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PHILHEALTH CIRCULAR
No. 2024 - 0007

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

SUBJECT : **Z Benefits Package for Breast Cancer**

I. RATIONALE

Breast cancer stands as a substantial health concern in the Philippines, posing a considerable burden to individuals affected by such illness. It ranks among the most prevalent cancers affecting Filipino women, with rising incidence rates. The disease not only leads to substantial mortality but also imposes a financial burden on affected individuals and families due to expensive treatments and prolonged healthcare needs.

In 2012, PhilHealth introduced the Z Benefits, one of which was a specific benefit package for breast cancer. PhilHealth's coverage of breast cancer aims to alleviate this burden by providing financial risk protection through a comprehensive benefit package. The primary objective is to reduce the financial barrier faced by patients and promote timely intervention, ultimately improving outcomes and quality of life for affected individuals and their families.

Thus, PhilHealth Board Resolution (PBR) No. 2883 series of 2024[1] approved the enhancement of the Z Benefits Package for Breast Cancer, which expands the coverage of service and treatment to address the health needs of the patients dealing with breast cancer.

II. OBJECTIVES

This PhilHealth Circular aims to define the policies and procedures for implementing the Z Benefits Package for Breast Cancer.

III. SCOPE

This PhilHealth Circular shall apply to all contracted health facilities (HFs) that deliver the minimum standard of care for breast cancer and all others involved in its implementation.

[1] PhilHealth Board Resolution (PBR) No. 2883 series of 2024: The enhancement of coverage of the Z Benefits Package for Breast Cancer

IV. DEFINITION OF TERMS

A. **Basic or Ward Accommodation**[2] – refers to the provision of regular meals, bed in shared room, fan ventilation, and shared toilet and bath.

B. **Case-based Provider Payment Mechanism** – refers to a provider payment system in which a hospital is reimbursed at a predetermined rate for each of the treatment phases or services rendered during the medical treatment given to an individual.

C. **Contracted Health Facility (HF)** – refers to a PhilHealth-accredited health facility that enters into a contract with PhilHealth for the provision of specialized care for the Z Benefits.

D. **Co-payment** – refers to a flat fee or predetermined rate paid at a point of service, as may be determined by PhilHealth. This amount will be charged to patients as their share for amenities or any additional or upgrade of services beyond the coverage of the benefits package. Co-payments shall have a fixed limit or cap but not exceeding the corresponding rate of the Z Benefits package. These co-payment rates shall be subject to negotiation by PhilHealth to determine the applicable rates and ensure financial risk protection of the members/dependents.

E. **Cost-sharing** – refers to the direct payment of a portion of health care cost by the members/dependents when receiving health services. This term generally includes deductibles, coinsurance, and co-payments, or similar charges.

F. **Electronic Medical Record (EMR) or Electronic Health Record (EHR)** – refers to 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.

G. **Fee Schedule** – refers to a predetermined list of fees or charges that outlines the prices or reimbursements for various medical procedures, services, or treatments. This list of items with equivalent rate is used to reimburse healthcare providers on a fee-for-service with a cap or a case-based payment mechanism.

H. **Fluorescence in Situ Hybridization**[3]– refers to a confirmatory test for HER2 that is done on breast cancer tissue removed during biopsy to check the DNA of the cancer cells for extra copies of the Her2/neu genes. Patients may avail of the FISH (fluorescence in situ hybridization) and the immunohistochemistry (IHC) HER2/neu test under the Breast Cancer Z Benefit diagnostic tests and prognostication package. If the IHC test or the FISH test is positive, then the patient can be given drugs that target the HER2/neu protein (e.g., trastuzumab), stopping the cancer cell from growing.

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[2] DOH AO No. 2021-0015: Standards on Basic and Non-basic Accommodation in All Hospitals
[3] https://www.cancer.gov/publications/dictionaries/cancer-terms/def/fluorescence-in-situ-hybridization

I. **Human Epidermal Growth Factor Receptor 2 (HER2/neu) Immunohistochemistry (IHC) Test**[4] – refers to a component of the breast panel under the diagnostic test and prognostication package of the Z Benefits that measures the amount of human epidermal growth factor receptor 2 (HER2) protein on cancer cells. Patients with HER2-positive breast cancer are candidates for chemotherapy and targeted therapy.

J. **Lost to Follow-up** – refers to a term used to characterize a breast cancer patient who has not returned to or followed up at a contracted health facility after sixty (60) calendar days from the scheduled visit or treatment, as advised.

K. **Member Empowerment (ME) Form** – refers to a document showing that the patient is fully informed of their Z Benefits 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.

L. **Minimum Standards of Care** – refer to the essential services that the contracted HFs are obliged to provide based on clinical practices guidelines or current best practices in the local setting.

M. **Multidisciplinary-Interdisciplinary Team (MDT) Approach** – refers to 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.

N. **Multidisciplinary Patient Care**[5] – refers to an integrated approach to cancer care in which medical and allied health care professionals consider all relevant treatment options and develop collaboratively an individual treatment plan for each patient.

O. **Pre-authorization** – refers to 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.

P. **Shadow Billing for Diagnosis-Related Group (DRG)**[6] – refers to the process whereby PhilHealth will provide sufficient time to allow accredited HF to adjust to the new rules in claims submission in preparation for the transition to a DRG system while following the All Case Rates (ACR) payment method to minimize disruptions in claims processing.

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[4] https://www.cancer.gov/publications/dictionaries/cancer-terms/def/her2-neu-test
[5] Republic Act No. 11215: National Integrated Cancer Control Act
[6] PhilHealth Circular 2023-0014: Implementation of Shadow Billing for the Transition to Diagnosis-Related Groups (DRG)

Q. Surveillance[7] – refers to an ongoing assessment of an early signs of relapse or evaluation of an individual who appears to be clinically stable, treated or not progressing. In public health, surveillance may also refer to the ongoing systematic collection and analysis of information about the incidence, prevalence, morbidity, survival, and mortality related to a disease or health-related event in a certain group of people.

V. POLICY STATEMENTS

A. Benefits Availment

1. The members/dependents shall undergo consultation and clinical breast examination for any abnormalities, lumps, and other relevant signs and symptoms by the attending physician. The contracted HF shall defer receiving any payments from individuals who are eligible to avail of the diagnostic tests based on all of the following criteria:

    a. Positive (+) breast mass AND/OR palpable axillary lymph node;
    b. BI-RADS category 4 to 5 result of either mammogram or ultrasound; and
    c. Biopsy result of confirmed malignant breast cancer or ductal carcinoma in situ (DCIS).

    The Checklist of Eligibility Criteria for Diagnostic Tests - Breast Cancer is specified in Annex A.1.

2. The diagnostic tests of patients conducted at the contracted HF shall adhere to the eligibility criteria outlined in Section V.A.1 to qualify for the benefits coverage of PhilHealth.

3. The applicable benefits package under the All Case Rates (ACR) shall cover the procedure of biopsy with histopathology. If the result confirms a malignant tumor, the contracted HF may proceed to provide prognostication services to the patient.

4. The Multidisciplinary-Interdisciplinary Team (MDT) of the contracted HF shall assess and evaluate patients diagnosed with breast cancer to determine the appropriate treatment protocol before seeking pre-authorization approval from PhilHealth.

5. The following are the selection criteria for pre-authorization:

    a. Breast cancer clinical stage requiring treatments that are covered under the Z Benefits:

        a.1. Stage 0 Ductal Carcinoma in Situ (DCIS)
        a.2. Stage I
        a.3. Stage II

[7] https://www.cancer.gov/publications/dictionaries/genetics-dictionary/def/surveillance; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6366832/#R1

a.4. Stage III
a.5. Stage IV

b. Breast cancer management involving any or all of the following phases:

b.1. Surgery
b.2. Chemotherapy (neo/adjuvant): patient has not initiated any chemotherapy treatment from any HF
b.3. Targeted therapy
b.4. Hormonotherapy
b.5. Surveillance

6. Pre-authorization from PhilHealth is necessary before providing services such as surgery, systemic therapy (cytotoxic chemotherapy, hormonotherapy, and targeted therapy), and surveillance to patients with breast cancer. The Pre-authorization Checklist and Request Form (Annex A.2) outline the clinical criteria for benefits availment.

7. While the submission of the Pre-authorization Checklist and Request Form is not yet fully automated, the designated liaison of the contracted HF shall submit the complete and properly accomplished original copy of the Pre-authorization Checklist and Request Form, a photocopy of the properly accomplished Member Empowerment Form or ME Form (Annex B), and photocopy of the MDT plan to the Local Health Insurance Office (LHIO) or the office of the Head of the PhilHealth Benefits Administration Section (BAS) with jurisdiction over the contracted HFs. These documents may also be scanned and emailed to the respective PROs for approval.

8. The selection criteria shall serve as the bases for PhilHealth's approval of the pre-authorization request submitted by the contracted HF. Once pre-authorization is approved, the patient shall be entitled to the necessary care and services within the coverage of the benefit package as prescribed by the MDT in the treatment plan.

9. PhilHealth members and their qualified dependents must be eligible to avail of PhilHealth benefits at the time of pre-authorization approval. All contracted HFs should remind these patients to update their membership profiles and premium contributions as part of their obligations.

10. The PhilHealth Benefit Eligibility Form (PBEF) shall be the primary proof of benefit eligibility. A "Yes" response shall mean that the member is entitled to avail of the Z benefits. As such, the contracted HFs shall no longer require proof of contribution for claims availment. While a "No" response would require the patient to register or apply for a PhilHealth Identification Number (PIN) prior to pre-authorization.

11. The approved Pre-authorization Checklist and Request Form shall be valid for sixty (60) calendar days from the date of approval by PhilHealth if there are no treatments initiated for chemotherapy (if neoadjuvant treatment) or surgery (if adjuvant treatment). All contracted HFs shall monitor the

validity of their approved pre-authorization and promptly notify PhilHealth upon the lapse of its validity.

12. In case of expiration of pre-authorization, the contracted HFs shall submit a new pre-authorization checklist and request. It will include reassessing the patient's clinical cancer staging as necessary.

13. In case of fortuitous events or natural calamities, PhilHealth shall accord an extension of ninety (90) days for surgery and fourteen (14) days for chemotherapy reckoned from the date of approval of the pre-authorization.

14. 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 breast cancer. The ME Form aims to support patients as active participants in healthcare decision-making by being educated and informed of the conditions and management options. Further, the ME Form encourages the attending healthcare professionals in the contracted HFs to dedicate adequate time to discuss with patients to achieve better health outcomes and patient satisfaction.

15. The contracted HF shall thoroughly discuss the cost-sharing aspect with the patient during the administration of the ME form. Moreover, the contracted HF shall inform the patient of any additional charges for amenities or upgrade of services not covered by the Z Benefits package

16. The patient may be charged applicable cost-sharing based on the corresponding service, treatment, cycle, or procedures. Such cost-sharing shall be payable at the point of service in a specific treatment, session, cycle, or service.

17. No co-payment shall be charged for services rendered on patients admitted in basic or ward accommodation. However, if they would opt for amenities, such as an upgrade of room accommodation or additional services not covered by PhilHealth, contracted HFs may charge co-payment that shall not exceed the rates prescribed in the contract for a specific service. The ME Form serves as the document of the agreement on co-payment between the patient and the contracted HF.

18. Patients enrolled for surgery, systemic therapy, or surveillance shall have a maximum deduction of five (5) days from the forty-five (45) day annual benefit limit, regardless of the patient's treatment phase. Such deductions are applicable only in the current year when the pre-authorization is approved.

19. If the remaining annual benefit is at least one (1) day at the time of pre-authorization application, the member shall remain eligible to avail of the Z Benefits. No further deductions shall be made on the 45-day annual benefit limit while enrolled under the Z benefits.

20. No deductions shall apply to the forty-five (45) day annual benefit limit for members/dependents eligible to undergo diagnostic tests or prognostication.

21. Patients currently undergoing treatment for breast cancer may qualify for enrollment in the Z Benefits package. The contracted HF may enroll the patient at any of the treatment phases by submitting a pre-authorization request in accordance with the following rules:

    a. Members/dependents with ongoing treatment for targeted therapy and hormonotherapy can continue these specific treatments under the coverage provided by the Z Benefits for the remaining sessions or duration of their treatment.

    b. Patients diagnosed with contralateral (opposite-side) breast cancer are eligible to undergo surgical procedures covered by Z Benefits six (6) months after their initial surgery.

    c. Patients who have completed their chemotherapy cycles at a health facility.

    Patients shall fully disclose any previous or ongoing treatments from any health facilities. The contracted HF shall ensure that the patient qualifies with the selection criteria and submit the mandatory requirements for pre-authorization as prescribed in this policy, including the MDT plan detailing the continuation of the treatment phases.

22. The Z Benefits shall not cover ongoing chemotherapy sessions for patients in the non-contracted HF. These patients shall complete the required cycles or sessions of chemotherapy before enrollment in the Z Benefits.

23. Patients who have undergone surgical procedures, whether or not covered by the Z Benefits package, and subsequently require surgical procedures on the ipsilateral (same side) breast due to cancer recurrence shall be covered under the All Case Rate (ACR).

24. Patients who have undergone surgical procedure under the Z Benefits package and require surgical procedures on the contralateral breast (opposite side) within the period of six (6) months after post-surgery shall be covered under the regular benefits.

25. Patients who underwent a procedure or treatment of breast cancer may avail of the surveillance packages at the contracted HF to monitor their condition and detect any potential recurrence or progression of the disease.

26. In cases of patient transfer due to non-renewal of contract of the contracted HF, change of address, or patient's choice, among others, the contracted HF shall refer or transfer their patient(s) to another HF that is contracted for the Z Benefits for breast cancer to facilitate the continuation of their treatment. The referring contracted HF shall accomplish the

following documents for submission to the referral contracted HF and PhilHealth:

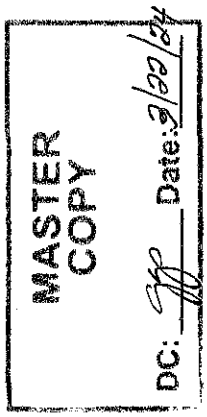
a. Properly accomplished ME Form (Annex D);
b. Breast Cancer Treatment Passport (Annex F);
c. Checklist for Patient Transfer (Annex G);
d. Letter of Intent for Transfer (Annex I);
e. Photocopy of approved Pre-authorization Checklist and Request;
f. Photocopy of MDT plan; and
g. Photocopy of Medical abstract

The referral contracted HF shall discuss any applicable co-payment for treatment or services to the patient prior to transfer to the facility for continuation of care under the Z Benefits. The contracted HF shall indicate the co-payment in the newly accomplished ME Form.

27. Patients with ongoing treatment for systemic therapy under the Z Benefits shall be permitted to transfer to another contracted HF based on the following circumstances:

Systemic Therapy	Allowed Schedule for Transfer
Cytotoxic Chemotherapy	After completion of the required cycles
Targeted Therapy	After 6th cycles (equivalent to 1 tranche)
Hormonotherapy	After 6th month prescription (equivalent to 1 tranche)

Table 1: Patient Transfer Schedule



28. Members/dependents who are not yet declared lost to follow-up and returned within sixty (60) days from the advised scheduled visit or treatment may continue the sessions, cycles, treatment, or services under the Z Benefits upon reassessment of the MDT and/or attending physicians, as applicable.

29. Patients who were already declared lost to follow-up and intend to continue the sessions, cycles, treatment, or services under the Z Benefits shall be required to undergo pre-authorization application and approval, subject to specific rules for availing the benefits.

B. Patient Management and Standards

1. The Z Benefits shall cover medical interventions for individuals diagnosed with breast cancer falling within the selection criteria, provided that the treatment aligns with the protocol of the Z Benefits Package for Breast Cancer.

2. The contracted HFs shall establish a streamlined process for assessing breast cancer patients and ensuring that patients who meet the selection criteria shall be entitled to access the benefits package.

3. The contracted HFs shall ensure efficiency and adherence to the patient selection criteria, guaranteeing that eligible patients avail of the benefit. The selection criteria ensure access to comprehensive care for breast cancer, supported by an evidence-based approach, to facilitate the efficient delivery of care and services.

