within two (2) years from the date of surgery; patients may be charged co-payment within the allowable limit as indicated in the contract of the HF
[c] PET scan may be accepted in place of CT scan

MANDATORY SERVICES	OTHER SERVICES as needed/ as indicated
	Medicines
	Antimicrobials, specify
	Pain relievers, specify
	Others:
	Blood support, *such as cross-matching, screening, and processing*

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No. - -	PhilHealth Accreditation No. - -
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Certified correct by:	Conforme by:
(Printed name and signature) Attending Radiation Oncologist	(Printed name and signature) Patient
PhilHealth Accreditation No. - -	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

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Annex C3.1: Rectal Cancer Pre-Operative Clinical Stage I with Post-Operative Pathologic Stage II to III – Post-surgery

Revised as of December 2022

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")*** 1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF MANDATORY AND OTHER SERVICES
Rectal cancer pre-operative clinical stage I with post-operative pathologic stage II - III Post Surgery

Specify the following:

Clinical stage prior to initiation of treatment	cT:	N:	M:
Pathologic stage	pT:	N:	M:

Place a (✓) in the appropriate tick box if DONE or GIVEN.

MANDATORY SERVICES	OTHER SERVICES as indicated/ as needed
Procedure	
Colonoscopy[a]	Surgery for closure of colostomy/ ileostomy[b]
Biopsy with histopathology	
Surgery (definitive)	*Proctoscopy*
Diagnostics	
Chest CT or chest x-ray (PA-LAT)	ECG
Pelvic MRI or endorectal ultrasound	CP clearance
CT scan of whole abdomen *preferably with contrast*[a, c]	SGPT
Fasting blood sugar (FBS)	Prothrombin time
Carcinoembryonic antigen (CEA), as baseline	Alkaline phosphatase
Complete blood count	Bilirubin
Blood typing	CEA for monitoring

[a] *should be done within 60 calendar days before the date of submission of the pre-authorization checklist and request to PhilHealth*
[b] *shall be covered under the Z Benefits within two (2) years from the date of surgery; patients may be charged co-payment within the allowable limit as indicated in the contract of the HF*
[c] *PET scan may be accepted in place of CT scan*

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MANDATORY SERVICES	OTHER SERVICES as indicated/ as needed
Albumin	SGPT for monitoring
Creatinine	Creatinine for monitoring
Medicines	
	Antiemetics, specify _____
	Antimicrobials, specify _____
	Pain relievers, specify _____
	Others: Blood support

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No. - -	PhilHealth Accreditation No. - -
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Certified correct by:	Conforme by:
(Printed name and signature) Attending Radiation Oncologist	(Printed name and signature) Patient
PhilHealth Accreditation No. - -	Date signed (mm/dd/yyyy)

Annex C3.2: Rectal Cancer Pre-Operative Clinical Stage I with Post-operative Pathologic Stage II to III – After completion of Chemoradiotherapy

Revised as of December 2022

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")***	
	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF MANDATORY AND OTHER SERVICES

***Rectal* cancer pre-operative clinical stage I with post-operative pathologic stage II – III**
After completion of chemoradiotherapy

Place a (✓) in the appropriate tick box if DONE or GIVEN.

MANDATORY SERVICES	*OTHER SERVICES (As needed)*
A. Any of the following protocols:	
Fluorouracil-Folinic acid (FU-FA)	Antiemetics, specify _____
Capecitabine	*Antimicrobials*, specify _____
	Pain relievers, specify _____
Radiotherapy (concurrent with chemotherapy)	Others:
Linear accelerator	Blood support
Standard	
Short course	
*Portal films or electronic portals**	

** Weekly for standard course and daily for short course*

Certified correct by:	Certified correct by:
(Printed name and signature) Medical Oncologist	(Printed name and signature) Radiologic Oncologist
PhilHealth Accreditation No. ☐☐☐☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	PhilHealth Accreditation No. ☐☐☐☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient
Date signed (mm/dd/yyyy)

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Annex C3.3: Rectal Cancer Pre-Operative Clinical Stage I with Post-operative Pathologic Stage II to III – After last cycle of Chemotherapy

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")*** 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF MANDATORY AND OTHER SERVICES

***Rectal* cancer pre-operative clinical stage I with post-operative pathologic stage II – III**
After last cycle of chemotherapy

Specify the following:

Clinical stage prior to initiation of treatment	cT:	N:	M:
Pathologic stage	pT:	N:	M:

Place a (✓) in the appropriate tick box if DONE or GIVEN.

MANDATORY SERVICES	OTHER SERVICES (As needed)
Procedures	
	☐ Surgery for closure of colostomy / ileostomy[a]
	☐ Proctoscopy
Diagnostics	
☐ Complete blood count	☐ Chest CT or Chest x-ray (PA-L)
☐ Creatinine	☐ ECG
	☐ Prothrombin time
	☐ Alkaline Phosphatase
	☐ Bilirubin
	☐ CEA, for monitoring
	☐ SGPT, for monitoring
	☐ Creatinine, for monitoring

[a] *shall be covered under the Z Benefits within two (2) years from the date of surgery; patients may be charged co-payment within the allowable limit as indicated in the contract of the HF*

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MANDATORY SERVICES	*OTHER SERVICES (As needed)*
Medicines	
A. Any of the following protocols:	
Capecitabine-Oxaliplatin (CapeOX)	
Fluorouracil-Folinic acid-Oxaliplatin (FOLFOX 4)	
Fluorouracil-Folinic acid-Oxaliplatin (mFOLFOX 6)	
	Antiemetics, specify
	Antimicrobials, specify
	Pain relievers, specify
	Others
	Blood support

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No. - -	PhilHealth Accreditation No. - -
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Radiation Oncologist	(Printed name and signature) Patient
PhilHealth Accreditation No. - -	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

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Annex C4.1: Rectal Cancer Pre-treatment Clinical Stage II to III – After completion of Chemoradiotherapy

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KAUNGA PARA SA LAHAT

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")*** 1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF MANDATORY AND OTHER SERVICES
Rectal cancer pre-treatment clinical stage II - III
After completion of chemoradiotherapy

Specify the following:

Clinical stage prior to initiation of treatment	cT:	N:	M:
Pathologic stage	pT:	N:	M:

Place a (✓) in the appropriate tick box if DONE or GIVEN.