4. The contracted HFs shall conduct an assessment and evaluation of breast cancer patients prior to enrollment in the Z Benefits. The MDT shall be composed of a medical oncologist, radio-oncologist, surgeon, pathologist, and radiology consultant. Their combined expertise ensures a comprehensive assessment and evaluation of the patient's condition and medical management.

5. The MDT approach is mandatory before initiating any treatment modality, and adherence to this approach is essential for all patient care covered under the Z Benefits. The MDT shall discuss the treatment plan of the patient prior to the pre-authorization application for the Z Benefits. The treatment plan shall be attached to the pre-authorization checklist and request form in accordance with Section V.A.6 of this policy. The whole cycle of care under Z Benefits may be availed of by the patient according to the rules prescribed per treatment phase during pre-authorization.

6. The patient's management shall proceed according to the MDT-approved treatment plan. Should there be a deviation from the MDT plan, the contracted HF shall attach a certification detailing the changes in the patient treatment plan upon submission of claims for reimbursement. The MDT shall affix their signature in the certification.

7. In case of a member/dependent who has an ongoing treatment for breast cancer, the MDT who is/are responsible for the specific treatment phases shall be required to submit an approved MDT treatment plan for the continuity of care as an attachment to pre-authorization for enrolment to the Z Benefits.

8. The patient may undergo neoadjuvant or adjuvant treatment as prescribed in the approved MDT treatment plan. For patients who are undergoing neoadjuvant chemotherapy, the medical oncologist shall fully administer the chemotherapy before any surgical intervention is initiated or performed.

9. PhilHealth shall reimburse surgical procedures involving both breasts on the same surgical operation date within the same confinement period at a fixed rate of one surgical procedure. The Z Benefits Package for breast cancer covers the management of post-operative complications associated with breast surgery that occur during the same confinement period.

10. In cases of bilateral surgical procedures occurring on different operation dates within the same confinement period due to contraindications, among others, shall be reimbursed at a fixed rate of one surgical procedure. The contracted HF may charge co-payment, except for patients admitted in basic or ward accommodation.

11. Any medical complications resulting in hospital confinements occurring after patient discharge that are secondary to other conditions or comorbidities shall be under the coverage of the applicable benefits of PhilHealth.

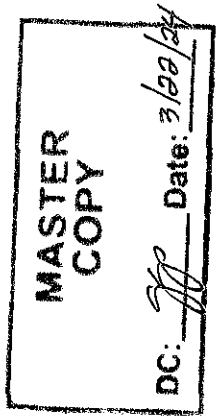
12. The medical oncologist shall be responsible for the drug management of the systemic therapy (hormonotherapy, targeted therapy, and chemotherapy), including planning, administration, and monitoring of drug therapeutic and safety effects.

13. The MDT or attending physician shall record all of the systemic therapy administered to a patient in the Breast Cancer Treatment Passport (Annex F).

14. The contracted HFs shall ensure the availability of the medicines in their pharmacy, including medical supplies, to prevent them from running out of stock.

15. The benefits package under the ACR shall cover the radiotherapy treatment of the patient.

16. All contracted HFs shall facilitate radiotherapy and biopsy services for their Z patients by coordinated referrals to other PhilHealth-accredited facilities, if applicable.



17. Contracted HFs for the Z Benefits on breast cancer are required to have a medical record of all their patients, preferably an Electronic Medical Record (EMR). For standardization, PhilHealth shall set the contents of the EMR in collaboration with experts on breast cancers and pertinent stakeholders. It should contain the quality indicators that PhilHealth shall require for monitoring, policy research, and quality improvement.

18. Once a cancer registry database is functional, PhilHealth shall develop a system capable of exchanging health information across all accredited or contracted HFs and integrate the analytical tools or information in the database for its interoperability.

19. PhilHealth shall establish quality standards and indicators in collaboration with the contracted HF, clinical experts, and other pertinent stakeholders. All contracted HFs for the Z Benefits for breast cancer 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 based on current evidence and clinical practice guidelines.

20. PhilHealth shall monitor all patients availing of the Z Benefits for breast cancer for all clinically relevant outcomes. In addition, claims of contracted HFs may be subject to post-audit by PhilHealth.

21. The contracted HFs shall document the patients' dropout, post-surgery complications, and drug adverse effects to provide the appropriate study and analysis in the context of quality healthcare. Contracted HFs should conduct the appropriate study and analysis of all their enrolled patients in the Z Benefits to enhance the quality of services.

22. Accredited public and private HFs shall participate in the shadow billing for diagnosis-related groups (DRGs) following PhilHealth Circular 2023-0014, "Implementation of Shadow Billing for the Transition to Diagnosis-Related Groups (DRG)" and its succeeding revisions, as applicable.

C. Z Benefits Coordinator for Breast Cancer

The contracted HFs shall be required to designate at least one (1) Z Benefits Coordinator for the Z Benefits for breast cancer, 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 (i.e., demographics, etc.) of all patients diagnosed with breast cancer, 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 (Annex A) 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 breast cancer, and other stakeholders. Contracted HFs shall train their respective Z Benefits coordinator/s.

   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.

D. Contracting of Health Facilities

1. PhilHealth shall contract capable accredited health facilities to render the services of Z Benefits for Breast Cancer. The contracted HFs are mandated to be capable of delivering all of the mandatory and other services as the minimum standards of care for all breast cancer patients enrolled under the Z Benefits.

2. The contract shall contain the additional terms and conditions between PhilHealth and the health facility that will provide the services under the Z Benefits package for Breast Cancer.

3. The accredited HF shall exclude targeted therapy from the co-payment proposal prior to contracting. Accredited HFs may refer to "Annex O" regarding the co-payment proposal for each of the services or treatment phases for the Z Benefits package for breast cancer, subject to negotiation and approval of PhilHealth.

4. The accredited HF shall identify the additional services, amenities, or procedures necessary for the patient's treatment not covered by the benefit package. They shall indicate the amount of the applicable co-payment in the contract based on the offered services outside the benefits package.

5. Contracted HFs with an existing contract for the Z Benefits package for breast cancer shall update their co-payment proposal as stated in Section V.D. of this policy.

E. Mandatory or the Minimum Standards of Care

1. Diagnostic Tests and Prognostication

Mandatory Services	
a. Diagnostic Test	a.1. Diagnostic Tests a.1.1. Mammography [a b f] a.1.2. Ultrasound [a c f] a.1.3. Clinical Consultation (Physical Examination and History)
b. Prognostication	b.1. Breast Panel [d g] b.1.1. Complete Blood Count with Platelet Count b.1.2. ER/PR Hormone Test b.1.3. Her2/neu Immunohistochemistry (IHC) Test b.1.4. Metabolic Panel with Liver Function Tests b.1.5. Alkaline Phosphatase

Mandatory Services	
	b.2. Fluorescent in situ hybridization (FISH) for Her2/neu amplification [e g]

Legend:

[a] Any of the following for Female less than 40 years old
[b] Required for all female 40 years old and above
[c] Ultrasound of both breast and axillary bed for male patient
[d] Biopsy with histopathology result of malignancy is required to avail the benefits under the prognostication (Breast panel); Maximum availment of one (1) before pre-authorization
[e] Required when the Immunohistochemistry (IHC) result is 2+, the HER2 status of the tumor is not clear and is called "equivocal", maximum of one (1) availment prior enrolment for pre-authorization
[f] Maximum of one (1) availment if the patient qualifies for the eligibility criteria before pre-authorization
[g] Not applicable for Stage 0 DCIS

Table 2: Diagnostic Tests and Prognostication

2. Surgical Procedures

Descriptions	Mandatory Services (Minimum Standards of Care)	Other Services
a. Surgery	a.1. Partial mastectomy or lumpectomy a.2. Subcutaneous/Simple/Total mastectomy a.3. Modified Radical Mastectomy a.4. Total Mastectomy with sentinel lymph node biopsy a.5. Partial mastectomy or lumpectomy with sentinel lymph node biopsy a.6. Partial mastectomy or lumpectomy with axillary node dissection a.7. Modified Radical Mastectomy with skin coverage for stage IIIB or above	
b. Diagnostic Tests		CBC with platelet count* Chest X-ray PA and lateral views* Ultrasound (whole abdomen)* ECG Creatinine

Descriptions	Mandatory Services (Minimum Standards of Care)	Other Services
		PT/PTT CP Clearance FBS Urinalysis* 2D echo** Electrolytes:* Sodium Potassium Chloride Calcium Phosphate
c. Medicines		Antimicrobials, as indicated Pain relievers, as indicated
d. Others		Blood support, such as cross-matching, screening, and processing, as needed
Legend: * Not required for Clinical Stage 0 DCIS ** Not required for HER2 negative breast cancer		

Table 3: Surgery Procedures

3. Systemic Therapy: Breast Cancer Treatment Protocols (Annex L)

Treatment Phase	Mandatory Services (Minimum Standards of Care)	Other Services
a. Hormonotherapy	a.1. Tamoxifen [a] (Premenopausal/ postmenopausal)	
	a.2. Anastrozole / Letrozole (Aromatase Inhibitor) (Postmenopausal)	
b. Cytotoxic Chemotherapy [b d]	b.1.1. Doxorubicin / Epirubicin (A) b.1.2. Cyclophosphamide (C) b.1.3. Docetaxel (T) b.1.4. Granulocyte colony-stimulating factor (G-CSF)	Antiemetic, as needed Antimicrobials, as indicated Pain relievers, as indicated

Treatment Phase	Mandatory Services (Minimum Standards of Care)	Other Services
	b.2.1. Doxorubicin / Epirubicin (A) b.2.2. Cyclophosphamide (C) b.2.3. Paclitaxel (Pacli)	Other medicines, as indicated
	b.3.1. Docetaxel (T) b.3.2. Carboplatin AUC (Cb) b.3.3. Granulocyte colony-stimulating factor (G-CSF)	
c. Targeted Therapy	c.1. Trastuzumab (H) [c e] c.2. 2D echo every 4th cycle	Granulocyte colony-stimulating factor (G-CSF) Antiemetic, as needed Antimicrobials, as indicated Pain relievers, as indicated Other medicines, as indicated

Legend:

[a] Tamoxifen is given to premenopausal and postmenopausal women, particularly ER+/PR+/HER2neu- patients. For postmenopausal ER+/PR+/HER2neu+ patients, an aromatase inhibitor is preferred

[b] Not required for Stage 0 DCIS

[c] For Her2-positive breast cancer

[d] Maximum of two (2) chemotherapy protocol during pre-authorization if the initial chemotherapy regimen cannot be tolerated by the patient

[e] Each tranche has a maximum of 6 cycles. Maximum of 3 tranches of targeted therapy once in a lifetime

Table 4: Systemic Therapy Protocol

4. Surveillance

Services	Descriptions
a. Basic Services	a.1. Clinical Consultation [a] a.2. Chest X-ray [b] a.3. Mammography of the contralateral breast (if mastectomy) [c] a.4. Mammography (bilateral, if lumpectomy) [c] a.5. Ultrasound (whole abdomen [d], or breast [e])

Services	Descriptions
	a.6. Gynecological Evaluation and Transvaginal Ultrasound [f]
b. Specific Services	b.1. 2D Echo [g] b.2. Bone Densitometry [h] b.3. Bone Scan [i]

Legend:

[a] Clinical consultation after completion of treatment, every 3-4 months for 1st 3 years particularly for high risk patients (Stage IIB-IIIC) then once every year if asymptomatic; every month if Stage IV.
[b] Chest X-ray once a year, as needed
[c] Can be availed of by patient at post-surgery, maximum of one (1) availment per year, as needed
[d] Ultrasound of whole abdomen, once a year, if needed
[e] Ultrasound of breast, once a year, if needed
[f] Gynecological exam and transvaginal ultrasound, once a year if with ongoing treatment of hormonotherapy
[g] 2D echo, once a year, after completion of treatment cycle of doxorubicin or trastuzumab, as per cardiology advice
[h] Bone densitometry, once a year if with ongoing treatment of aromatase inhibitor
[i] Bone scan, once a year if symptomatic, as needed

Table 5: Surveillance Services

F. Package Codes and Rates

1. Diagnostic Tests and Prognostication

Package Codes	Mandatory Services	Package Rates (PHP)
Z021A1	Diagnostic Tests Mammography, Ultrasound, and Clinical Consultation (Physical Examination and History)	3,500
Z021A2	Diagnostic Tests Mammography Clinical Consultation (Physical Examination and History)	2,500
Z021A3	Diagnostic Tests Ultrasound Clinical Consultation (Physical Examination and History)	1,000

Package Codes	Mandatory Services	Package Rates (PHP)
Z021B	Breast Panel Complete Blood Count with Platelet Count ER/PR Hormone Test Her2/neu Immunohistochemistry (IHC) Test Metabolic Panel with Liver Function Tests Alkaline Phosphatase	10,000
Z021C	Fluorescent in Situ Hybridization (FISH) for Her2/neu amplification	1,400

Table 6: Diagnostic Tests and Prognostication Package Rates and Codes

2. Surgical Procedures

Package Codes		Descriptions	Package Rates (PHP)
Neoadjuvant	Adjuvant		
Z021D1	Z021D2	Partial mastectomy or lumpectomy	30,000
Z021E1	Z021E2	Subcutaneous/ Simple/ Total mastectomy	100,000
Z021F1	Z021F2	Modified Radical Mastectomy	
Z021G1	Z021G2	Partial mastectomy or Lumpectomy with sentinel lymph node biopsy	
Z021H1	Z021H2	Partial mastectomy or Lumpectomy with axillary node dissection	
Z021I1	Z021I2	Total Mastectomy with sentinel lymph node biopsy	
Z021J1	Z021J2	Modified Radical Mastectomy with skin coverage for clinical stage IIIB or above	140,000

Table 7: Surgical Procedures Package Rates and Codes

3. Hormonotherapy

Package Codes	Descriptions	Tranche No.	Package Rate per Tranche (PHP)	Amount per Prescription (PHP)
Z021K1	Tamoxifen (for premenopausal / postmenopausal	1	2,700	450 per Monthly Prescription
Z021K2		2	2,700	
Z021L1	Anastrozole / Letrozole (postmenopausal)	1	18,000	3,000 per Monthly Prescription
Z021L2		2	18,000	

Table 8: Hormonotherapy Package Rates and Codes

4. Cytotoxic Chemotherapy

Package Codes		Descriptions	Number of Cycles	Package Rate (PHP)	Amount per Cycle (PHP)
Neo-adjuvant	Adjuvant				
Z021M11	Z021M21	Doxorubicin/ Epirubicin (A) + Cyclophosphamide (C) + Docetaxel (T)	AC x 4 cycles	55,000	13,750
Z021M12	Z021M22		T x 4 cycles	67,000	16,750
Z021N11	Z021N21	Doxorubicin/ Epirubicin (A) + Cyclophosphamide (C) + Paclitaxel (Pacli)	AC x 4 cycles	43,920	10,980
Z021N12	Z021N22		Pacli x 12 cycles	154,080	12,840
Z021O1	Z021O2	Docetaxel (T) + Carboplatin (Cb)	T + Cb x 6 cycles	185,010	30,835

Table 9: Cytotoxic Chemotherapy Protocol, Package Rates and Codes

5. Targeted Therapy

Package Codes	Descriptions	Package Rate (PHP)	Package Rate per Cycle (PHP)
Z021P1	Trastuzumab (H), Tranche 1	1,000,008 (333,336 per Tranche, (one tranche is equivalent to 6 cycles) (maximum of 18 cycles)	55,556
Z021P2	Trastuzumab (H), Tranche 2		
Z021P3	Trastuzumab (H), Tranche 3		

Table 10. Targeted Therapy Package Rates and Codes

6. Surveillance

Package Codes	Descriptions	Package Rate (PHP)
Basic Services		
Z021Q1	Mammography (contralateral if mastectomy or bilateral, if lumpectomy) and Clinical Consultation	2,500
Z021Q2	Ultrasound (Breast) and Clinical Consultation or Ultrasound (Whole Abdomen) and Clinical Consultation	1,100
Z021Q3	Gynecological Evaluation and Transvaginal Ultrasound	1,100
Z021Q4	Chest X-ray	300
Specific Services		
Z021R	2D Echo	2,500
Z021S	Bone Densitometry	2,500
Z021T	Bone Scan	4,000