MANDATORY SERVICES	OTHER SERVICES as indicated/ as needed
Procedures	
Colonoscopy[a]	Surgery for diversion
Biopsy with histopathology	Surgery for closure of colostomy/ileostomy[b]
Histopathology (post-operative)	Proctoscopy
Radiotherapy (preferably, linear accelerator)	
Diagnostics	
Chest CT or Chest X-ray (PA-L)[c]	CP Clearance
Pelvic MRI or endorectal ultrasound	SGPT
CT scan of whole abdomen *preferably with contrast*[a, c]	Prothrombin time
Fasting blood sugar (FBS)	Alkaline phosphatase
Carcinoembryonic antigen (CEA), as baseline	Bilirubin
	CEA for monitoring
Complete blood count	SGPT for monitoring

[a] *should be done within 60 calendar days before the date of submission of the pre-authorization checklist and request to PhilHealth*
[b] *shall be covered under the Z Benefits within two (2) years from the date of surgery; patients may be charged co-payment within the allowable limit as indicated in the contract of the HF*
[c] *PET scan may be accepted in place of CT scan*

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MANDATORY SERVICES	OTHER SERVICES as indicated/ as needed
Blood typing	Creatinine for monitoring
Albumin	Chest X-ray
Creatinine	ECG

Place a (✓) in the appropriate tick box if DONE or GIVEN.

MANDATORY SERVICES	OTHER SERVICES as indicated/ as needed
Medicines, as indicated	
A. Any of the following protocols:	
Fluorouracil-Folinic acid (FU-FA)	Antiemetics, specify _____
Capecitabine	*Antimicrobials,* specify _____
	Pain relievers, specify _____
Radiotherapy (concurrent with chemotherapy)	Others:
Linear accelerator	Blood support
Standard	
Short course	
*Portal films or electronic portals**	

** Weekly for standard course and daily for short course*

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No. - -	PhilHealth Accreditation No. - -
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Certified correct by:	Conforme by:
(Printed name and signature) Attending Radiation Oncologist	(Printed name and signature) Patient
PhilHealth Accreditation No. - -	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KATIWASAY PARA SA LAHAT

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")***	
	1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF MANDATORY AND OTHER SERVICES
***Rectal* cancer pre-treatment clinical stage II - III**
Post Surgery

Place a (✓) in the appropriate tick box if DONE or GIVEN.

MANDATORY SERVICES	OTHER SERVICES as indicated/ as needed
Procedure	
Surgery (definitive)	Proctoscopy
	Biopsy
Diagnostic	
Complete blood count	Pelvic MRI or endorectal ultrasound
Albumin	CT scan of whole abdomen CT scan of whole abdomen *preferably with contrast*[a, b]
Creatinine	Chest CT
	ECG
	CP clearance
	SGPT
	Prothrombin time
	Alkaline phosphatase
	Bilirubin
	CEA for monitoring
	SGPT for monitoring
	Creatinine for monitoring

MASTER COPY Date: 2/7/23 DC: Ryan

[a] *should be done within 60 calendar days before the date of submission of the pre-authorization checklist and request to PhilHealth*
[b] *PET scan may be accepted in place of CT scan*

Place a (✓) in the appropriate tick box if DONE or GIVEN.

MANDATORY SERVICES	OTHER SERVICES as indicated/ as needed
	Medicines
	Antiemetics, specify _____
	Antimicrobials, specify _____
	Pain relievers, specify _____
	Others: Blood support

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No. - -	PhilHealth Accreditation No. - -
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Certified correct by:	Conforme by:
(Printed name and signature) Attending Radiation Oncologist	(Printed name and signature) Patient
PhilHealth Accreditation No. - -	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

Annex C4.3: Rectal Cancer Pre-treatment Clinical Stage II to III – After last cycle of Chemotherapy

Revised as of December 2022

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www.philhealth.gov.ph

UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")***	
	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF MANDATORY AND OTHER SERVICES
Rectal cancer pre-treatment clinical stage II – III
After last cycle of chemotherapy

Place a (✓) in the appropriate tick box if DONE or GIVEN.

MANDATORY SERVICES	***OTHER SERVICES (As needed)***
Medicines	
A. Any of the following protocols:	
Capecitabine-Oxaliplatin (CapeOX)	
Capecitabine	
Fluorouracil-Folinic acid-Oxaliplatin (FOLFOX 4)	
Fluorouracil-Folinic acid-Oxaliplatin (mFOLFOX 6)	
Fluorouracil-Folinic acid (EU-FA)	
	Antiemetics, specify _____
	Antimicrobials, specify _____
	Pain relievers, specify _____
	Others
	Blood support

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Medical Oncologist	(Printed name and signature) Patient
PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐☐ - ☐	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

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DC: Date: 2/7/23

PhilHealth

Benefits

Share your opinion with us!

We would like to know how you feel about the services that pertain to the Z Benefit Package in order that we can improve and meet your needs. This survey will only take a few minutes. Please read the items carefully. If you need to clarify items or ask questions, you may approach your friendly health facility or you may contact PhilHealth call center at 8441-7442. Your responses will be kept confidential and anonymous.

For items 1 to 3, please tick on the appropriate box.

1. Z benefit package availed is for:
   - ☐ Acute lymphoblastic leukemia
   - ☐ Breast cancer
   - ☐ Prostate cancer
   - ☐ Kidney transplantation
   - ☐ Cervical cancer
   - ☐ Coronary artery bypass surgery
   - ☐ Surgery for Tetralogy of Fallot
   - ☐ Surgery for ventricular septal defect
   - ☐ ZMORPH/Expanded ZMORPH
   - ☐ Orthopedic implants
   - ☐ PD First Z benefits
   - ☐ Colorectal cancer
   - ☐ Prevention of preterm delivery
   - ☐ Preterm and small baby
   - ☐ Children with developmental disability
   - ☐ Children with mobility impairment
   - ☐ Children with visual disability
   - ☐ Children with hearing impairment

2. Respondent's age is:
   - ☐ 19 years old & below
   - ☐ between 20 to 35
   - ☐ between 36 to 45
   - ☐ between 46 to 55
   - ☐ between 56 to 65
   - ☐ above 65 years old

3. Sex of respondent
   - ☐ male
   - ☐ female

For items 4 to 8, please select the one best response by ticking the appropriate box.