Table 11. Surveillance Package Rates and Codes

G. Filing Schedule

The filing schedule for claims submission are as follows:

Package Codes	Descriptions	Amount (PHP)	Filing Schedule
A. Diagnostic Tests and Prognostication			
Z021A1	Diagnostic Tests	3,500	Within 60 days upon completion of the services
Z021A2	Diagnostic Tests	2,500	Within 60 days upon completion of the services
Z021A3	Diagnostic Tests	1,000	Within 60 days upon completion of the services
Z021B	Breast Panel	10,000	Within 60 days upon completion of the services
Z021C	Fluorescent in Situ Hybridization (FISH)	1,400	Within 60 days upon completion of the service
B. Surgery Procedures			
Z021D1 (Neo-adjuvant) / Z021D2 (Adjuvant)	Partial Mastectomy or Lumpectomy	30,000	Within 60 days after discharge from surgery
Z021E1 (Neo-adjuvant) / Z021E2 (Adjuvant)	Subcutaneous/ Simple / Total Mastectomy	100,000	Within 60 days after discharge from surgery
Z021F1 (Neo-adjuvant) / Z021F2 (Adjuvant)	Modified Radical Mastectomy	100,000	Within 60 days after discharge from surgery

Package Codes	Descriptions	Amount (PHP)	Filing Schedule
Z021G1 (Neo-adjuvant) Z021G2 (Adjuvant)	Partial Mastectomy or Lumpectomy with Sentinel Lymph Node Biopsy	100,000	Within 60 days after discharge from surgery
Z021H1 (Neo-adjuvant) Z021H2 (Adjuvant)	Partial Mastectomy or Lumpectomy with Axillary Node Dissection	100,000	Within 60 days after discharge from surgery
Z021I1 (Neo-adjuvant) Z021I2 (Adjuvant)	Total Mastectomy with Sentinel Lymph Node biopsy	100,000	Within 60 days after discharge from surgery
Z021J1 (Neo-adjuvant) Z021J2 (Adjuvant)	Modified Radical Mastectomy with skin coverage for IIIB and above	140,000	Within 60 days after discharge from surgery
C. Hormonotherapy			
Package Codes	Descriptions	Amount (PHP)	Filing schedule
Z021K1	Tamoxifen; Tranche 1 (Premenopausal/ Postmenopausal)	2,700 (450 per Monthly Prescription)	Within 60 days after the 6th Month Prescription
Z021K2	Tamoxifen; Tranche 2 (Premenopausal/ Postmenopausal)	2,700 (450 per Monthly Prescription)	Within 60 days after the 12th Month Prescription

Package Codes	Descriptions	Amount (PHP)	Filing Schedule
Z021L1	Anastrozole / Letrozole Tranche 1 (Postmenopausal)	18,000 (3,000 per Monthly Prescription)	Within 60 days after the 6th Month Prescription
Z021L2	Anastrozole / Letrozole Tranche 2 (Postmenopausal)	18,000 (3,000 per Monthly Prescription)	Within 60 days after the 12th Month Prescription
D. Cytotoxic Chemotherapy			
Z021M11 (Neo-adjuvant)	Doxorubicin/ Epirubicin (A) + Cyclophosphamide (C) + Docetaxel (T)	(AC) 55,000 (13,750 rate cycle, maximum of 4 cycles)	Within 60 days upon the completion of the last cycle
Z021M21 (Adjuvant)			
Z021M12 (Neo-adjuvant)		(T) 67,000 (16,750 rate cycle, maximum of 4 cycles)	
Z021M22 (Adjuvant)			
Z021N11 (Neo-adjuvant)	Doxorubicin/ Epirubicin (A) + Cyclophosphamide (C) + Paclitaxel (Pacli)	(AC) 43,920 (10,980 rate cycle, maximum of 4 cycles)	Within 60 days upon the completion of the last cycle
Z0021N12 (Adjuvant)			
Z021N21 (Neo-adjuvant)		(Pacli) 154,080 (12,840 rate cycle, maximum of 12 cycles)	
Z021N22 (Adjuvant)			

Package Codes	Descriptions	Amount (PHP)	Filing Schedule
Z021O1 (Neo-adjuvant)	Docetaxel (T) + Carboplatin (Cb)	185,010 (30,835 rate cycle, maximum of 6 cycles)	Within 60 days upon the completion of the last cycle
Z021O2 (Adjuvant)			
E. Targeted Therapy			
Z021P1	Trastuzumab (H), Tranche 1	1,000,008 (333,336 per tranche, one tranche is equivalent to 6 cycles)	Within 60 days after the completion of 6th cycle
Z021P2	Trastuzumab (H), Tranche 2		Within 60 days after the completion of 12th cycle
Z021P3	Trastuzumab (H), Tranche 3	(55,556, rate cycle, maximum of 18 cycles)	Within 60 days after the completion of 18th cycle
F. Surveillance			
Z021Q1	Surveillance, Basic Services	2,500	Within 60 days upon completion of the services
Z021Q2	Surveillance, Basic Services	1,100	Within 60 days upon completion of the services
Z021Q3	Surveillance, Basic Services	1,100	Within 60 days upon completion of the services
Z021Q4	Surveillance, Basic Services	300	Within 60 days upon completion of the services
Z021R	Surveillance, 2D Echo	2,500	Within 60 days upon completion of the services
Z021S	Surveillance, Bone Densitometry	2,500	Within 60 days upon completion of the services
Z021T	Surveillance, Bone Scan	4,000	Within 60 days upon completion of the services

Table 12. Filing Schedule of the Z Benefits package for Breast Cancer

H. Claims Filing

1. The contracted HFs shall render all the mandatory services required for a treatment phase or service given to a patient, including other services if necessary.

2. There shall be NO direct filing of claims by the members/dependents. All Z Benefits claims shall be filed by the contracted HF.

3. The contracted HF shall be responsible for the accuracy, adherence to the guidelines, and efficient handling of all claims filed on behalf of the patients. All required documents, forms, and attachments should be properly filled out before claims filing. The contracted HFs shall submit the complete requirements for claims submission, including its attachment as required per treatment phase or service.

4. If the patient is declared lost to follow-up or death, the contracted HF shall file the claims per treatment phase or services given to the patient.

5. In cases of changes in the chemotherapy treatment protocol, the corresponding claims forms per treatment protocol shall be accomplished separately and filed simultaneously in accordance with the filing schedule in Table 12.

6. The MDT or attending PhilHealth-accredited physicians shall affix their signature to attest that all the mandatory services for a specific treatment phase were rendered to the patient in the corresponding document for reimbursement of claims.

7. Contracted HF should strictly monitor patients enrolled in the Z Benefits. The Z Benefits shall not cover any additional services availed of by patients outside the treatment protocol.

8. The contracted HFs shall properly indicate the OOP and/or co-payment of the member/patient and other funding sources in PhilHealth Claim Form 2 (CF2) Part III, "Consumption Benefits" and in the Statement of Account (SOA).

9. The contracted HFs shall follow the existing guidelines of the SOA[8] requirement for claims submission under the Z Benefits.

10. Contracted HF shall follow all relevant laws, such as, but not limited to, Republic Act (RA) No. 9994 [Expanded Senior Citizens Act of 2010], as amended and RA No. 10754 [An Act Expanding the Benefits and Privileges of Persons with Disability(PWD)], including prospective laws providing mandatory discounts, guidelines of the Bureau of Internal Revenue (BIR), and the order of charging based on Joint Administrative Order No. 2020-0001, entitled: Operational Guidelines for the Implementation of the

[8] PhilHealth Circular No. 2022-0024: Statement Of Account (SOA) Requirement For Z Benefit Claims Submission

Medical and Financial Assistance to Indigent and Financially-Incapacitated Patients, pursuant to Republic Act No. 11463 also known as "Malasakit Centers Act of 2019."

11. The contracted HFs shall follow the filing schedule set by PhilHealth under the Z Benefits for breast cancers for each treatment phase or service.

12. The contracted HF shall exhaust efforts to contact, navigate, or obtain information about the whereabouts or situation of their enrolled patients in the Z Benefits. In case of patients who are declared lost of follow-up or when the patient expires, the contracted HFs shall file claims based on the applicable scenarios:

    a. The contracted HF shall submit to PhilHealth a notarized sworn declaration that the patient is declared lost to follow-up. The contracted HF shall submit their claims within thirty (30) days from such declaration.

    b. If the patient expires during treatment, the contracted HF shall submit a photocopy of the death certificate or a notarized sworn declaration issued by the authorized government agencies as an attachment to the claims. The contracted HF shall submit their claims within thirty (30) days from the receipt of the death certificate or notarized sworn declaration issued by the authorized government agencies.

13. The contracted HF shall submit to PhilHealth the "Breast Cancer Medical Records Summary Form" (Annex M) for all deaths and lost to follow-up patients and Outcome Indicators for Breast Cancer (Annex N).

14. The contracted HFs are required to submit the following documents according to the services or treatment phases:

    a. Diagnostic Tests and Prognostication:

        a.1. Photocopy of completely accomplished Eligibility Criteria for Diagnostic Test and Prognostication – Breast Cancer (Annex A.1)
        a.2. Properly Accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)
        a.3. Photocopy of Properly Accomplished PhilHealth Claim Form 2 (CF2)
        a.4. Checklist of Mandatory and Other Services for Diagnostics and Prognostication (Annex C.1))
        a.5. Completed Z Satisfaction Questionnaire (Annex D)
        a.6. Checklist of Requirements for Reimbursement for Diagnostic Test and Prognostication (Annex E.1)
        a.7. Transmittal Form (Annex H)
        a.8. Original or Certified True Copy (CTC) of the Statement of Account (SOA) or its equivalent

b. Surgery:

b.1. Pre-authorization Checklist and Request (Annex A.2)
b.2. Properly Accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)
b.3. Photocopy of Properly Accomplished PhilHealth Claim Form 2 (CF2)
b.4. Photocopy of Member Empowerment Form (Annex B)
b.5. Checklist of Mandatory and Other Services for Surgery (Annex C.2)
b.6. Z Satisfaction Questionnaire (Annex D)
b.7. Checklist of Requirements for Reimbursement – Surgery (Annex E.2)
b.8. Transmittal Form (Annex H)
b.9. Photocopy of Multidisciplinary – Interdisciplinary Team (MDT) Plan
b.10. Original or Certified True Copy (CTC) of the Statement of Account (SOA) or its equivalent
b.11. Photocopy of Accomplished Surgical Operative Report
b.12. Photocopy of Accomplished Anesthesia Report
b.13. Photocopy of Histopathology Report

c. Chemotherapy:

c.1. Pre-authorization Checklist and Request (Annex A.2)
c.2. Properly Accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)
c.3. Photocopy of Properly Accomplished PhilHealth Claim Form 2 (CF2)
c.4. Photocopy of Member Empowerment Form (Annex B)
c.5. Checklist of Mandatory and Other Services for Chemotherapy (Annex C.3)
c.6. Z Satisfaction Questionnaire (Annex D)
c.7. Checklist of Requirements for Reimbursement – Chemotherapy (Annex E.3)
c.8. Breast Cancer Treatment Passport (Annex F)
c.9. Transmittal Form (Annex H)
c.10. Photocopy of Multidisciplinary – Interdisciplinary Team (MDT) Plan
c.11. Original or Certified True Copy (CTC) of the Statement of Account (SOA) or its equivalent

d. Hormonotherapy:

d.1. Pre-authorization Checklist and Request (Annex A.2)
d.2. Properly Accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)
d.3. Photocopy of Properly Accomplished PhilHealth Claim Form 2 (CF2)
d.4. Photocopy of Member Empowerment Form (Annex B)

d.5. Checklist of Mandatory and Other Services for Hormonotherapy (Tranche 1 Annex C.4.1); (Tranche 2 Annex C.4.2)
d.6. Z Satisfaction Questionnaire (Annex D)
d.7. Checklist of Requirements for Reimbursement – Hormonotherapy (Tranche 1 Annex E.4.1); (Tranche 2 Annex E.4.2)
d.8. Breast Cancer Treatment Passport (Annex F)
d.9. Transmittal Form (Annex H)
d.10. Photocopy of the Multidisciplinary–Interdisciplinary Team (MDT) Plan
d.11. Original or Certified True Copy (CTC) of the Statement of Account (SOA) or its equivalent

e. Targeted Therapy

e.1. Pre-authorization Checklist and Request (Annex A.2)
e.2. Properly Accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)
e.3. Photocopy of Properly Accomplished PhilHealth Claim Form 2 (CF2)
e.4. Photocopy of Member Empowerment Form (Annex B)
e.5. Checklist of Mandatory and Other Services for Targeted Therapy (Tranche 1 Annex C.5.1); (Tranche 2 Annex C.5.2); (Tranche 3 Annex C.5.3)
e.6. Z Satisfaction Questionnaire (Annex D)
e.7. Checklist of Requirements for Reimbursement – Targeted Therapy (Tranche 1 Annex E.5.1); (Tranche 2 Annex E.5.2); (Tranche 3 Annex E.5.3)
e.8. Breast Cancer Treatment Passport (Annex F)
e.9. Transmittal Form (Annex H)
e.10. Photocopy of the Multidisciplinary–Interdisciplinary Team (MDT) Plan
e.11. Original or Certified True Copy (CTC) of the Statement of Account (SOA) or its equivalent

f. Surveillance:

f.1. Pre-authorization Checklist and Request (Annex A.2)
f.2. Properly Accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)
f.3. Photocopy of Properly Accomplished PhilHealth Claim Form 2 (CF2)
f.4. Photocopy of Member Empowerment Form (Annex B)
f.5. Checklist of Mandatory and Other Services for Surveillance (Annex C.6)
f.6. Z Satisfaction Questionnaire (Annex D)
f.7. Checklist of Requirements for Reimbursement – Surveillance (Annex E.6)
f.8. Transmittal Form (Annex H)
f.9. Original or Certified True Copy (CTC) of the Statement of Account (SOA) or its equivalent

15. The Z Satisfaction Questionnaire (Annex D) shall be administered to all patients enrolled in Z Benefits prior to final discharge disposition from the contracted HF per services or treatment phase. These are validated during field monitoring by PhilHealth and shall be used as the basis of the Corporation for benefits enhancement, policy research and quality improvement purposes.

16. Existing rules or guidelines on late filing shall apply.

17. If the delay in the filing of claims is due to natural calamities or other fortuitous events, the existing guidelines of the Corporation on the provisions of special privileges to those affected by fortuitous events shall apply.

I. Claims Evaluation and Payment

1. PhilHealth shall have the right to subject any or all claims to medical review before and/or after payment or reimbursement of the contracted HFs, following the existing guidelines.

2. The policy on Return to Sender (RTS) shall not apply for the Z Benefits Packages. PhilHealth shall review and determine the completeness of all forms submitted by the contracted HFs. The PROs and LHIOs shall have the prerogative not to accept incomplete documents. However, they should directly coordinate with the contracted HFs regarding the deficiencies in the documents submitted. Once the documents are complete, the contracted HF shall submit these to PhilHealth for payment of claims within the required filing schedule.

3. PhilHealth shall reimburse the contracted HFs based on the predetermined package rates or case-based payment set for each service or treatment phase covered by the Z Benefits package, except for targeted therapy. Reimbursement for targeted therapy shall be based on the actual amount as reflected in the SOA or its equivalent, not to exceed the amount per cycle as indicated in Table 10.

4. When the patient expires or is declared lost to follow-up, PhilHealth shall only reimburse the corresponding amount of the benefit package based on the number of cycles or sessions, prescriptions, or services rendered by the contracted HF.

5. Claims for the applicable treatment phase or service for breast cancer within the same period shall not be considered overlapping claims.

6. Any change of member/patient category upon approval of the pre-authorization shall not affect the benefit availment.

7. Any amount declared in the SOA that are below or above the package rates shall not be interpreted as over or underpayment. All rates are considered inclusive of government taxes or net of mandatory discounts, as applicable.

8. PhilHealth shall process all claims submitted by the contracted HFs within thirty (30) working days upon receipt of claims applications, provided that the mandatory documents and attachments are complied with.