4. How would you rate the services received from the health facility (HF) in terms of availability of medicines or supplies needed for the treatment of your condition?
   - ☐ adequate
   - ☐ inadequate
   - ☐ don't know

MASTER COPY Date: 2/7/23 DC

5. How would you rate the patient's or family's involvement in the care in terms of patient empowerment? (You may refer to your Member Empowerment Form)
   ☐ excellent
   ☐ satisfactory
   ☐ unsatisfactory
   ☐ don't know

6. In general, how would you rate the health care professionals that provided the services for the Z benefit package in terms of doctor-patient relationship?
   ☐ excellent
   ☐ satisfactory
   ☐ unsatisfactory
   ☐ don't know

7. In your opinion, by how much has your HF expenses been lessened by availing of the Z benefit package?
   ☐ less than half
   ☐ by half
   ☐ more than half
   ☐ don't know

8. Overall patient satisfaction (PS mark) is:
   ☐ excellent
   ☐ satisfactory
   ☐ unsatisfactory
   ☐ don't know

9. If you have other comments, please share them below:
   _____
   _____
   _____

Thank you. Your feedback is important to us!

_____
Signature of Patient/ Parent/ Guardian

Date accomplished: _____

Annex E1.1: Colon Cancer Stage I to II (low risk) – Post-surgery

Revised as of December 2022

Republic of the Philippines

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www.philhealth.gov.ph

UNIVERSAL HEALTH CARE
KALUSUGAN AT KAGINHAWAAN PARA SA LAHAT

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	**(Answer only if the patient is a dependent; otherwise, write, "same as above")** 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

TRANCHE REQUIREMENTS CHECKLIST
Colon Cancer Stage I-II (Low Risk)
Post-Surgery

	Please Check
1. Tranche Requirements Checklist (Annex *E1.1*-Colon CA)	
2. *Photocopy* of approved Pre-Authorization Checklist & Request (Annex A1-Colon 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 *CF2*	
5. Checklist of Mandatory and Other Services (Annex *C1.1*-Colon CA)	
6. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
7. *Photocopy of the* Multidisciplinary-interdisciplinary Team (MDT) Plan	
8. *Original or certified true copy (CTC) of the Statement of Account (SOA)*	
9. *Photocopy of accomplished surgical operative report*	
10. *Photocopy of accomplished anesthesia report*	
11. Histopathology result after definitive surgery	
DATE COMPLETED (mm/dd/yyyy)	
DATE FILED (mm/dd/yyyy)	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No. ☐☐☐☐☐ - ☐☐☐☐☐☐☐ - ☐	PhilHealth Accreditation No. ☐☐☐☐☐ - ☐☐☐☐☐☐☐ - ☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient
Date signed (mm/dd/yyyy)

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Annex E1.2: Colon Cancer Post-Surgery Stage II (high risk) to III – Post-surgery

Revised as of December 2022

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	**(Answer only if the patient is a dependent; otherwise, write, "same as above")** 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

TRANCHE 1 REQUIREMENTS CHECKLIST
Colon Cancer Post-Surgery Stage II (High Risk) - III
Post Surgery

		Please Check
1.	Tranche Requirements Checklist (Annex E1.2-Colon CA)	
2.	*Photocopy* of approved Pre – Authorization Checklist & Request (Annex A1-Colon 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 C1.2-Colon CA)	
6.	Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
7.	*Photocopy of the* Multidisciplinary-interdisciplinary Team (MDT) Plan	
8.	*Original or certified true copy (CTC) of the Statement of Account (SOA)*	
9.	*Photocopy of accomplished surgical operative report*	
10.	*Photocopy of accomplished anesthesia report*	
11.	Histopathology result after definitive surgery	
DATE COMPLETED (mm/dd/yyyy)		
DATE FILED (mm/dd/yyyy)		

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No. ☐☐☐☐☐ - ☐☐☐☐☐☐☐ - ☐	PhilHealth Accreditation No. ☐☐☐☐☐ - ☐☐☐☐☐☐☐ - ☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient
Date signed (mm/dd/yyyy)

MASTER COPY Date: 2/7/23 DC: [illegible]

Annex E1.3: Colon Cancer Stage II (high risk) to III – After completion of Chemotherapy

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Republic of the Philippines

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Citystate Centre, 709 Shaw Boulevard, Pasig City
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www.philhealth.gov.ph

UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	**(Answer only if the patient is a dependent; otherwise, write, "same as above")**	
	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

TRANCHE REQUIREMENTS CHECKLIST
Colon Cancer Stage II (High Risk) -III
After completion of chemotherapy

		Please Check
1.	Tranche Requirements Checklist (Annex *E1.3*-Colon CA)	
2.	*Photocopy* of approved Pre –Authorization Checklist & Request (Annex A1-Colon 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 C*1.3*-Colon CA)	
6.	Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
7.	*Photocopy of the Multidisciplinary-interdisciplinary Team (MDT)* Plan	
8.	*Original or certified true copy (CTC) of the Statement of Account (SOA)*	
9.	*Photocopy of* chemotherapy treatment summary form	
DATE COMPLETED (mm/dd/yyyy)		
DATE FILED (mm/dd/yyyy)		

Certified correct by:	Conforme by:
(Printed name and signature) Attending Medical Oncologist	(Printed name and signature) Patient
PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐ -	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

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Annex E2.1: Rectal Cancer Stage I (clinical and pathologic stage) – Post-surgery

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")*** 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

TRANCHE REQUIREMENTS CHECKLIST
Rectal Cancer Stage 1 (Clinical and Pathologic Stage) Post Surgery

	Please Check
1. Tranche Requirements Checklist (Annex E2.1 – Rectal CA)	
2. Photocopy of approved Pre-Authorization Checklist & Request (Annex A2– Rectal CA)	
3. Photocopy of completely accomplished ME FORM (Annex B)	
4. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF2	
5. Checklist of Mandatory and Other Services (Annex *C2.1*- Rectal CA)	
6. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
7. Photocopy of the Multidisciplinary-interdisciplinary Team (MDT) Plan	
8. Original or certified true copy (CTC) of the Statement of Account (SOA)	
9. Photocopy of accomplished surgical operative record	
10. Photocopy of accomplished anesthesia report	
11. Histopathology result after definitive surgery	
DATE COMPLETED (mm/dd/yyyy)	
DATE FILED (mm/dd/yyyy)	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No. ☐☐☐☐☐ - ☐☐☐☐☐☐☐ - ☐	PhilHealth Accreditation No. ☐☐☐☐☐ - ☐☐☐☐☐☐☐ - ☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Radiation Oncologist	(Printed name and signature) Patient
PhilHealth Accreditation No. ☐☐☐☐☐ - ☐☐☐☐☐☐☐ - ☐	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KAUNLARAN PARA SA LAHAT

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")*** 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

TRANCHE REQUIREMENTS CHECKLIST

Rectal cancer pre-operative clinical stage I with post-operative pathologic stage II - III
Post Surgery

	Please Check
1. Tranche Requirements Checklist (Annex *E3.1* – Rectal CA)	
2. Photocopy of approved Pre-Authorization Checklist & Request (Annex A2– Rectal CA)	
3. Photocopy of completely accomplished ME FORM (Annex B)	
4. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF2	
5. Checklist of Mandatory and Other Services (Annex *C3.1*- Rectal CA)	
6. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
7. Photocopy of the Multidisciplinary-interdisciplinary team (MDT) Plan	
8. Original or certified true copy (CTC) of the Statement of Account (SOA)	
9. Photocopy of accomplished surgical operative record	
10. Photocopy of accomplished anesthesia report	
11. *Photocopy of the* histopathology result after definitive surgery	
DATE COMPLETED (mm/dd/yyyy)	
DATE FILED (mm/dd/yyyy)	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No. ☐☐☐☐☐ - ☐☐☐☐☐☐☐☐ - ☐	PhilHealth Accreditation No. ☐☐☐☐☐ - ☐☐☐☐☐☐☐☐ - ☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)
Certified correct by:	Certified correct by:
(Printed name and signature) Attending Radiation Oncologist	(Printed name and signature) Patient
PhilHealth Accreditation No. ☐☐☐☐☐ - ☐☐☐☐☐☐☐☐ - ☐	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

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Annex E3.2: Rectal Cancer Pre-Operative Clinical Stage I with Post-operative Pathologic Stage II to III – After completion of Chemoradiotherapy

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UNIVERSAL HEALTH CARE
KAKUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent, otherwise, write, "same as above")***	
	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

TRANCHE REQUIREMENTS CHECKLIST

Rectal cancer pre-operative clinical stage I with post-operative pathologic stage II - III
After completion of chemoradiotherapy

	Please Check
1. Tranche Requirements Checklist (Annex *E3.2* – Rectal CA)	
2. *Photocopy* of approved Pre –Authorization Checklist & Request (Annex A2-Rectal CA)	
3. *Photocopy* of completely accomplished ME FORM (Annex B)	
4. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF2	
5. Checklist of Mandatory and Other Services (Annex *C3.2*- Rectal CA)	
6. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
7. *Photocopy of the Multidisciplinary-interdisciplinary Team (MDT)* Plan	
8. *Original or certified true copy (CTC) of the Statement of Account (SOA)*	
9. Photocopy of radiation treatment summary form	
10. Photocopy of chemotherapy treatment summary form	
DATE COMPLETED (mm/dd/yyyy)	
DATE FILED (mm/dd/yyyy)	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Medical Oncologist	(Printed name and signature) Attending Radiation Oncologist
PhilHealth Accreditation No. ☐☐☐☐☐ - ☐☐☐☐☐☐☐☐ - ☐	PhilHealth Accreditation No. ☐☐☐☐☐ - ☐☐☐☐☐☐☐☐ - ☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient
Date signed (mm/dd/yyyy)

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Annex E3.3: Rectal Cancer Pre-Operative Clinical Stage I with Post-operative Pathologic Stage II to III - After last cycle of Chemotherapy

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")*** 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

TRANCHE REQUIREMENTS CHECKLIST

Rectal cancer pre-operative clinical stage I with post-operative pathologic stage II – III after last cycle of chemotherapy

	Please Check
1. Tranche Requirements Checklist (Annex E3.3 – Rectal CA)	
2. *Photocopy* of approved Pre –Authorization Checklist & Request (Annex A2-Rectal 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 C3.3- Rectal CA)	
6. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
7. *Photocopy of the Multidisciplinary-interdisciplinary Team (MDT)* Plan	
8. *Original or certified true copy (CTC) of the Statement of Account (SOA)*	
9. Photocopy of chemotherapy treatment summary form	
DATE COMPLETED *(mm/dd/yyyy)*	
DATE FILED *(mm/dd/yyyy)*	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Medical Oncologist	(Printed name and signature) Attending Radiation Oncologist
PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐ - ☐	PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐ - ☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient
Date signed (mm/dd/yyyy)

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Annex E4.1: Rectal Cancer Pre-treatment Clinical Stage II to III – After completion of Chemoradiotherapy

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")*** 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

TRANCHE REQUIREMENTS CHECKLIST

Rectal cancer pre-treatment clinical stage II-III
After completion of chemoradiotherapy

	Please Check
1. Tranche Requirements Checklist (Annex E4.1 – Rectal CA)	
2. Photocopy of approved Pre-Authorization Checklist & Request (Annex A2– Rectal CA)	
3. Photocopy of completely accomplished MF FORM (Annex B)	
4. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF2	
5. Checklist of Mandatory and Other Services (Annex C4.1- Rectal CA)	
6. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
7. *Photocopy of the* Mulidisciplinary-interdisciplinary team (MDT) Plan	
8. *Original or certified true copy (CTC) of the Statement of Account (SOA)*	
9. Copy of radiation treatment summary form	
10. Copy of chemotherapy treatment summary form	
DATE COMPLETED *(mm/dd/yyyy)*	
DATE FILED *(mm/dd/yyyy)*	

MASTER COPY
DC: Date: 2/7/23

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")***	
	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No.	PhilHealth Accreditation No.
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Radiation Oncologist	(Printed name and signature) Patient
PhilHealth Accreditation No.	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

Annex E4.2: Rectal Cancer Pre-treatment Clinical Stage II to III: Post-surgery

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KATIWASAY PARA SA LAHAT

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")*** 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