9. Claims filed by the contracted HF shall be denied based on the following instances:

    a. If a mandatory service was not provided by the contracted HF;
    b. If the required signatures in the forms are missing in the documents submitted;
    c. Improperly filled-out forms;
    d. Late filing;
    e. Incomplete attachments.

10. The contracted HF may apply for a motion for reconsideration (MR) for all denied Z Benefits claims based on existing PhilHealth policies.

11. Rules on pooling professional fees for government facilities shall apply. There will be no differentiation between facility and professional fees (PF). Payments shall be credited on the accounts of the contracted health facilities. It is the sole responsibility of the contracted HF to distribute the PF to their health professionals based on their mutual agreements and internal processes prior to contracting.

J. Monitoring

PhilHealth shall enforce current policies and guidelines on monitoring the performance of the contracted HFs in its policy implementation of the Z Benefits package for Breast Cancer and establish strict control mechanisms to prevent adverse provider behaviors and fraud detection.

Field monitoring activities shall be conducted for the service provision by contracted HFs. It shall follow the guidance, tools, and consent forms provided in the guiding principles of the Z Benefits.

The Corporation shall establish the performance indicators and outcome measures to monitor compliance with the policies of this Circular and the general treatment algorithm in collaboration with relevant stakeholders and experts and incorporate the indicators into the relevant monitoring policies.

K. Policy Review

PhilHealth shall conduct a regular policy review of the Z Benefits for Breast Cancer in consultation and collaboration with relevant stakeholders, experts, and technical staff representatives from the Corporation.

L. Marketing and Promotion

PhilHealth shall conduct communication and social marketing activities to educate the general public and increase their awareness of Z Benefits and to promote informed decision-making and participation among patients, healthcare professionals, healthcare providers, and other stakeholders, including marketing and promotional activities shall be undertaken following the Integrated Marketing and Communication Plan of PhilHealth.

M. List of Annexes (Posted on Official PhilHealth Website)

1. Annex A.1: Checklist of Eligibility Criteria for Diagnostic Tests and Prognostication – Breast Cancer
2. Annex A.2: Pre-authorization Checklist and Request Form
3. Annex B: Member Empowerment (ME) Form
4. Annex C: Checklist of Mandatory or Other Services
    - C.1. Checklist of Mandatory and Other Services for Diagnostics and Prognostication
    - C.2. Checklist of Mandatory and Other Services for Surgery
    - C.3. Checklist of Mandatory and Other Services for Chemotherapy
    - C.4.1. Checklist of Mandatory and Other Services for Hormonotherapy Tranche 1
    - C.4.2. Checklist of Mandatory and Other Services for Hormonotherapy Tranche 2
    - C.5.1. Checklist of Mandatory and Other Services for Targeted Therapy - Tranche 1
    - C.5.2. Checklist of Mandatory and Other Services for Targeted Therapy - Tranche 2
    - C.5.3. Checklist of Mandatory and Other Services for Targeted Therapy - Tranche 3
    - C.6. Checklist of Mandatory and Other Services for Surveillance
5. Annex D: Z Satisfaction Questionnaire
6. Annex E: Checklist of Requirements for Reimbursement
    - E.1. Checklist of Requirements for Reimbursement – Diagnostic Tests and Prognostication
    - E.2. Checklist of Requirements for Reimbursement – Surgery
    - E.3. Checklist of Requirements for Reimbursement – Chemotherapy
    - E.4.1. Checklist of Requirements for Reimbursement – Hormonotherapy Tranche 1

E.4.2. Checklist of Requirements for Reimbursement – Hormonotherapy Tranche 2
E.5.1. Checklist of Requirements for Reimbursement – Targeted Therapy Tranche 1
E.5.2. Checklist of Requirements for Reimbursement – Targeted Therapy Tranche 2
E.5.3. Checklist of Requirements for Reimbursement – Targeted Therapy Tranche 3
E.6. Checklist of Requirements for Reimbursement – Surveillance

7. Annex F: Breast Cancer Treatment Passport
8. Annex G: Checklist for Patient Transfer
9. Annex H: Transmittal Form
10. Annex I: Letter of Intent for Transfer to a Contracted Health Facility
11. Annex J: Sample Claim Form (CF) 2

J.1. Diagnostic Tests or Prognostication
J.2. Surgery
J.3. Cytotoxic Chemotherapy
J.4.1. Hormonotherapy Tranche 1
J.4.2. Hormonotherapy Tranche 2
J.5.1. Targeted Therapy Tranche 1
J.5.2. Targeted Therapy Tranche 2
J.5.3. Targeted Therapy Tranche 3
J.6. Surveillance

12. Annex K: Pathway of the Benefits Availment of Z Benefits for Breast Cancer
13. Annex L: Breast Cancer Treatment Protocols
14. Annex M: Breast Cancer Medical Records Summary Form
15. Annex N: Outcome Indicators
16. Annex O: Guide on Co-payment Proposal of the Z Benefits Package for Breast Cancer

VI. PENALTY CLAUSE

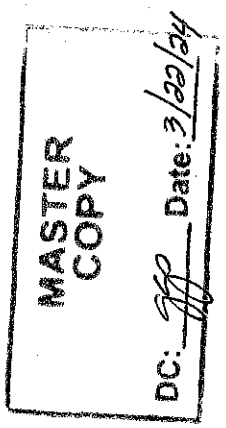
Any violation of this PhilHealth Circular shall be dealt with and penalized in accordance with pertinent provisions of RA No. 7875, as amended by RA Nos. 9241, 10606, and RA No. 11223, and their respective Implementing Rules and Regulations, and other relevant laws.

VII. TRANSITORY CLAUSE

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

B. Once the ZBITS module for pre-authorization is functional, the contracted HF shall process the Pre-authorization Checklist and Request through the HCI portal and attach the required documents, such as ME Form and the MDT plan. 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. In the meantime, the contracted HF may assign a case number for tracking purposes.

C. The contracted HF shall submit a new pre-authorization request to the PRO for patients with approved pre-authorization but have not initiated any treatment under the previous policy.



D. Claims for surgical procedures with approved pre-authorization date prior to the effectivity of this PhilHealth Circular shall follow the rules on claims processing as outlined in PC No. 2021-0022 "The Guiding Principles of the Z Benefits (Revision 1). The contracted HF may submit a new pre-authorization request for the continuation of other treatments and services provided under this policy.

E. Breast cancer patients currently enrolled under the Z Benefits and undergoing treatment for chemotherapy shall be processed and completed according to the guidelines for claims processing and requirements for claims submission provided in PC No. 2021-0022.

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 specific provisions on PhilHealth Circular (PC) No. 030 s. 2012 entitled "Case Type Z Benefit Package For Acute Lymphocytic (Lymphoblastic) Leukemia (ALL), Breast Cancer, Prostate Cancer And Kidney Transplant" and PC No. 2021-0022 entitled "The Guiding Principles of the Z Benefits (Revision 1)" relevant to Z Benefits Package for Breast Cancer.

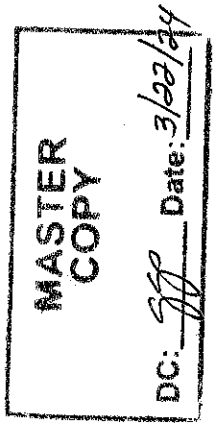
All PhilHealth Circulars, issuances, rules, and regulations or part thereof that are contrary to and inconsistent with this PhilHealth Circular are hereby repealed, amended, or modified accordingly.

X. DATE OF EFFECTIVITY

This PhilHealth Circular shall take effect on March 30, 2024 following the completion of its publication in the Official Gazette or any newspaper of general circulation. Three (3) certified copies shall be filed with the Office of the National Administrative Register (ONAR) of the University of the Philippines Law Center.

EMMANUEL R. LEDESMA, JR.
President and Chief Executive Officer

Date signed: 03/20/2024



Annex A.1: Checklist of Eligibility Criteria for Diagnostic Tests and Prognostication – Breast Cancer

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No._____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 Eligibility Criteria for Diagnostic Test and Prognostication for Breast Cancer

Place a (✓) in the status column if YES or write NA, if not applicable

Eligibility Criteria	Status
1. Positive (+) breast mass; AND/OR	
2. Palpable axillary lymph node	
3. BI-RADS results Place a (✓) in the appropriate tick box ☐ Category 4 ☐ Category 5	
4. Biopsy results (malignant breast cancer)	
5. Immunohistochemistry (IHC) result 2+ [a]	
6. HER2 status results is not clear or equivocal [a]	

[a] Required for procedures requiring Fluorescent in situ hybridization (FISH) for Her2/Neu amplification

Certified Correct by:	Conforme by:
(Printed name and signature) Attending Physician	(Printed name and signature) Patient
PhilHealth Accreditation No.	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

MASTER COPY
DC: ____ Date: 3/22/24

Annex A.2: Pre-authorization Checklist and Request Form

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No._____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

(Place a ✓ opposite appropriate answer)

History of Previous Treatment ☐ Not Applicable	**Date of Procedure or Last Session or Cycles (mm/dd/yyyy)**
☐ Surgery (Specify Site): _____	
☐ Hormonal Therapy	
☐ Cytotoxic Chemotherapy	
☐ Targeted Therapy (Specify Number of Cycles Provided):	

(Place a ✓ opposite appropriate answer)

Menstrual Stage	
☐ Pre-menopausal	☐ Post-menopausal
HER2 Status	
☐ 0 – 1+ (HER2 Negative)	☐ 2+ (Borderline) ☐ 3+ (HER2 Positive)

(Place a ✓ opposite appropriate answer)

Laterality and Clinical Staging [a]	
☐ **Right**	☐ **Left**
☐ cStage 0	☐ cStage 0
☐ cStage IA	☐ cStage IA
☐ cStage IB	☐ cStage IB
☐ cStage IIA	☐ cStage IIA
☐ cStage IIB	☐ cStage IIB
☐ cStage IIIA	☐ cStage IIIA
☐ cStage IIIB	☐ cStage IIIB
☐ cStage IIIC	☐ cStage IIIC
☐ cStage IV	☐ cStage IV

[a] If bilateral, tick in the appropriate box both laterality and its corresponding clinical staging

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(Place a ✓opposite appropriate answer)

Applicable Treatment Protocol	
Surgery	☐ Adjuvant ☐ Neoadjuvant
☐ Hormonal Therapy	
Cytotoxic Chemotherapy	☐ Adjuvant ☐ Neoadjuvant Protocol: ☐ Doxorubicin (A) + Cyclophosphamide (C) + Docetaxel (T) ☐ Doxorubicin (A) + Cyclophosphamide (C) + Paclitaxel (Pacli) ☐ Docetaxel (T) + Carboplatin (Cb)
☐ Targeted Therapy	If with previous targeted therapy Specify number of cycles to be provided: _____
☐ Surveillance	

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 ☐☐-☐☐☐☐☐☐☐☐-☐	

Certified Correct by Attending Medical Oncologist:

Printed Name and Signature
PhilHealth Accreditation No.
☐☐☐☐.☐☐☐☐☐☐☐☐.☐☐

Certified Correct by Attending Surgeon:

Printed Name and Signature
PhilHealth Accreditation No.
☐☐☐☐.☐☐☐☐☐☐☐☐.☐☐

Certified Correct by Attending Radiologic Oncologist:

Printed Name and Signature
PhilHealth Accreditation No.
☐☐☐☐.☐☐☐☐☐☐☐☐.☐☐

Conforme by:

Printed Name and Signature
Patient
Date Signed (mm/dd/yyyy):

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Note:
Once approved, the contracted HF shall print the approved pre-authorization form 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.

PRE-AUTHORIZATION REQUEST
Breast 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 Medical Oncologist	(Printed Name and Signature) Attending Surgeon
PhilHealth Accreditation No.	PhilHealth Accreditation No.

Certified Correct by:	Certified Correct by:
(Printed Name and Signature) Attending Radiologic Oncologist	(Printed Name and Signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No.	PhilHealth Accreditation No.

Conforme by:
(Printed Name and Signature) Patient

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(For PhilHealth Use Only)
☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

INITIAL APPLICATION			**COMPLIANCE TO REQUIREMENTS**		
Activity	**Initial**	**Date**	☐ APPROVED ☐ DISAPPROVED (State reason/s)		
Received by LHIO/BAS:			_____ (Printed name and signature) Head or authorized BAS representative		
Endorsed to BAS (if received by LHIO):					
☐Approved ☐Disapproved			**Activity**	**Initial**	**Date**
Released to HF:			Received by BAS:		
The pre-authorization for chemotherapy (neoadjuvant) and surgery (adjuvant) shall be valid for 60 calendar days.			☐ Approved ☐Disapproved		
			Released to HF:		

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

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.

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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

Iba pa
Others
☐ Point of Service (POS) Financially Incapable

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 NA 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*		
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.* * Para sa Z Benefits Package ng Breast Cancer, ang halaga ng babayaran ng pasyente ay base lamang sa yugto ng paggamot batay sa plano ng gamutan ng MDT. Walang dagdag bayad para sa benepisyo ng targeted therapy.		

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For the Z Benefits Package for Breast Cancer, the co-payment of the patient shall be based per treatment phase in accordance with the agreed treatment plan of the MDT. No-copayment shall be applicable for benefits under targeted therapy.		
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.* * Para sa Z Benefits Package ng Breast Cancer, ang halaga ng babayaran ng pasyente ay base lamang sa yugto ng paggamot batay sa plano ng gamutan ng MDT. Walang dagdag bayad para sa benepisyo ng targeted therapy. *For the Z Benefits Package for Breast Cancer, the co-payment of the patient shall be based per treatment phase in accordance with the agreed treatment plan of the MDT. No-copayment shall be applicable for benefits under targeted therapy.*		
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 nauukol *Put a (√) opposite appropriate answer or NA 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*		

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Case No. _____

CHECKLIST OF MANDATORY AND OTHER SERVICES
Breast Cancer - Diagnostics and Prognostication

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 ☐☐-☐☐☐☐☐☐☐☐-☐	

Place a (✓) in the appropriate tick box

MANDATORY SERVICES	
Diagnostic Test	
☐ Ultrasound **AND/OR**	Date of procedure (mm/dd/yyyy): _____
☐ Mammography **AND**	Date of procedure (mm/dd/yyyy): _____
☐ Clinical Consultation	Date of consultation (mm/dd/yyyy): _____
Breast Panel	
☐ ER/PR Hormone Test	Date of procedure (mm/dd/yyyy): _____
☐ Her2/neu Immunohistochemistry (IHC) testing	Date of procedure (mm/dd/yyyy): _____
☐ Complete Blood Count with platelet count	Date of procedure (mm/dd/yyyy): _____
☐ Metabolic panel with liver function tests	Date of procedure (mm/dd/yyyy): _____
☐ Alkaline phosphatase	Date of procedure (mm/dd/yyyy): _____
Fluorescent in situ hybridization (FISH)	
☐ Fluorescent in situ hybridization (FISH) for Her2 Neu amplification	Date of procedure (mm/dd/yyyy): _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 ☐☐-☐☐☐☐☐☐☐☐-☐	

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

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Case No. _____

CHECKLIST OF MANDATORY AND OTHER SERVICES
Breast Cancer - Post-Surgery

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 ☐☐-☐☐☐☐☐☐☐☐-☐	

Place a (✓) in the appropriate tick box.

Clinical Staging, Laterality and Surgical Procedure [a]	
☐ **Left**	☐ **Right**
A. Clinical Staging: ☐ cStage 0 ☐ cStage IA ☐ cStage IB ☐ cStage IIA ☐ cStage IIB ☐ cStage IIIA ☐ cStage IIIB ☐ cStage IIIC ☐ cStage IV	A. Clinical Staging: ☐ cStage 0 ☐ cStage IA ☐ cStage IB ☐ cStage IIA ☐ cStage IIB ☐ cStage IIIA ☐ cStage IIIB ☐ cStage IIIC ☐ cStage IV
B. Procedure: (any of the following) ☐ Partial mastectomy or lumpectomy ☐ Subcutaneous/Simple/Total mastectomy ☐ Modified Radical Mastectomy ☐ Partial mastectomy or Lumpectomy with sentinel lymph node biopsy ☐ Partial mastectomy or Lumpectomy with axillary node dissection ☐ Total Mastectomy with sentinel lymph node biopsy ☐ Modified Radical Mastectomy with skin coverage for IIIB or above	B. Procedure: (any of the following) ☐ Partial mastectomy or lumpectomy ☐ Subcutaneous/Simple/Total mastectomy ☐ Modified Radical Mastectomy ☐ Partial mastectomy or Lumpectomy with sentinel lymph node biopsy ☐ Partial mastectomy or Lumpectomy with axillary node dissection ☐ Total Mastectomy with sentinel lymph node biopsy ☐ Modified Radical Mastectomy with skin coverage for IIIB or above

[a] If bilateral, tick in the appropriate box both laterality, its corresponding clinical staging and surgical procedure

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Place a (✓) in the appropriate tick box.

MANDATORY SERVICES	OTHER SERVICES
A. Diagnostics	
	☐ CBC with platelet count*
	☐ Chest X-ray PA and lateral views*
	☐ Ultrasound of whole abdomen*
	☐ ECG
	☐ Creatinine
	☐ PT/PTT
	☐ CP Clearance
	☐ FBS
	Electrolytes*
	☐ Sodium
	☐ Potassium
	☐ Chloride
	☐ Calcium
	☐ Phosphate
	☐ Urinalysis*
	☐ 2D echo**

*not required for cStage 0 DCIS
**not required for HER2 negative breast cancer

Certified correct by:	Conforme 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)	

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Case No. _____

CHECKLIST OF MANDATORY AND OTHER SERVICES
Breast Cancer - Chemotherapy

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

Place a (✓) in the appropriate tick box.

MANDATORY SERVICES			OTHER SERVICES as indicated/ as needed
Chemotherapy* (any one of the following treatment protocols):			
	☐ **Neoadjuvant therapy**	**Date (mm/dd/yyy)**	
Protocol A: AC+T	**Z0211M11** ☐ Doxorubicin/ Epirubicin (A) + Cyclophosphamide (C)	1._____ 2._____ 3._____ 4._____	
	Z0211M12 ☐ Docetaxel (T)	1._____ 2._____ 3._____ 4._____	
Protocol B: AC+Pacli	**Z0211N11** ☐ Doxorubicin/ Epirubicin (A) + Cyclophosphamide (C)	1._____ 2._____ 3._____ 4._____	
	Z0211N12 ☐ Paclitaxel (Pacli)	1._____ 2._____ 3._____ 4._____ 5._____ 6._____ 7._____ 8._____ 9._____ 10._____ 11._____ 12._____	

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Protocol C: T+Cb	**Z0210I** ☐ Docetaxel (T) + Carboplatin (Cb)	1._____ 2._____ 3._____ 4._____ 5._____ 6._____
☐ **Adjuvant therapy**		**Date (mm/dd/yyy)**
Protocol A: AC+T	**Z021M21** ☐ Doxorubicin/ Epirubicin (A) + Cyclophosphamide (C)	1._____ 2._____ 3._____ 4._____
	Z021M22 ☐ Docetaxel (T)	1._____ 2._____ 3._____ 4._____
Protocol B: AC+Pacli	**Z021N21** ☐ Doxorubicin/ Epirubicin (A) + Cyclophosphamide (C)	1._____ 2._____ 3._____ 4._____
	Z021N22 ☐ Paclitaxel (Pacli)	1._____ 2._____ 3._____ 4._____ 5._____ 6._____ 7._____ 8._____ 9._____ 10._____ 11._____ 12._____
Protocol C: T+Cb	**Z0210I2** ☐ Docetaxel (T) + Carboplatin (Cb)	1._____ 2._____ 3._____ 4._____ 5._____ 6._____
☐ Granulocyte colony-stimulating factor (G-CSF)		
		☐ Anti-emetic, specify
		☐ Antimicrobials, specify
		☐ Pain relievers, specify
		☐ Other medicines, specify

*not required for Stage 0 DCIS

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 ☐☐-☐☐☐☐☐☐☐☐-☐	

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 C.4.1: Checklist of Mandatory and Other Services for Hormonotherapy Tranche 1

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Case No. _____

CHECKLIST OF MANDATORY AND OTHER SERVICES
Breast Cancer – Hormonotherapy (Tranche 1)

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 ☐☐-☐☐☐☐☐☐☐☐-☐	

Place a (✓) in the appropriate tick box.

Laterality and Clinical Staging [a]	
☐ **Right**	☐ **Left**
☐ cStage 0	☐ cStage 0
☐ cStage IA	☐ cStage IA
☐ cStage IB	☐ cStage IB
☐ cStage IIA	☐ cStage IIA
☐ cStage IIB	☐ cStage IIB
☐ cStage IIIA	☐ cStage IIIA
☐ cStage IIIB	☐ cStage IIIB
☐ cStage IIIC	☐ cStage IIIC
☐ cStage IV	☐ cStage IV

[a] If bilateral, tick in the appropriate box both laterality and its corresponding clinical staging

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Place a (✓) in the appropriate tick box if the services is done and indicate the date

SERVICES	**DATE OF PRESCRIPTION (mm/dd/yyyy)**
Tick one, whichever is applicable	1. Date: _____
	2. Date: _____
	3. Date: _____
☐ Tamoxifen [a b c] (Premenopausal/Postmenopausal)	4. Date: _____
	5. Date: _____
OR	6. Date: _____

☐ Anastrozole / Letrozole [b c] (Aromatase Inhibitor) (Postmenopausal)	1. Date: _____
	2. Date: _____
	3. Date: _____
	4. Date: _____
	5. Date: _____
	6. Date: _____

[a] Tamoxifen is given to premenopausal and postmenopausal women, particularly ER+/PR+/HER2neu- patients. For postmenopausal ER+/PR+/HER2neu+ patients, an aromatase inhibitor is preferred
[b] For cStage 0 – IIIC, prescription shall be given every 3 months
[c] For cStage IV prescription shall be given every month

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

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Annex C.4.2: Checklist of Mandatory and Other Services for Hormonotherapy Tranche 2

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Case No. _____

CHECKLIST OF MANDATORY AND OTHER SERVICES
Breast Cancer – Hormonotherapy (Tranche 2)

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 ☐☐-☐☐☐☐☐☐☐☐-☐	

Place a (✓) in the appropriate tick box.

Laterality and Clinical Staging [a]	
☐ **Right**	☐ **Left**
☐ cStage 0	☐ cStage 0
☐ cStage IA	☐ cStage IA
☐ cStage IB	☐ cStage IB
☐ cStage IIA	☐ cStage IIA
☐ cStage IIB	☐ cStage IIB
☐ cStage IIIA	☐ cStage IIIA
☐ cStage IIIB	☐ cStage IIIB
☐ cStage IIIC	☐ cStage IIIC
☐ cStage IV	☐ cStage IV

[a] If bilateral, tick in the appropriate box both laterality and its corresponding clinical staging

Place a (✓) in the appropriate tick box if the services is done and indicate the date

SERVICES	**DATE OF PRESCRIPTION (mm/dd/yyyy)**
Tick one, whichever is applicable	7. Date: _____
	8. Date: _____
☐ Tamoxifen [a b c] (Premenopausal/Postmenopausal)	9. Date: _____
	10. Date: _____
OR	11. Date: _____
	12. Date: _____

MASTER COPY Date: 3/22/24 DC: _____

☐ Anastrozole / Letrozole [b c] (Aromatase Inhibitor) (Postmenopausal)	7. Date: _____
	8. Date: _____
	9. Date: _____
	10. Date: _____
	11. Date: _____
	12. Date: _____

[a] Tamoxifen is given to premenopausal and postmenopausal women, particularly ER+/PR+/HER2neu- patients. For postmenopausal ER+/PR+/HER2neu+ patients, an aromatase inhibitor is preferred
[b] For cStage 0 – IIIC, prescription shall be given every 3 months
[c] For cStage IV prescription shall be given every month

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

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Annex C.5.1: Checklist of Mandatory and Other Services for Targeted Therapy - Tranche 1

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Case No. _____

CHECKLIST OF MANDATORY AND OTHER SERVICES
Breast Cancer – Targeted Therapy (Tranche 1)

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 ☐☐-☐☐☐☐☐☐☐☐-☐	

Place a (✓) in the appropriate tick box.

Laterality and Clinical Staging [a]	
☐ **Right**	☐ **Left**
☐ cStage 0	☐ cStage 0
☐ cStage IA	☐ cStage IA
☐ cStage IB	☐ cStage IB
☐ cStage IIA	☐ cStage IIA
☐ cStage IIB	☐ cStage IIB
☐ cStage IIIA	☐ cStage IIIA
☐ cStage IIIB	☐ cStage IIIB
☐ cStage IIIC	☐ cStage IIIC
☐ cStage IV	☐ cStage IV

[a] If bilateral, tick in the appropriate box both laterality and its corresponding clinical staging

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Place a (✓) in the appropriate tick box if the services is done and indicate the date

SERVICES	**DATE OF PRESCRIPTION (mm/dd/yyyy)**
☐ Trastuzumab (H) [a b]	1. Date: _____
	2. Date: _____
	3. Date: _____
	4. Date: _____

	5. Date: _____
	6. Date: _____
☐ 2D Echo [c]	Date conducted: _____
[redacted]	☐ Granulocyte colony-stimulating factor (G-CSF)
	☐ Antiemetic, specify: _____
	☐ Antimicrobials, specify: _____
	☐ Pain relievers, specify: _____
	☐ Other medicines, specify: _____

[a] For Her2-positive breast cancer
[b] One tranche is equivalent to 6 cycles; maximum of 3 tranches of targeted therapy once in a lifetime
[c] Must be done every after 4th cycles of the targeted therapy

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

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Annex C.5.2: Checklist of Mandatory and Other Services for Targeted Therapy - Tranche 2

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Case No. _____

CHECKLIST OF MANDATORY AND OTHER SERVICES
Breast Cancer – Targeted Therapy (Tranche 2)

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 ☐☐-☐☐☐☐☐☐☐☐-☐	

Place a (✓) in the appropriate tick box.

Laterality and Clinical Staging [a]	
☐ **Right**	☐ **Left**
☐ cStage 0	☐ cStage 0
☐ cStage IA	☐ cStage IA
☐ cStage IB	☐ cStage IB
☐ cStage IIA	☐ cStage IIA
☐ cStage IIB	☐ cStage IIB
☐ cStage IIIA	☐ cStage IIIA
☐ cStage IIIB	☐ cStage IIIB
☐ cStage IIIC	☐ cStage IIIC
☐ cStage IV	☐ cStage IV

[a] If bilateral, tick in the appropriate box both laterality and its corresponding clinical staging

Place a (✓) in the appropriate tick box if the services is done and indicate the date

SERVICES	**DATE OF PRESCRIPTION (mm/dd/yyyy)**
☐ Trastuzumab (H) [a b]	7. Date: _____
	8. Date: _____
	9. Date: _____
	10. Date: _____
	11. Date: _____
	12. Date: _____

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SERVICES	DATE OF PRESCRIPTION (mm/dd/yyyy)
☐ 2D Echo [c]	Date conducted: _____
[redacted]	☐ Granulocyte colony-stimulating factor (G-CSF)
	☐ Antiemetic, specify: _____
	☐ Antimicrobials, specify: _____
	☐ Pain relievers, specify: _____
	☐ Other medicines, specify: _____

[a] For Her2-positive breast cancer
[b] One tranche is equivalent to 6 cycles; maximum of 3 tranches of targeted therapy once in a lifetime
[c] Must be done every after 4th cycles of the targeted therapy

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

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Annex C.5.3: Checklist of Mandatory and Other Services for Targeted Therapy - Tranche 3

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Case No. _____

CHECKLIST OF MANDATORY AND OTHER SERVICES
Breast Cancer – Targeted Therapy (Tranche 2)

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

Place a (✓) in the appropriate tick box.

Laterality and Clinical Staging [a]	
☐ **Right**	☐ **Left**
☐ cStage 0	☐ cStage 0
☐ cStage IA	☐ cStage IA
☐ cStage IB	☐ cStage IB
☐ cStage IIA	☐ cStage IIA
☐ cStage IIB	☐ cStage IIB
☐ cStage IIIA	☐ cStage IIIA
☐ cStage IIIB	☐ cStage IIIB
☐ cStage IIIC	☐ cStage IIIC
☐ cStage IV	☐ cStage IV

[a] If bilateral, tick in the appropriate box both laterality and its corresponding clinical staging

Place a (✓) in the appropriate tick box if the services is done and indicate the date

SERVICES	DATE OF PRESCRIPTION (mm/dd/yyyy)
☐ Trastuzumab (H) [a b]	13. Date: _____
	14. Date: _____
	15. Date: _____
	16. Date: _____
	17. Date: _____
	18. Date: _____

MASTER COPY Date: 3/22/24 DC:

SERVICES	DATE OF PRESCRIPTION (mm/dd/yyyy)
☐ 2D Echo [c]	Date conducted: _____
	☐ Granulocyte colony-stimulating factor (G-CSF)
	☐ Antiemetic, specify: _____
	☐ Antimicrobials, specify: _____
	☐ Pain relievers, specify: _____
	☐ Other medicines, specify: _____

[a] For Her2-positive breast cancer
[b] One tranche is equivalent to 6 cycles; maximum of 3 tranches of targeted therapy once in a lifetime
[c] Must be done every after 4th cycles of the targeted therapy

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

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Case No. _____

CHECKLIST OF MANDATORY AND OTHER SERVICES
Breast Cancer – Surveillance

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

Place a (✓) in the appropriate tick box.

Laterality and Clinical Staging [a]	
☐ **Right**	☐ **Left**
☐ cStage 0	☐ cStage 0
☐ cStage IA	☐ cStage IA
☐ cStage IB	☐ cStage IB
☐ cStage IIA	☐ cStage IIA
☐ cStage IIB	☐ cStage IIB
☐ cStage IIIA	☐ cStage IIIA
☐ cStage IIIB	☐ cStage IIIB
☐ cStage IIIC	☐ cStage IIIC
☐ cStage IV	☐ cStage IV

[a] If bilateral, tick in the appropriate box both laterality and its corresponding clinical staging

Place a (✓) in the appropriate tick box

Basic Services	
☐ Mammography (contralateral if mastectomy or bilateral, if lumpectomy) [c] **AND/OR**	Date conducted (mm/dd/yyy): _____
☐ Ultrasound breast [e] or whole [d] abdomen **AND/OR**	Date conducted (mm/dd/yyy): _____
☐ Gynecological evaluation and Transvaginal ultrasound [f] **AND/OR**	Date conducted (mm/dd/yyy): _____
☐ Chest X-Ray [b] **AND/OR**	Date conducted (mm/dd/yyy): _____
☐ Clinical Consultation [a]	Date of Consultation (mm/dd/yyyy): _____

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Specific Services	
☐ 2D echo [g] **AND/OR**	Date conducted (mm/dd/yyy): _____
☐ Bone densitometry [h] **AND/OR**	Date conducted (mm/dd/yyy): _____
☐ Bone scan [i]	Date conducted (mm/dd/yyy): _____

Rules on surveillance

[a] Clinical consultation after completion of treatment, every 3-4 months for 1st 3 years particularly for high risk patients (Stage IIB-IIIC) then once every year if asymptomatic; every month if Stage IV.

[b] Chest X-ray once a year, as needed

[c] Can be availed of post-surgery, as needed, maximum of one (1) availment per year

[d] Ultrasound of whole abdomen, once a year, if needed

[e] Ultrasound of breast, once a year, if needed

[f] Gynecological exam and transvaginal ultrasound, once a year if on hormonotherapy

[g] 2D echo, as per cardiology advice, once a year, after completion of treatment cycle of doxorubicin or trastuzumab

[h] Bone densitometry, once a year if on aromatase inhibitor

[i] Bone scan, as needed, once a year if symptomatic

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

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PhilHealth Z 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

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

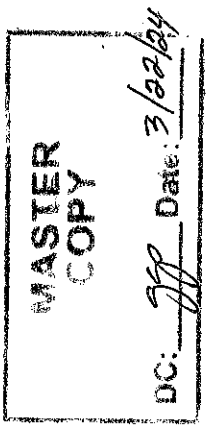
8. Overall patient satisfaction (PS mark) is:
   - □ excellent
   - □ satisfactory
   - □ unsatisfactory
   - □ don't know

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 E.1: Checklist of Requirements for Reimbursement – Diagnostic Test and Prognostication

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 REQUIREMENTS FOR REIMBURSEMENT
Breast Cancer - Diagnostic Test and Prognostication

Place a (✔) in the appropriate tick box.