TRANCHE REQUIREMENTS CHECKLIST

Rectal cancer pre-treatment clinical stage II-III

After Discharge from Surgery

	Please Check
1. Tranche Requirements Checklist (Annex *E4.2* – Rectal CA)	
2. *Photocopy of approved Pre-Authorization Checklist & Request (Annex A2—Rectal CA)*	
3. *Photocopy of completely accomplished MF FORM (Annex B)*	
4. *Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF2*	
5. Checklist of Mandatory and Other Services (Annex *C4.2*- Rectal CA)	
6. *Photocopy of* completed Z Satisfaction Questionnaire (Annex D)	
7. *Photocopy of the Multidisciplinary-interdisciplinary Team (MDT) Plan*	
8. *Original or certified true copy (CTC) of the Statement of Account (SOA)*	
9. *Photocopy of accomplished surgical* operative record	
10. *Photocopy of accomplished anesthesia report*	
11. Histopathology result after definitive surgery	
DATE COMPLETED *(mm/dd/yyyy)*:	
DATE FILED *(mm/dd/yyyy)*:	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Patient
PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐☐ - ☐	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

MASTER COPY Date: 2/7/23 DG

Annex E4.3: Rectal Cancer Pre-treatment Clinical Stage II to III: After last cycle of Chemotherapy

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UNIVERSAL HEALTH CARE

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")*** 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

TRANCHE REQUIREMENTS CHECKLIST

Rectal cancer pre-treatment clinical stage II - III
After last cycle of chemotherapy

	Please Check
1. Tranche Requirements Checklist (Annex E*4.3* – Rectal CA)	
1. *Photocopy* of approved Pre –Authorization Checklist & Request (Annex A2-Rectal CA)	
2. *Photocopy* of completely accomplished ME FORM (Annex B)	
2. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF2	
3. Checklist of Mandatory and Other Services (Annex *C4.3*- Rectal CA)	
4. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
5. *Photocopy of the Multidisciplinary interdisciplinary Team (MDT)* Plan	
6. Original or certified true copy (CTC) of the Statement of Account (SOA)	
7. Photocopy of chemotherapy treatment summary form	
DATE COMPLETED *(mm/dd/yyyy)*	
DATE FILED *(mm/dd/yyyy)*	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Medical Oncologist	(Printed name and signature) Attending Radiation Oncologist
PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐ - ☐	PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐ - ☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient
Date signed (mm/dd/yyyy)

MASTER COPY Date: 2/7/23 DC: [illegible]

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Quality Indicators Checklist for the Z Benefits for Colorectal Cancer

A. Structure
Tertiary government or private hospital with the following minimum requirements:

Infrastructure:
a. major operating room
b. surgery ward
c. facilities for in and out-patient chemotherapy infusion
d. pharmacy
e. pathology laboratory with CEA and histopathology
f. Cobalt or linear accelerator facilities
g. conference room for multidisciplinary meeting
h. multidisciplinary out-patient clinics
i. endoscopy facilities (with at least 1 colonoscope, rigid proctoscope and endorectal ultrasound)
j. radiology facilities, (with at least x-ray and CT scan, preferably with MRI)

Manpower
1. Medical Oncology
   a. Training program in Medical Oncology accredited by the Philippine Society of Medical Oncology or the Philippine Society of Oncologists
      OR
   b. With at least 1 Medical Oncology consultant who is a Fellow of the Philippine Society of Medical Oncology or the Philippine Society of Oncologists

2. Radiation Oncology
   a. Training program in Radiation Oncology accredited by the Philippine Radiation Oncology Society OR with at least 1 Radiation Oncology consultant who is a Fellow of the Philippine Radiation Oncology Society
      AND
   b. Cobalt or linear accelerator facilities; OR with a formal referral process to a nearby radiation oncology facility

3. Surgery
   a. Colon Cancer
      i. Training program in General Surgery accredited by the Philippine Society of General Surgery
      OR

ii. With at least 3 General Surgeon consultants who are Fellows of the Philippine Society of General Surgeons

b. Rectal Cancer

i. Training program in Colorectal Surgery accredited by the Philippine Society of Colorectal Surgeons;

OR

ii. With at least 1 Colorectal Surgeon consultant who is a Fellow of the Philippine Society of Colorectal Surgeons;

OR

iii. With at least 1 General Surgeon consultant who is BOTH a Fellow of the Philippine Society of General Surgeons AND certified to have officially completed the didactics and hands-on course on Total Mesorectal Excision Course given by the Philippine Society of Colorectal Surgery

4. Radiology consultants
5. Pathology consultants
6. Oncology nurse who is a certified member of the Philippine Oncology Nurses Association
7. Stoma nurse who is a certified member of the Enterostomal Nursing Association of the Philippines

B. Process

1. A regular multidisciplinary meeting must be held no fewer than twice a month, to be attended by consultants from surgery, medical oncology and radiation oncology.
2. All patients enrolled into the PhilHealth Z-benefit package must be duly endorsed and signed by all the designated consultants from surgery, medical oncology and radiation oncology.
3. All patients enrolled into the PhilHealth Z-benefit package must have a multidisciplinary meeting where treatments plans are discussed and decided upon by the multidisciplinary team, before any treatment is started. This meeting, as well as the treatment plans must be duly documented, noted and signed by all the designated consultants from surgery, medical oncology and radiation oncology.
4. 95% of Stage II and III Rectal Cancer patients enrolled in the Z-package must have pre-operative neoadjuvant radiotherapy (with or without chemotherapy), as duly decided upon in the multidisciplinary meeting.
5. The hospital must monitor and report patient compliance with all aspects of the multidisciplinary treatment, noting reasons for non-compliance. Programs to improve compliance (e.g. patient navigation systems) must be developed, implemented, and documented.

C. Outcomes to be reported

1. At least 90% compliance with treatment plans
2. At least 95% pre-op radiotherapy for Stage II and III rectal cancer
3. At least 75% of colon cancers must have pre-treatment multidisciplinary meeting
4. At least 90% of rectal cancers must have pre-treatment multidisciplinary meeting
5. 2, 3 and 5 year survival rates (hopefully aim for at least 60% cure rates)
6. Recurrence rates
7. Mortality and morbidity rates from treatment
8. Quality of life measures

9. At least 95% follow up rate
10. 100% documentation of multidisciplinary meeting, treatment plans, compliance, treatment and follow up
11. Quality of TME for rectal cancer (>60% with complete or partially complete circumferential resection margins on pathology reports)
12. Quality of pathology reports (at least 12 nodes and status of circumferential resection margins reported).

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Pathway for the Z Benefits for Colorectal Cancer

Referred to/ Visits Cancer Clinic for cancer diagnosis verification

↓

A change in bowel habit, whether constipation or diarrhea, direct suspicion of colorectal cancer

COLON: A tumor in the ascending colon may present with microcytic anemia, occult blood in the stool, or a palpable mass in the right lower quadrant. A tumor in the descending colon presents with hematochezia, obstructive symptoms and small caliber stools.
RECTUM: Lesions in the rectum present with local bleeding, pain, change in bowel habits and stool caliber, and then tenesmus.

↓

COLON: Colonoscopy is a very accurate diagnostic tool for detecting and defining primary colon lesions; once a colon mass is seen, biopsy can be done via colonoscopy.

RECTUM: Most cancers can be detected by simple digital exam (65-80%). Once discovered, proctosigmoidoscopy with biopsy follows

↓

Biopsy (+) Referred to/ Visits Cancer Clinic for pre-treatment evaluation
Chest x-ray, ultrasound abdomen negative for metastasis

↓

Z Package Considers ONLY:
Colon Stage M0, N0-N1, any T (0-IIIB)
Rectum Stage M0, N0-N2, any T (I-III)

↓

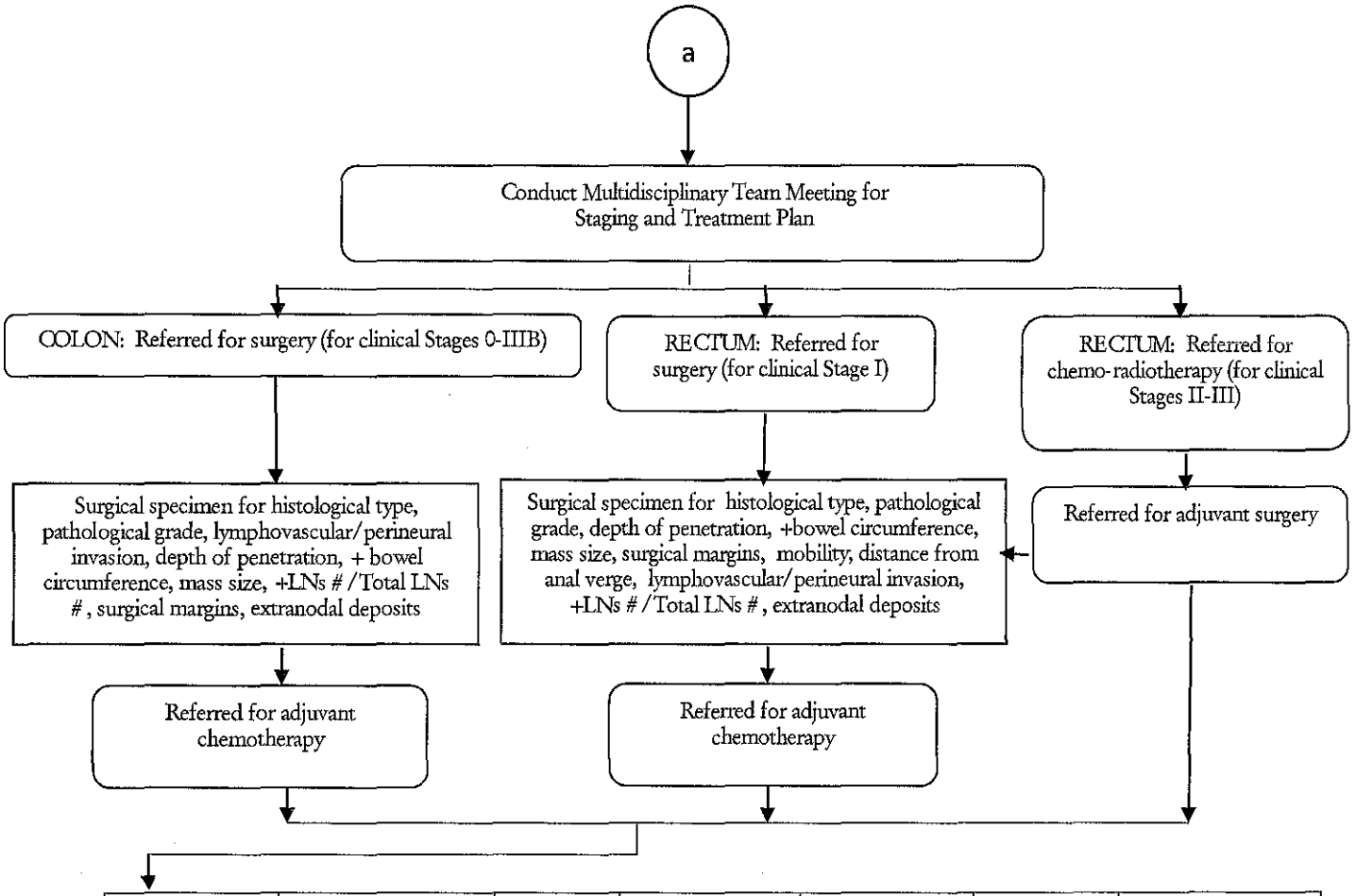
COLON: CT scan of whole abdomen (preferably with contrast), CEA, FBS, SGPT, AP, CBC, Blood typing, Albumin, Creatinine, CXR (PA-L), ECG as baseline. CP clearance, prothrombin time, and other services mentioned in the Z package as needed
RECTUM: CTscan of whole abdomen and pelvis (with contrast, preferably triple contrast), Pelvic MRI, CEA, FBS, SGPT, AP, CBC, Blood typing, Albumin, Creatinine, CXR (PA-L), ECG, Endorectal ultrasound as baseline. CP clearance, Prothrombin time, and other services mentioned in the Z package as needed

↓

Conduct Multidisciplinary Team Meeting for
Staging and Treatment Plan

↓

a



Disease Stage	Surgery (Done by Colo-Rectal Surgeons)	Risk Category	Drug Therapy Regimen (Done by Medical Oncologists)	Radiotherapy (Done by Radio-Oncologists)	Support Drugs	Diagnostics/ Treatment Response Monitoring
COLON						
A. Polyp with invasive cancer Tisi-T1, N0, M0	Polypectomy	High Risk **(NOTE 1)**	No chemotherapy	No radiotherapy	Antibiotics, antiemetics, pain relievers, filgrastim, blood support (with x-matching, typing, processing)	PE, Symptomatology, weight, CEA, CXR PAL, UTS abdomen (CT scan if high suspicion), SGPT, Creatinine Colonoscopy after 1 year then as indicated
T3N0M0	Colectomy with enbloc removal of regional LN **(NOTE 2)**	<12 LNs removed; positive surgical margins	Cape1250 OR FU500/ FA200 **(NOTE 3)**	No radiotherapy		