Requirements	Please Check
1. Checklist of Requirements for Reimbursement – Diagnostic Test (Annex E.1)	
2. Photocopy of completely accomplished Eligibility Criteria for Diagnostic Test (Annex A.1)	
3. Properly accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)	
4. Properly accomplished PhilHealth Claim Form (CF) 2	
5. Checklist of Mandatory and Other Services (Annex C.1-Diagnostic Test Breast CA)	
6. Completed Z Satisfaction Questionnaire (Annex D)	
7. Original or certified true copy (CTC) of the Statement of Account (SOA) or its equivalent	
8. Transmittal Form (Annex H)	
DATE COMPLETED (mm/dd/yyyy):	
DATE FILED (mm/dd/yyyy):	

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

MASTER COPY
Date: 3/22/24
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Annex E.2: Checklist of Requirements for Reimbursement – Surgery

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 REQUIREMENTS FOR REIMBURSEMENT
Breast Cancer – Surgical Procedure

Place a (✔) in the appropriate tick box.

Requirements	Please Check
1. Checklist of Requirements for Reimbursement - Surgery (Annex E.2)	
2. Properly accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)	
3. Properly accomplished PhilHealth Claim Form (CF) 2	
4. Photocopy of approved Pre-authorization Checklist and Request (Annex A.2)	
5. Photocopy of Member Empowerment Form (Annex B)	
6. Checklist of Mandatory and Other Services (Annex C.2)	
7. Completed Z Satisfaction Questionnaire (Annex D)	
8. Transmittal Form (Annex H)	
9. Photocopy of multidisciplinary – interdisciplinary team (MDT) plan	
10. Original or certified true copy (CTC) of the Statement of Account (SOA) or its equivalent	
11. Photocopy of accomplished surgical operative report	
12. Photocopy of accomplished anesthesia report	
13. Photocopy of histopathology report	
DATE COMPLETED (mm/dd/yyyy):	
DATE FILED (mm/dd/yyyy):	

Certified correct by:	Conforme 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
DC: Date: 3/22/24

Annex E.3: Checklist of Requirements for Reimbursement – Chemotherapy

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PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 REQUIREMENTS FOR REIMBURSEMENT
Breast Cancer – Chemotherapy

Place a (✓) in the appropriate tick box.

Requirements	Please Check
1. Checklist of Requirements for Reimbursement – Chemotherapy (Annex E.3)	
2. Photocopy of approved Pre-authorization Checklist and Request (Annex A.2)	
3. Properly accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)	
4. Properly accomplished PhilHealth Claim Form (CF) 2	
5. Photocopy of Member Empowerment Form (Annex B)	
6. Checklist of Mandatory and Other Services (Annex C.3)	
7. Completed Z Satisfaction Questionnaire (Annex D)	
8. Breast Cancer Treatment Passport (Annex F)	
9. Transmittal Form (Annex H)	
10. Photocopy of the multidisciplinary – interdisciplinary team (MDT) plan	
11. Original or certified true copy (CTC) of the Statement of Account (SOA) or its equivalent	
DATE COMPLETED (mm/dd/yyyy):	
DATE FILED (mm/dd/yyyy):	

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

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Annex E.4.1: Checklist of Requirements for Reimbursement – Hormonotherapy Tranche 1

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 REQUIREMENTS FOR REIMBURSEMENT
Breast Cancer – Hormonotherapy Tranche 1

Place a (✓) in the appropriate tick box.

Requirements	Please Check
1. Checklist of Requirements for Reimbursement – Hormonotherapy Tranche 1 (Annex E.4.1)	
2. Photocopy of approved Pre-authorization Checklist and Request (Annex A.2)	
3. Properly accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)	
4. Properly accomplished PhilHealth Claim Form (CF) 2	
5. Photocopy of Member Empowerment Form (Annex B)	
6. Checklist of Mandatory and Other Services (Annex C.4.1)	
7. Completed Z Satisfaction Questionnaire (Annex D)	
8. Breast Cancer Treatment Passport (Annex F)	
9. Transmittal Form (Annex H)	
10. Photocopy of the multidisciplinary – interdisciplinary team (MDT) plan	
11. Original or certified true copy (CTC) of the Statement of Account (SOA) or its equivalent	
DATE COMPLETED (mm/dd/yyyy):	
DATE FILED (mm/dd/yyyy):	

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

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Annex E.4.2: Checklist of Requirements for Reimbursement – Hormonotherapy Tranche 2

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 REQUIREMENTS FOR REIMBURSEMENT
Breast Cancer – Hormonotherapy Tranche 2

Place a (✓) in the appropriate tick box.

Requirements	Please Check
1. Checklist of Requirements for Reimbursement – Hormonotherapy Tranche 2 (Annex E.4.2)	
2. Photocopy of approved Pre-authorization Checklist and Request (Annex A.2)	
3. Properly accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)	
4. Properly accomplished PhilHealth Claim Form (CF) 2	
5. Photocopy of Member Empowerment Form (Annex B)	
6. Checklist of Mandatory and Other Services (Annex C.4.2)	
7. Completed Z Satisfaction Questionnaire (Annex D)	
8. Breast Cancer Treatment Passport (Annex F)	
9. Transmittal Form (Annex H)	
10. Photocopy of the multidisciplinary – interdisciplinary team (MDT) plan	
11. Original or certified true copy (CTC) of the Statement of Account (SOA) or its equivalent	
DATE COMPLETED (mm/dd/yyyy):	
DATE FILED (mm/dd/yyyy):	

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

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Annex E.5.1: Checklist of Requirements for Reimbursement – Targeted Therapy Tranche 1

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

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Date: 3/22/24
QC:

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT
Breast Cancer – Targeted Therapy (Tranche 1)

Place a (✔) in the appropriate tick box.

Requirements	Please Check
1. Checklist of Requirements for Reimbursement – Targeted Therapy (Annex E.5.1)	
2. Photocopy of approved Pre-authorization Checklist and Request (Annex A.2)	
3. Properly accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)	
4. Properly accomplished PhilHealth Claim Form (CF) 2	
5. Photocopy of Member Empowerment Form (Annex B)	
6. Checklist of Mandatory and Other Services (Annex C.5.1)	
7. Completed Z Satisfaction Questionnaire (Annex D)	
8. Breast Cancer Treatment Passport (Annex F)	
9. Transmittal Form (Annex H)	
10. Photocopy of the multidisciplinary – interdisciplinary team (MDT) plan	
11. Original or certified true copy (CTC) of the Statement of Account (SOA) or its equivalent	
DATE COMPLETED (mm/dd/yyyy):	
DATE FILED (mm/dd/yyyy):	

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

Annex E.5.2: Checklist of Requirements for Reimbursement – Targeted Therapy Tranche 2

PhilHealth
Your Partner in Health

BAGONG PILIPINAS

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 REQUIREMENTS FOR REIMBURSEMENT
Breast Cancer – Targeted Therapy (Tranche 2)

Place a (✓) in the appropriate tick box.

Requirements	Please Check
1. Checklist of Requirements for Reimbursement – Targeted Therapy (Annex E.5.2)	
2. Photocopy of approved Pre-authorization Checklist and Request (Annex A.2)	
3. Properly accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)	
4. Properly accomplished PhilHealth Claim Form (CF) 2	
5. Photocopy of Member Empowerment Form (Annex B)	
6. Checklist of Mandatory and Other Services (Annex C.5.2)	
7. Completed Z Satisfaction Questionnaire (Annex D)	
8. Breast Cancer Treatment Passport (Annex F)	
9. Transmittal Form (Annex H)	
10. Photocopy of the multidisciplinary – interdisciplinary team (MDT) plan	
11. Original or certified true copy (CTC) of the Statement of Account (SOA) or its equivalent	
DATE COMPLETED (mm/dd/yyyy):	
DATE FILED (mm/dd/yyyy):	

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

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Annex E.5.3: Checklist of Requirements for Reimbursement – Targeted Therapy Tranche 3

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Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 REQUIREMENTS FOR REIMBURSEMENT
Breast Cancer – Targeted Therapy (Tranche 3)

Place a (√) in the appropriate tick box.

Requirements	Please Check
1. Checklist of Requirements for Reimbursement – Targeted Therapy (Annex E.5.3)	
2. Photocopy of approved Pre-authorization Checklist and Request (Annex A.2)	
3. Properly accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)	
4. Properly accomplished PhilHealth Claim Form (CF) 2	
5. Photocopy of Member Empowerment Form (Annex B)	
6. Checklist of Mandatory and Other Services (Annex C.5.3)	
7. Completed Z Satisfaction Questionnaire (Annex D)	
8. Breast Cancer Treatment Passport (Annex F)	
9. Transmittal Form (Annex H)	
10. Photocopy of the multidisciplinary – interdisciplinary team (MDT) plan	
11. Original or certified true copy (CTC) of the Statement of Account (SOA) or its equivalent	
DATE COMPLETED (mm/dd/yyyy):	
DATE FILED (mm/dd/yyyy):	

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

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Annex E.6: Checklist of Requirements for Reimbursement – Surveillance

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 REQUIREMENTS FOR REIMBURSEMENT
Breast Cancer - Surveillance

Place a (√) in the appropriate tick box.

Requirements	Please Check
1. Checklist of Requirements for Reimbursement – Surveillance 2. (Annex E.6)	
3. Photocopy of approved Pre-authorization Checklist and Request (Annex A.2)	
4. Photocopy of Member Empowerment Form (Annex B)	
5. Properly accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)	
6. Properly accomplished PhilHealth Claim Form (CF) 2	
7. Checklist of Mandatory and Other Services (Annex C.6)	
8. Completed Z Satisfaction Questionnaire (Annex D)	
9. Original or certified true copy (CTC) of the Statement of Account (SOA) or its equivalent	
10. Transmittal Form (Annex H)	
DATE COMPLETED (mm/dd/yyyy):	
DATE FILED (mm/dd/yyyy):	

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

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Annex F: Breast Cancer Treatment Passport

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		AGE: _____
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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

Breast Cancer Treatment Passport

A. Cytotoxic Chemotherapy

Name of Drug		Dosage	Preparation	Date Initiated (mm/dd/yyyy)	Patient/ Parent/ Guardian's Signature	Attending Physician's signature
Generic Name	Brand Name					
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						

MASTER COPY Date: 3/22/24 DC: _____

B. **Hormonotherapy**

Name of Drug		Dosage	Preparation	Date Given (mm/dd/yyyy)	Patient/ Parent/ Guardian's Signature	Attending Physician's signature
Generic Name	Brand Name					
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						

C. **Targeted Therapy**

Name of Drug		Dosage	Preparation	Date Given (mm/dd/yyyy)	Patient/ Parent/ Guardian's Signature	Attending Physician's signature
Generic Name	Brand Name					
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						

MASTER COPY Date: 3/22/24

Annex G: Checklist for Patient Transfer

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 FOR PATIENT TRANSFER
Z Benefits Package for Breast Cancer

For breast cancer patients enrolled in the Z benefits who will be transferred to a referral contracted HF, the following checklist shall be accomplished:

NAME OF REFERRAL CONTRACTED HF:
ADDRESS OF REFERRAL CONTRACTED HF:

Requirements	YES OR NO (tick appropriate box)	Signature of Responsible Person
1. Updated Medical Abstract	☐ Yes ☐ No	
2. Letter of Referral from the Attending Physician	☐ Yes ☐ No	_____ Name and Signature Attending Physician
3. Certified true copy of the breast cancer treatment passport	☐ Yes ☐ No	_____ Name and Signature Z Benefits Coordinator
4. Letter of Intent from the patient requesting for transfer to a referral contracted HF (Annex I)	☐ Yes ☐ No	_____ Name and Signature Patient/Parent/Guardian

Certified complete by:	Conforme by:
_____ Printed name and signature Z Benefits Coordinator	_____ Printed name and signature Patient/Parent/Guardian
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

MASTER COPY Date: 3/22/24

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

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 Benefits Package Code, include the code for the order of tranche payment, treatment phase, sessions or cycles, as applicable. For the Case Number, copy the case number that is provided in the approved pre-authorization checklist and request. The Remarks column may include some relevant notes which pertain to the filed claim that need to be relayed to PhilHealth.

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

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)		

MASTER COPY DC: Date: 3/22/24

Annex I: Letter of Intent for Transfer to a Contracted Health Facility

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

Letter of Intent for the Transfer of Care to a Referral Contracted HF

This is to certify, that patient _____ (Name of the Patient), born on _____ (Date of Birth),

age _____ years old, residing at _____ (Address),

was diagnosed with _____ (Diagnosis) on _____ (Date: mm/dd/yyyy)

at the _____ (Name of the Referring Contracted HF)

We would like request for transfer of Breast Cancer Care to _____ (Name of Referral Contracted HF)

under the care of _____ (Name of the Attending Physician).

We understand that upon transfer to a referral contracted HF, we will have to waive all subsequent claims as the referring contracted HF.

MASTER COPY Date: 3/26/24 DC:

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

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

MASTER COPY
DC: ___ Date: 3/22/24

	Certified correct by:
	(Printed name and signature) Z Benefits Coordinator, Referring Contracted HF
	Date signed (mm/dd/yyyy)

Acknowledged by:	Acknowledged by:
(Printed name and signature) BAS Head or Authorized Signatory, PhilHealth Regional Office _____ In-charge of the Referring Contracted HF (To provide a copy to the referring Contracted HF five working days upon receipt of the form; scanned copy is allowed)	(Printed name and signature) Head or Z Benefits Coordinator, Referral Contracted HF
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Annex J.1: Sample CF2 for Diagnostic Test or Prognostication

SAMPLE CLAIM FORM 2 FOR DIAGNOSTIC TEST OR PROGNOSTICATION

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 • Trunkline (02) 441-7444
www.philhealth.gov.ph
email: actioncenter@philhealth.gov.ph

CF-2
(Claim Form 2)
Revised September 2018

Series #

IMPORTANT REMINDERS:
PLEASE WRITE IN CAPITAL **LETTERS** AND **CHECK** THE APPROPRIATE BOXES.
This form together with other supporting documents should be filed within sixty (60) calendar days from date of discharge.
All information, fields and tick boxes required in this form are necessary. Claim forms with incomplete information shall not be processed.
FALSE/INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CRIMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.