Disease Stage	Surgery (Done by Colo-Rectal Surgeons)	Risk Category	Drug Therapy Regimen (Done by Medical Oncologists)	Radiotherapy (Done by Radio-Oncologists)	Support Drugs	Diagnostics/ Treatment Response Monitoring
B. Cancer appropriate for resection						
Resectable, non-obstructing (T1-3 N1 M0)	Colectomy with enbloc removal of regional LN	LVI negative or Low grade	For low risk: Cape2000 OR FU500/FA500	No radiotherapy	Antibiotics, anti-emetics, pain relievers, filgrastim, blood support (with x-matching, typing, processing)	PE, Symptomatology, weight, CEA, CXR PAL, UTS abdomen (CT scan if high suspicion), SGPT, Creatinine Colonoscopy after 1 year then as indicated
Resectable, non-obstructing (T1-3 N1 M0)	Colectomy with enbloc removal of regional LN	LVI positive or High grade	For intermediate to high risk: CapeOX Or FOLFOX 4	No radiotherapy		
Resectable, obstructing (T4, N0-1, M0)	One-stage colectomy with en-bloc removal of regional LN Or Resection with diversion Or Stent, followed by colectomy with en bloc removal of regional LN Or Diversion followed by colectomy with en bloc removal of regional LN	High risk	CapeOX Or FOLFOX 4	No radiotherapy		
C. Medically inoperable (T1 N0 M0/ Significant medical co-morbidities)	No definitive surgery		Cape2000 OR FU500/FA 500	No radiotherapy	Antibiotics, anti-emetics, pain relievers, filgrastim, blood support (with x-matching, typing, processing)	PE, Symptomatology, weight, CEA, CXR PAL, UTS abdomen (CT scan for high suspicion), SGPT, Creatinine Colonoscopy after 1 year then as indicated
Medically inoperable (T2-4 N0-1 M0)	Diversion as needed		CapeOX Or FOLFOX 4	No radiotherapy		

Disease Stage	Surgery (Done by Colo-Rectal Surgeons)	Risk Category	Drug Therapy Regimen (Done by Medical Oncologists)	Radiotherapy (Done by Radio-Oncologists)	Support Drugs	Diagnostics/ Treatment Response Monitoring
RECTUM						
Appropriate for resection						
T1-2 N0	Transabdominal resection Or Transanal excision if appropriate	Low Risk: pT1-2 N0M0	No chemotherapy	No radiotherapy	Antibiotics, anti-emetics, pain relievers, filgrastim, blood support (with x-matching, typing, processing)	PE, Symptomatology, weight, CEA, CXR PAL, UTS abdomen (MRI in high suspicion), SGPT, Colonoscopy after 1 year then as indicated **(NOTE 7)**
		High Risk: pT3N0M0/ pT1-3N1-2	Adjuvant Chemotherapy: Cape2000 Or CapeOX Or FU500/FA500 Or FOLFOX4 Followed by Concurrent Chemo-Radiotherapy: Cape825RT Or FU400/ FA20RT	Concurrent Chemotherapy RT **(NOTE 4)**		
T3N0 or anyT, N1-2	Trans abdominal resection	High Risk	Cape825 RT Or FU400/ FA20RT FOLLOWED BY: Cape2000 Or CapeOX Or FU500/FA500 Or FOLFOX4	Pre-operative Cape825 RT Or FU400/ FA20RT **(NOTES 5 & 6)**		
A. Unresectable, T4M0	Pre-op ChemoRT, then resect if possible	High Risk	Cape825RT Or FU400/ FA20RT FOLLOWED BY: Cape2000 Or CapeOX Or FU500/FA500 Or FOLFOX4	Pre-operative Cape825RT Or FU400/ FA20RT		

Disease Stage	Surgery (Done by Colo-Rectal Surgeons)	Risk Category	Drug Therapy Regimen (Done by Medical Oncologists)	Radiotherapy (Done by Radio-Oncologists)	Support Drugs	Diagnostics/ Treatment Response Monitoring
B. Medically in-operable (T1 N0 M0/ Significant medical co-morbidities)	No definitive surgery	Low Risk	Cape825 RT Or FU400/ FA 20RT	Cape825RT Or FU 400/FA 20RT		
Medically in-operable (T2-4 N0-1 M0)	Diversion as needed	High Risk	Cape825RT Or FU400/ FA20RT FOLLOWED BY: Cape2000 Or CapeOX Or FU500/FA500 Or FOLFOX4	Cape825RT Or FU400/ FA20RT		

Note 1: **Prognostic factors**

- High Risk (Genetics): First-degree relatives of patients with diagnosed adenomas or invasive carcinoma are at increased risk for colorectal cancer. Colon cancer patients, especially those 50 years or younger and those with suspected hereditary non-**polyposis** colon cancer (HNPCC), familial adenomatous polyposis (FAP) and attenuated FAP should be counselled regarding family history
- **Colon** cancer patients who are high risk for systemic recurrence after colon resection are those with histological grade 3-4, lymphatic/vascular invasion, and/or bowel obstruction.
- Probability for **rectum** cancer to recur is relatively low if: 1) <30 % circumference of bowel, 2) <3 cm in size, 3) margin clear (3 >mm), 4) mobile, non-fixed, 5) within 8 cm of anal verge, 6) T1 or T2, 7) fragmented polyp, 8) no lymphovascular or perineural invasion, 9) well to moderately differentiated, and or 10) no evidence of lymphadenopathy on pretreatment imaging.

Note 2: **Surgery**

Colectomy:

- LNs at the origin of feeding vessels should be identified for pathologic exam
- Clinically +LNs outside the field of resection that are considered suspicious should be biopsied or removed, if possible
- Positive LNS left behind indicate an incomplete (R2) resection
- A minimum of 12 LNs need to be examined to establish N stage
- Resection needs to be complete to be considered curative (R0)

Conversion to resectable disease:

- Re-evaluate for resection one (1) month after pre-op chemotherapy/ chemoradiotherapy
- When considering whether disease has been converted to resectable, all original sites should be amenable to resection
- Pre-operative chemotherapy regimens with high response rates should be considered for patients for potentially convertible disease.