PART I - HEALTH CARE INSTITUTION (HCI) INFORMATION

1. PhilHealth Accreditation Number (PAN) of Health Care Institution: H 9 3 0 0 X X X X
2. Name of Health Care Institution: ABCDF Medical Center
3. Address: SHAW BLVD (Building Number and Street Name) | PASIG CITY (City/Municipality) | (Province)

PART II - PATIENT CONFINEMENT INFORMATION

1. Name of Patient: DELA CRUZ (Last Name) | JUANA (First Name) | (Name Extension (JR/SR/III)) | MAPAGPALA (Middle Name (ex. DELACRUZ JUAN JR SIPAG))

2. Was patient referred by another Health Care Institution (HCI)?
☑ NO ☐ YES
Name of referring Health Care Institution | Building Number and Street Name | City/Municipality | Province | Zip code

3. Confinement Period:
a. Date Admitted: 03 (month) - 30 (day) - 2024 (year) b. Time Admitted: (hour) : (min) ☐ AM ☐ PM
c. Date Discharge: 03 (month) - 30 (day) - 2024 (year) d. Time Discharge: (hour) : (min) ☐ AM ☐ PM

4. Patient Disposition: (select only 1)
☑ a. Improved
☐ b. Recovered
☐ c. Home/Discharged Against Medical Advise
☐ d. Absconded
☐ e. Expired (date) Time: (hour) : (min) ☐ AM ☐ PM
☐ f. Transferred/Referred
Name of Referral Health Care Institution | Building Number and Street Name | City/Municipality | Province | Zip code
Reason/s for referral/transfer:

OUTPATIENT

5. Type of Accomodation: ☐ Private ☐ Non-Private (Charity/Service)

6. Admission Diagnosis/es: Breast Cancer

7. Discharge Diagnosis/es (Use additional CF2 if necessary):

	Diagnosis	ICD-10 Code/s	Related Procedure/s (if there's any)	RVS Code	Date of Procedure	Laterality (check applicable box)
a.	Breast Cancer		i.			☐ left ☐ right ☐ both
			ii.			☐ left ☐ right ☐ both
			iii.			☐ left ☐ right ☐ both
b.			i.			☐ left ☐ right ☐ both
			ii.			☐ left ☐ right ☐ both
			iii.			☐ left ☐ right ☐ both

MASTER COPY Date: 3/30/24

8. Special Considerations:
a. For the following repetitive procedures, check box that applies and enumerate the procedure/sessions dates (mm-dd-yyyy). For chemotherapy, see guidelines.
☐ Hemodialysis ☐ Peritoneal Dialysis ☐ Radiotherapy (LINAC) ☐ Radiotherapy (COBALT)
☐ Blood Transfusion ☐ Brachytherapy ☐ Chemotherapy ☐ Simple Debridement
b. For Z-Benefit Package: **Z-Benefit Package Code:** Z021A1
c. For MCP Package (enumerate four dates (mm-dd-year) of pre-natal check-ups)
1 2 3 4
d. For TB DOTS Package ☐ Intensive Phase ☐ Maintenance Phase
e. For Animal Bite Package (write the dates (mm-dd-year) when the following doses of vaccine were given) **Note: Anti Rabies Vaccine (ARV), Rabies Immunoglobulin (RIG)**
Day 0 ARV **Day 3 ARV** **Day 7 ARV** **RIG** **Others (Specify)**
f. For Newborn Care Package ☐ Essential Newborn Care ☐ Newborn Hearing Screening Test ☐ Newborn Screening Test
For Newborn Screening, *please attach NBS Filter Sticker here*
For Essential Newborn Care (check applicable boxes)
☐ Immediate drying of newborn ☐ Timely cord clamping ☐ Weighing of the newborn ☐ BCG vaccination ☐ Hepatitis B vaccination
☐ Early skin-to-skin contact ☐ Eye Prophylaxis ☐ Vitamin K administration ☐ Non-separation of mother/baby for early breastfeeding initiation
g. For Outpatient HIV/AIDS Treatment Package **Laboratory Number:**

9. PhilHealth Benefits:
ICD 10 or RVS Code: a. First Case Rate b. Second Case Rate

Indicate the date of the procedure was done

Write OUTPATIENT in lieu of time admitted & discharged

Tick YES if the patient was referred by another HF

This is not required as diagnostic or prognostication is provided an out-patient setting

Tick the box for the laterality

Indicate the diagnosis

Indicate the appropriate "benefit package code"

This is not required

10. Accreditation Number/Name of Accredited Health Care Professional/Date Signed and Professional Fees/Charges
(Use additional CF2 if necessary):

Accreditation number/Name of Accredited Health Care Professional/Date Signed	Details
Accreditation No.: 1 2 3 4 - 5 6 7 8 9 0 1 - 2 (sgd) MARY DELA ROSAS, MD Signature Over Printed Name Date Signed: month / day / year	☑ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____
Accreditation No.: _____ Signature Over Printed Name Date Signed: month / day / year	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____
Accreditation No.: _____ Signature Over Printed Name Date Signed: month / day / year	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____

Tick this box if patient paid no additional Professional fee

Tick this box if patient paid an additional Professional fee

PART III - CERTIFICATION OF CONSUMPTION OF BENEFITS AND CONSENT TO ACCESS PATIENT RECORD/S

NOTE: Member/Patient should sign only after the applicable charges have been filled out

A. CERTIFICATION OF CONSUMPTION OF BENEFITS:

☑ PhilHealth benefit is enough to cover HCI and PF Charges.
No purchase of drugs/medicines, supplies, diagnostics, and co-pay for professional fees by the member/patient.

	Total Actual Charges*
Total Health Care Institution Fees	3,500.00
Total Professional Fees	
Grand Total	3,500.00

☐ ~~The benefit of the member/patient was completely consumed prior to co-pay OR~~ the benefit of the member/patient is not completely consumed BUT with purchases/expenses for drugs/medicines, supplies, diagnostics and others.

a.) The total co-pay for the following are:

	Total Actual Charges*	Amount after Application of Discount (i.e., personal discount, Senior Citizen/PWD)	PhilHealth Benefit	Amount after PhilHealth Deduction
Total Health Care Institution Fees	3,500.00		3,500.00	Amount P 0.00 Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☑ Others (i.e., PCSO, Promissory note, etc.)
Total Professional Fees (for accredited and non-accredited professionals)				Amount P _____ Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☐ Others (i.e., PCSO, Promissory note, etc.)

b.) Purchases/Expenses **NOT** included in the Health Care Institution Charges

Total cost of purchase/s for drugs/medicines and/or medical supplies bought by the patient/member within/outside the HCI during confinement	☐ None ☐ Total Amount P _____
Total cost of diagnostic/laboratory examinations paid by the patient/member done within/outside the HCI during confinement	☐ None ☐ Total Amount P _____

* **NOTE:** Total Actual Charges should be based on Statement of Account (SOA)

Tick this box if patient has No co-payment

Tick this box if patient has a co-payment

Indicate the amount if the patient has co-payment, as applicable

B. CONSENT TO ACCESS PATIENT RECORD/S:

I hereby consent to the submission and examination of the patient's pertinent medical records for the purpose of verifying the veracity of this claim to effect efficient processing of benefit payment.
I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all legal liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim for reimbursement before PhilHealth.

JUANA MAPAGPALA DELA CRUZ
Signature Over Printed Name of Member/Patient/Authorized Representative

Date Signed: 0 3 (month) - 3 0 (day) - 2 0 2 4 (year)

If patient/representative is unable to write, put right thumbmark. Patient/Representative should be assisted by an HCI representative.

MASTER COPY
Date: 3/22/24

Relationship of the representative to the member/patient: ☐ Spouse ☐ Child ☐ Parent ☐ Sibling ☐ Others, Specify _____

Reason for signing on behalf of the member/patient: ☐ Patient is Incapacitated ☐ Other Reasons _____

☐ Patient ☐ Representative

Affix signature of the patient/parent /authorized representative

Indicate date signed

PART IV - CERTIFICATION OF CONSUMPTION OF HEALTH CARE INSTITUTION

I certify that services rendered were recorded in the patient's chart and health care institution records and that the herein information given are true and correct.

CARDING DELOS REYES — Signature Over Printed Name of Authorized HCI Representative
RECORDS OFFICER — Official Capacity/Designation
Date Signed: 0 4 (month) - 0 1 (day) - 2 0 2 4 (year)

Affix signature of HF representative

SAMPLE CLAIM FORM 2 FOR BREAST CANCER (SURGERY)

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email: actioncenter@philhealth.gov.ph

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(Claim Form 2)
Revised September 2018

Series #

IMPORTANT REMINDERS:
PLEASE WRITE IN CAPITAL **LETTERS** AND **CHECK** THE APPROPRIATE BOXES.
This form together with other supporting documents should be filed within sixty (60) calendar days from date of discharge.
All information, fields and tick boxes required in this form are necessary. Claim forms with incomplete information shall not be processed.
FALSE/INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CRIMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.

PART I - HEALTH CARE INSTITUTION (HCI) INFORMATION

1. PhilHealth Accreditation Number (PAN) of Health Care Institution: H 9 3 0 0 X X X X
2. Name of Health Care Institution: ABCDF Medical Center
3. Address: SHAW BLVD (Building Number and Street Name) | PASIG CITY (City/Municipality) | (Province)

PART II - PATIENT CONFINEMENT INFORMATION

1. Name of Patient: DELA CRUZ (Last Name) | JUANA (First Name) | (Name Extension JR/SR/III) | MAGTBAY (Middle Name; ex: DELACRUZ JUANJRSPAG)

2. Was patient referred by another Health Care Institution (HCI)?
☑ NO ☐ YES
Name of referring Health Care Institution | Building Number and Street Name | City/Municipality | Province | Zip code

3. Confinement Period:
a. Date Admitted: 03 (month) 30 (day) 2024 (year) b. Time Admitted: 09 (hour) 20 (min) ☑ AM ☐ PM
c. Date Discharge: 04 (month) 09 (day) 2024 (year) d. Time Discharge: 12 (hour) 20 (min) ☐ AM ☑ PM

4. Patient Disposition: (select only 1)
☑ a. Improved
☐ b. Recovered
☐ c. Home/Discharged Against Medical Advise
☐ d. Absconded
☐ e. Expired — Date: (month) (day) (year) Time: (hour) (min) ☐ AM ☐ PM
☐ f. Transferred/Referred — Name of Referral Health Care Institution; Building Number and Street Name; City/Municipality; Province; Zip code
Reason/s for referral/transfer:

5. Type of Accomodation: ☐ Private ☐ Non-Private (Charity/Service)

6. Admission Diagnosis/es: Breast Cancer

7. Discharge Diagnosis/es (Use additional CF2 if necessary)

	Diagnosis	ICD-10 Code/s	Related Procedure/s (if there's any)	RVS Code	Date of Procedure	Laterality (check applicable box)
a.	Breast Cancer					☑ left ☐ right ☐ both
						☐ left ☐ right ☐ both
						☐ left ☐ right ☐ both
b.						☐ left ☐ right ☐ both
						☐ left ☐ right ☐ both
						☐ left ☐ right ☐ both

MASTER COPY Date: 3/22/24

8. Special Considerations:
a. For the following repetitive procedures, check box that applies and enumerate the procedure/sessions dates (mm-dd-yyyy). For chemotherapy, see guidelines.
☐ Hemodialysis ☐ Blood Transfusion
☐ Peritoneal Dialysis ☐ Brachytherapy
☐ Radiotherapy (LINAC) ☐ Chemotherapy
☐ Radiotherapy (COBALT) ☐ Simple Debridement
b. For Z-Benefit Package — **Z-Benefit Package Code:** Z021F1
c. For MCP Package (enumerate four dates (mm-dd-year) of pre-natal check-ups)
1 ____ 2 ____ 3 ____ 4 ____
d. For TB DOTS Package ☐ Intensive Phase ☐ Maintenance Phase
e. For Animal Bite Package (write the dates (mm-dd-year) when the following doses of vaccine were given) **Note: Anti Rabies Vaccine (ARV), Rabies Immunoglobulin (RIG)**
Day 0 ARV ____ **Day 3 ARV** ____ **Day 7 ARV** ____ **RIG** ____ **Others (Specify)** ____
f. For Newborn Care Package ☐ Essential Newborn Care ☐ Newborn Hearing Screening Test ☐ Newborn Screening Test
For Newborn Screening, *please attach NBS Filter Sticker here*
For Essential Newborn Care (check applicable boxes)
☐ Immediate drying of newborn ☐ Timely cord clamping ☐ Weighing of the newborn ☐ BCG vaccination ☐ Hepatitis B vaccination
☐ Early skin-to-skin contact ☐ Eye Prophylaxis ☐ Vitamin K administration ☐ Non-separation of mother/baby for early breastfeeding initiation
g. For Outpatient HIV/AIDS Treatment Package — **Laboratory Number:** ____

9. PhilHealth Benefits:
ICD 10 or RVS Code: a. First Case Rate ____ Second Case Rate ____

Indicate the date of admission and discharge

Indicate the time of admission and time of discharge

Tick YES if the patient was referred by another HF

Indicate the type of accommodation

Tick the box for the laterality

Indicate the diagnosis

Indicate the appropriate code for surgery (neo-adjuvant or adjuvant), "as indicated in the Z benefit package code"

This is not required

10. Accreditation Number/Name of Accredited Health Care Professional/Date Signed and Professional Fees/Charges
(Use additional CF3 if necessary)

Accreditation number/Name of Accredited Health Care Professional/Date Signed	Details
Accreditation No.: 1 2 3 4 - 5 6 7 8 9 0 1 - 2 (sgd) MARY DELA ROSAS, MD Signature Over Printed Name Date Signed: month day year	☑ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P
Accreditation No.: Signature Over Printed Name Date Signed: month day year	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P
Accreditation No.: Signature Over Printed Name Date Signed: month day year	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P

Tick this box if patient paid no additional Professional fee

Tick this box if patient paid an additional Professional fee

PART III - CERTIFICATION OF CONSUMPTION OF BENEFITS AND CONSENT TO ACCESS PATIENT RECORD/S

NOTE: Member/Patient should sign only after the applicable boxes have been filled out.

A. CERTIFICATION OF CONSUMPTION OF BENEFITS:

☑ PhilHealth benefit is enough to cover HCI and PF Charges.
No purchase of drugs/medicines, supplies, diagnostics, and co-pay for professional fees by the member/patient.

	Total Actual Charges*
Total Health Care Institution Fees	100,000.00
Total Professional Fees	
Grand Total	100,000.00

☐ The benefit of the member/patient was completely consumed prior to co-pay OR the benefit of the member/patient is not completely consumed BUT with purchases/expenses for drugs/medicines, supplies, diagnostics and others.

a.) The total co-pay for the following are:

	Total Actual Charges*	Amount after Application of Discount (i.e., personal discount, Senior Citizen/PWD)	PhilHealth Benefit	Amount after PhilHealth Deduction
Total Health Care Institution Fees	100,000.00		100,000.00	Amount P 0.00 Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☑ Others (i.e., PCSO, Promissory note, etc.)
Total Professional Fees (for accredited and non-accredited professionals)				Amount P Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☐ Others (i.e., PCSO, Promissory note, etc.)

b.) Purchases/Expenses **NOT** included in the Health Care Institution Charges

Total cost of purchase/s for drugs/medicines and/or medical supplies bought by the patient/member within/outside the HCI during confinement	☐ None ☐ Total Amount P
Total cost of diagnostic/laboratory examinations paid by the patient/member done within/outside the HCI during confinement	☐ None ☐ Total Amount P

*** NOTE:** Total Actual Charges should be based on Statement of Account (SOA)

Tick this box if patient has NO co-payment

Tick this box if patient has a co-payment

Patients admitted in basic or ward accommodation shall not be charged co-payment. Otherwise, indicate the amount if the patient has co-payment, as applicable

B. CONSENT TO ACCESS PATIENT RECORD/S:

I hereby consent to the submission and examination of the patient's pertinent medical records for the purpose of verifying the veracity of this claim to effect efficient processing of benefit payment.
I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all legal liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim for reimbursement before PhilHealth.

JUANA MAGTIBAY DELA CRUZ
Signature Over Printed Name of Member/Patient/Authorized Representative

Date Signed: 0 4 - 0 9 - 2 0 2 4 (month - day - year)

Relationship of the representative to the member/patient: ☐ Spouse ☐ Child ☐ Parent ☐ Sibling ☐ Others, Specify

Reason for signing on behalf of the member/patient: ☐ Patient is Incapacitated ☐ Other Reasons

If patient/representative is unable to write, put right thumbmark. Patient/ Representative should be assisted by an HCI representative.

☐ Patient ☐ Representative

MASTER COPY

Affix signature of the patient/parent /authorized representative

Indicate date signed

PART IV - CERTIFICATION OF CONSUMPTION OF HEALTH CARE INSTITUTION

I certify that services rendered were recorded in the patient's chart and health care institution records and that the herein information given are true and correct.

CARDING DELOS REYES
Signature Over Printed Name of Authorized HCI Representative

RECORDS OFFICER
Official Capacity/Designation

Date Signed: 0 4 - 1 0 - 2 0 2 4 (month - day - year)

Affix signature of HF representative

SAMPLE CLAIM FORM 2 FOR CHEMOTHERAPY

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre 709 Shaw Boulevard, Pasig City
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FALSE/INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CRIMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.