Optimal time between surgery and pre-operative chemo-radiotherapy:

- There may be benefits in prolonging the interval between chemoradiotherapy and surgery beyond the 6 to 8 weeks that is commonly practiced (Foster JD et al. Dis Colon Rectum, 2013).
- Delaying surgery until the 15th or 16th week after the start of CRT (10-11 weeks from the end of CRT) seemed to result in the highest chance of a pCR (Sloothaak DA et al. Br J Surg, 2013).

Colostomy reversal:

- The reversal operation (2nd surgery) is usually done for early stage cancers when the patient is in good health without evidence of cancer disease and fully recovered from the effects of the colostomy formation operation, as well as chemotherapy. This will usually be at least 12 weeks or more after the initial surgery, or at least 6-8 weeks from last chemotherapy/ chemo-radiotherapy cycle.
- There's no time limit for having the stoma reversed and some people may live with their colostomy for several years before it is reversed.
- In some cases, reversing a colostomy may not be recommended. For example, if the anal sphincter muscles were damaged after surgery.

Note 3: **Chemotherapy Regimens:**

- **Cape1250:** Capecitabine 1250 mg/m^2 2x day from Day 1 to Day 14 every 3 weeks x 8 cycles
- **Cape2000:** Capecitabine 2000 mg/m^2 2x day from Day 1 to Day 14 every 3 weeks x 6 cycles
- **CapeOX:** Oxaliplatin 130 mg/m^2 on Day 1 plus capecitabine 850 mg/m^2 2x day from Day 1 to Day 14 every 3 weeks x 6 cycles
- **FU500/FA200:** Fluorouracil 500 mg/m^2 once a week x 6 weeks plus Folinic acid 200 mg/m^2 once a week x 6 weeks cycle to be repeated every 8 weeks for 4 cycles
- **FU500/FA500:** Folinic acid 500 mg/m^2 IV plus Flourouracil 500 mg/m^2 on Days 1, 8, 15, 22, 29, 36 every 8 weeks for 6 cycles

- **FOLFOX 4**: Oxaliplatin 85 mg/m^2 on Day 1 plus Folinic acid 200mg/m^2 on Day 1 and Day 2 plus Fluorouracil 400 mg/m^2 IV bolus followed by 600 mg/m^2 IV infusion on Day 1 and Day 2 every 2 weeks cycle for 6 cycles

Note 4: **Surgery →Adjuvant Chemotherapy → Chemo-RT Regimens**

- Adjuvant FU500/FA500 or FOLFOX4
  - FOLLOWED BY - FU440/FA20RT: FU 400 mg/m^2 plus FA 20 mg/m^2 for 4 days during Weeks 1 and 5 of radiotherapy
- Adjuvant Cape2000 or CapeOX
  - FOLLOWED BY - Cape825RT: Capecitabine 825 mg/m^2 2x day for 5 days of radiotherapy x 5 weeks

Note 5: **Pre-op Chemo-RT Regimens → Surgery →Adjuvant Chemotherapy:**

- **FU440/FA20RT**: FU 400 mg/m^2 plus FA 20 mg/m^2 for 4 days during Weeks 1 and 5 of radiotherapy
  - **FOLLOWED BY** - Adjuvant FU500/FA500 or FOLFOX4
- **Cape825RT**: Capecitabine 825 mg/m^2 2x day for 5 days of radiotherapy x 5 weeks
  - **FOLLOWED BY** - Adjuvant Cape2000 or CapeOX

Note 6: All patients who received pre-op chemoradiation and were down-staged must receive systemic adjuvant chemotherapy.

Note 7: Minimum surveillance work-up aside from complete physical exam (plus colostomy site), symptom & weight monitoring, are CEA, chest x-ray PA-L and UTS of whole abdomen (CTscan if highly suspect) every 4-6 months during the 1st year; colonoscopy within one year.

Annex H: Transmittal Form of Claims for the Z Benefits
Revised as of September 2022

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

TRANSMITTAL FORM OF CLAIMS FOR THE Z BENEFITS

NAME OF CONTRACTED HEALTH *FACILITY*	ADDRESS OF *HF*

Instructions for filling out this Transmittal Form. Use additional sheets if necessary.
1. Use CAPITAL letters or UPPER CASE letters in filling out the form.
2. For the period of confinement, follow the format (mm/dd/yyyy).
3. For the Z Benefit Package Code, include the code for the order of tranche payment. Example: breast cancer, second tranche should be written as "Z0022".
4. For the Case Number, copy the case number that is provided in the approved pre-authorization checklist and request.
5. The Remarks column may include some relevant notes which pertain to the filed claim that need to be relayed to PhilHealth.

MASTER COPY DC: Date: 2/7/19

Case Number	Name of Patient (Last, First, Middle Initial, Extension)	Period of Confinement		Z Benefit Package Code	Remarks
		Date admitted	Date discharged		
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

Certified correct by authorized representative of the *HF*		For PhilHealth Use Only	Initials	Date
Printed Name and Signature	Designation	Received by Local Health Insurance Office (LHIO)		
	Date signed (mm/dd/yyyy)	Received by the Benefits Administration Section (BAS)		

Annex I: Outcomes Report Form for Colon and Rectal Cancers

Revised as of December 2022

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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UNIVERSAL HEALTH CARE
KALUSUGAN AT GANHIGA PARA SA LAHAT

OUTCOMES REPORT FORM
Colon and *Rectal* Cancers

Instructions in filling out this form:
PhilHealth shall require this form for renewal of contract.
The Z Benefits Coordinator of the contracted health *facility (HF)* shall facilitate completion of this form.
The contracted *HF* submits this form to the PhilHealth Regional Office within three months prior to end of the contract.
Non-submission of this form may be grounds for non-renewal of contract by PhilHealth.
Attach additional sheets when necessary.
This form may be reproduced.

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")***	
	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

Name of patient (Last name, first name, middle name)	Pathologic stage	Date of filing of claims of initial tranche (mm/dd/yyyy)	Date of filing of claims of final tranche (mm/dd/yyyy)	Status of Patient: 0- Alive; 1- Dead; 2- Lost to follow up; 3- Local recurrence of cancer; 4- Distant recurrence of cancer				
				Year 1	Year 2	Year 3	Year 4	Year 5

Certified correct by:

(Printed name and signature)
Executive Director/Chief of Hospital/
Medical Director/ Medical Center Chief

PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐ - ☐☐

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DC: Date: 2/7/23