PART I - HEALTH CARE INSTITUTION (HCI) INFORMATION

1. PhilHealth Accreditation Number (PAN) of Health Care Institution: H 9 3 0 0 X X X X
2. Name of Health Care Institution: ABCDF Medical Center
3. Address: SHAW BLVD (Building Number and Street Name) PASIG CITY (City/Municipality) (Province)

PART II - PATIENT CONFINEMENT INFORMATION

1. Name of Patient: DELA CRUZ (Last Name) JUANA (First Name) (Name Extension (JR/SR/II)) MAPAGPALA (Middle Name (ex: DELA CRUZ JUAN JR SIPAG))

2. Was patient referred by another Health Care Institution (HCI)?
☑ NO ☐ YES
Name of referring Health Care Institution | Building Number and Street Name | City/Municipality | Province | Zip code

3. Confinement Period:
a. Date Admitted: 03 (month) 30 (day) 2024 (year) b. Time Admitted: (hour) (min) ☐ AM ☐ PM
c. Date Discharge: 07 (month) 30 (day) 2024 (year) d. Time Discharge: OUTPATIENT ☐ AM ☐ PM

4. Patient Disposition: (select only 1)
☑ a. Improved
☐ b. Recovered
☐ c. Home/Discharged Against Medical Advise
☐ d. Absconded
☐ e. Expired (month/day/year) Time: (hour/min) ☐ AM ☐ PM
☐ f. Transferred/Referred
Name of Referral Health Care Institution | Building Number and Street Name | City/Municipality | Province | Zip code
Reason/s for referral/transfer:

5. Type of Accomodation: ☐ Private ☐ Non-Private (Charity/Service)

6. Admission Diagnosis/es: Breast Cancer

7. Discharge Diagnosis/es (Use additional CF2 if necessary):

Diagnosis	ICD-10 Code/s	Related Procedure/s (if there's any)	RVS Code	Date of Procedure	Laterality (check applicable box)
a. Breast Cancer		i.			left ☐ right ☑ both ☐
		ii.			left ☐ right ☐ both ☐
		iii.			left ☐ right ☐ both ☐
b.		i.			left ☐ right ☐ both ☐
		ii.			left ☐ right ☐ both ☐
		iii.			left ☐ right ☐ both ☐

8. Special Considerations:
a. For the following repetitive procedures, check box that apply and enumerate the procedure/sessions dates (mm-dd-yyyy). For chemotherapy, see guidelines.
☐ Hemodialysis ☐ Peritoneal Dialysis ☐ Radiotherapy (LINAC) ☐ Radiotherapy (COBALT)
☐ Blood Transfusion ☐ Brachytherapy ☑ Chemotherapy ☐ Simple Debridement
b. For Z-Benefit Package — **Z-Benefit Package Code:** Z021M11, Z021M12
c. For MCP Package (enumerate four dates [mm-dd-year] of pre-natal check-ups)
1 2 3 4
d. For TB DOTS Package ☐ Intensive Phase ☐ Maintenance Phase
e. For Animal Bite Package (write the dates [mm-dd-year] when the following doses of vaccine were given) **Note: Anti Rabies Vaccine (ARV), Rabies Immunoglobulin (RIG)**
Day 0 ARV **Day 3 ARV** **Day 7 ARV** **RIG** **Others (Specify)**
f. For Newborn Care Package ☐ Essential Newborn Care ☐ Newborn Hearing Screening Test ☐ Newborn Screening Test
For Newborn Screening, *please attach NBS Filter Sticker here*
For Essential Newborn Care (check applicable boxes)
☐ Immediate drying of newborn ☐ Timely cord clamping ☐ Weighing of the newborn ☐ BCG vaccination ☐ Hepatitis B vaccination
☐ Early skin-to-skin contact ☐ Eye Prophylaxis ☐ Vitamin K administration ☐ Non-separation of mother/baby for early breastfeeding initiation
g. For Outpatient HIV/AIDS Treatment Package **Laboratory Number:**

9. PhilHealth Benefits:
ICD 10 or RVS Code: a. First Case Rate b. Second Case Rate

Date: 3/29/24

Date of the initial chemotherapy session

Date of the end cycle or in case of lost to follow-up or death, indicate the last cycle given to the patient

Write OUTPATIENT in lieu of time admitted & discharged

Tick YES if the patient was referred by another HF

This is not required, as treatment provided is an out-patient setting

Tick the box for the laterality

Indicate the diagnosis

Indicate the appropriate code for chemotherapy (neo-adjuvant or adjuvant), "The code may consist of two as indicated in the Z benefit package code"

This is not required

10. Accreditation Number/Name of Accredited Health Care Professional/Date Signed and Professional Fees/Charges
(Use additional CF2 if necessary):

Accreditation number/Name of Accredited Health Care Professional/Date Signed	Details
Accreditation No.: 1234-5678901-2 (sgd) MARY DELA ROSAS, MD Signature Over Printed Name Date Signed: month - day - year	☑ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P ______
Accreditation No.: ____ - ____ - __ Signature Over Printed Name Date Signed: month - day - year	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P ______
Accreditation No.: ____ - ____ - __ Signature Over Printed Name Date Signed: month - day - year	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P ______

Tick this box if patient paid no additional Professional fee

Tick this box if patient paid an additional Professional fee

PART III - CERTIFICATION OF CONSUMPTION OF BENEFITS AND CONSENT TO ACCESS PATIENT RECORD/S

NOTE: Member/Patient should sign only after the applicable charges have been filled out.

A. CERTIFICATION OF CONSUMPTION OF BENEFITS:

☑ PhilHealth benefit is enough to cover HCI and PF Charges.
No purchase of drugs/medicines, supplies, diagnostics, and co-pay for professional fees by the member/patient.

	Total Actual Charges*
Total Health Care Institution Fees	130,000.00
Total Professional Fees	
Grand Total	130,000.00

Tick this box if patient has NO co-payment

☐ The benefit of the member/patient was completely consumed prior to co-pay OR the benefit of the member/patient is not completely consumed BUT with purchases/expenses for drugs/medicines, supplies, diagnostics and others.

Tick this box if patient has a co-payment

a.) The total co-pay for the following are:

	Total Actual Charges*	Amount after Application of Discount (i.e., personal discount, Senior Citizen/PWD)	PhilHealth Benefit	Amount after PhilHealth Deduction
Total Health Care Institution Fees	130,000.00		122,000.00	Amount P 0.00 Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☑ Others (i.e., PCSO, Promissory note, etc.)
Total Professional Fees (for accredited and non-accredited professionals)				Amount P Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☐ Others (i.e., PCSO, Promissory note, etc.)

Indicate the amount if the patient has co-payment, as applicable

b.) Purchases/Expenses **NOT** included in the Health Care Institution Charges

Total cost of purchase/s for drugs/medicines and/or medical supplies bought by the patient/member within/outside the HCI during confinement	☐ None	☐ Total Amount P ______
Total cost of diagnostic/laboratory examinations paid by the patient/member done within/outside the HCI during confinement	☐ None	☐ Total Amount P ______

*** NOTE:** Total Actual Charges should be based on Statement of Account (SOA)

B. CONSENT TO ACCESS PATIENT RECORD/S:

I hereby consent to the submission and examination of the patient's pertinent medical records for the purpose of verifying the veracity of this claim to effect efficient processing of benefit payment.
I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all legal liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim for reimbursement before PhilHealth.

JUANA MAPAGPALA DELA CRUZ
Signature Over Printed Name of Member/Patient/Authorized Representative

Affix signature of the patient/parent /authorized representative

Date Signed: 07-30-2024 (month day year)

Indicate date signed

Relationship of the representative to the member/patient: ☐ Spouse ☐ Child ☐ Parent ☐ Sibling ☐ Others, Specify

Reason for signing on behalf of the member/patient: ☐ Patient is Incapacitated ☐ Other Reasons ______

If patient/representative is unable to write, put right thumbmark. Patient/Representative should be assisted by an HCI representative.
☐ Patient ☐ Representative

MASTER COPY Date: 3/22/24

PART IV - CERTIFICATION OF CONSUMPTION OF HEALTH CARE INSTITUTION

I certify that services rendered were recorded in the patient's chart and health care institution records and that the herein information given are true and correct.

CARDING DELOS REYES — Signature Over Printed Name of Authorized HCI Representative
RECORDS OFFICER — Official Capacity/Designation
Date Signed: 07-31-2024 (month day year)

Affix signature of HF representative

Annex J.4.1: Sample CF2 for Hormonotherapy Tranche 1

SAMPLE CLAIM FORM 2 FOR HORMONOTHERAPY TRANCHE 1

This form may be reproduced and is NOT FOR SALE

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 • Trunkline (02) 441-7444
www.philhealth.gov.ph
email: actioncenter@philhealth.gov.ph

CF-2
(Claim Form 2)
Revised September 2018

Series #

IMPORTANT REMINDERS:
PLEASE WRITE IN CAPITAL **LETTERS** AND **CHECK** THE APPROPRIATE BOXES.
This form together with other supporting documents should be filled within sixty (60) calendar days from date of discharge.
All information, fields and tick boxes required in this form are necessary. Claim forms with incomplete information shall not be processed.
FALSE/INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CRIMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.

PART I - HEALTH CARE INSTITUTION (HCI) INFORMATION

1. PhilHealth Accreditation Number (PAN) of Health Care Institution: H 9 3 0 0 X X X X
2. Name of Health Care Institution: ABCDF Medical Center
3. Address: SHAW BLVD (Building Number and Street Name) PASIG CITY (City/Municipality) (Province)

PART II - PATIENT CONFINEMENT INFORMATION

1. Name of Patient: DELA CRUZ (Last Name) JUANA (First Name) (Name Extension (JR/SR/III)) MAPAGPALA (Middle Name ex: DELA CRUZ JUAN JR SPMC)

2. Was patient referred by another Health Care Institution (HCI)?
☑ NO ☐ YES
Name of referring Health Care Institution | Building Number and Street Name | City/Municipality | Province | Zip code

3. Confinement Period:
a. Date Admitted: 03 (month) - 30 (day) - 2024 (year) b. Time Admitted: (hour) : (min) ☐ AM ☐ PM
c. Date Discharge: 09 (month) - 31 (day) - 2024 (year) d. Time Discharge: OUTPATIENT ☐ AM ☐ PM

4. Patient Disposition: (select only 1)
☑ a. Improved
☐ b. Recovered
☐ c. Home/Discharged Against Medical Advise
☐ d. Absconded
☐ e. Expired (month/day/year) Time: (hour : min) ☐ AM ☐ PM
☐ f. Transferred/Referred
Name of Referral Health Care Institution | Building Number and Street Name | City/Municipality | Province | Zip code
Reason/s for referral/transfer:

5. Type of Accomodation: ☐ Private ☐ Non-Private (Charity/Service)

6. Admission Diagnosis/es: Breast Cancer

7. Discharge Diagnosis/es (Use additional CF2 if necessary):

Diagnosis	ICD-10 Code/s	Related Procedure/s (if there's any)	RVS Code	Date of Procedure	Laterality (check applicable box)
a. Breast Cancer		i.			☑ left ☐ right ☐ both
		ii.			☐ left ☐ right ☐ both
		iii.			☐ left ☐ right ☐ both
b.		i.			☐ left ☐ right ☐ both
		ii.			☐ left ☐ right ☐ both
		iii.			☐ left ☐ right ☐ both

MASTER COPY Date: 3/22/24 DC: mp

8. Special Considerations:
a. For the following repetitive procedures, check box that applies and enumerate the procedure/sessions dates (mm-dd-yyyy). For chemotherapy, see guidelines.
☐ Hemodialysis ☐ Peritoneal Dialysis ☐ Radiotherapy (LINAC) ☐ Radiotherapy (COBALT)
☐ Blood Transfusion ☐ Brachytherapy ☐ Chemotherapy ☐ Simple Debridement
b. For Z-Benefit Package **Z-Benefit Package Code:** Z021K1
c. For MCP Package (enumerate four dates [mm-dd-year] of pre-natal check-ups)
1 2 3 4
d. For TB DOTS Package ☐ Intensive Phase ☐ Maintenance Phase
e. For Animal Bite Package (write the dates [mm-dd-year] when the following doses of vaccine were given) **Note: Anti Rabies Vaccine (ARV), Rabies Immunoglobulin (RIG)**
Day 0 ARV **Day 3 ARV** **Day 7 ARV** **RIG** **Others (Specify)**
f. For Newborn Care Package ☐ Essential Newborn Care ☐ Newborn Hearing Screening Test ☐ Newborn Screening Test
For Newborn Screening, *please attach NBS Filter Sticker here*
For Essential Newborn Care (check applicable boxes)
☐ Immediate drying of newborn ☐ Timely cord clamping ☐ Weighing of the newborn ☐ BCG vaccination ☐ Hepatitis B vaccination
☐ Early skin-to-skin contact ☐ Eye Prophylaxis ☐ Vitamin K administration ☐ Non-separation of mother/baby for early breastfeeding initiation
g. For Outpatient HIV/AIDS Treatment Package **Laboratory Number:**

9. PhilHealth Benefits:
ICD 10 or RVS Code: a. First Case Rate Second Case Rate

Date of the 1st month of prescription

Date of the 6th month of prescription or if lost to follow-up or death, indicate the last prescription given

Write OUTPATIENT in lieu of time admitted & discharged

Tick YES if the patient was referred by another HF

This is not required, as treatment provided is an out-patient setting

Tick the box for the laterality

Indicate the diagnosis

Indicate the appropriate code for hormonotherapy, as indicated in the Z benefit package code"

This is not required

10. Accreditation Number/Name of Accredited Health Care Professional/Date Signed and Professional Fees/Charges
(Use additional CF2 if necessary)

Accreditation number/Name of Accredited Health Care Professional/Date Signed	Details
Accreditation No.: 1 2 3 4 - 5 6 7 8 9 0 1 - 2 (sgd) MARY DELA ROSAS, MD Signature Over Printed Name Date Signed: month day year	☑ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____
Accreditation No.: _____ Signature Over Printed Name Date Signed: month day year	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____
Accreditation No.: _____ Signature Over Printed Name Date Signed: month day year	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____

Tick this box if patient paid no additional Professional fee

Tick this box if patient paid an additional Professional fee

PART III - CERTIFICATION OF CONSUMPTION OF BENEFITS AND CONSENT TO ACCESS PATIENT RECORD/S

NOTE: Member/Patient should sign only after the applicable charges have been filled out.

A. CERTIFICATION OF CONSUMPTION OF BENEFITS:

☑ PhilHealth benefit is enough to cover HCI and PF Charges.
No purchase of drugs/medicines, supplies, diagnostics, and co-pay for professional fees by the member/patient.

	Total Actual Charges*
Total Health Care Institution Fees	2,700.00
Total Professional Fees	
Grand Total	2,700.00

Tick this box if patient has NO co-payment

☐ ~~The benefit of the member/patient was completely consumed prior to co-pay OR~~ the benefit of the member/patient is not completely consumed BUT with purchases/expenses for drugs/medicines, supplies, diagnostics and others.

Tick this box if patient has a co-payment

a.) The total co-pay for the following are:

	Total Actual Charges*	Amount after Application of Discount (i.e., personal discount, Senior Citizen/PWD)	PhilHealth Benefit	Amount after PhilHealth Deduction
Total Health Care Institution Fees	2,700.00		2,700.00	Amount P 0.00 Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☑ Others (i.e., PCSO, Promissory note, etc.)
Total Professional Fees (for accredited and non-accredited professionals)				Amount P _____ Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☐ Others (i.e., PCSO, Promissory note, etc.)

Indicate the amount if the patient has co-payment, as applicable

b.) Purchases/Expenses **NOT** included in the Health Care Institution Charges

Total cost of purchase/s for drugs/medicines and/or medical supplies bought by the patient/member within/outside the HCI during confinement	☐ None ☐ Total Amount P _____
Total cost of diagnostic/laboratory examinations paid by the patient/member done within/outside the HCI during confinement	☐ None ☐ Total Amount P _____

*** NOTE:** Total Actual Charges should be based on Statement of Account (SOA)

B. CONSENT TO ACCESS PATIENT RECORD/S:

I hereby consent to the submission and examination of the patient's pertinent medical records for the purpose of verifying the veracity of this claim to effect efficient processing of benefit payment.
I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all legal liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim for reimbursement before PhilHealth.

JUANA MAPAGPALA DELA CRUZ
Signature Over Printed Name of Member/Patient/Authorized Representative

Affix signature of the patient/parent /authorized representative

Date Signed: 0 9 - 3 1 - 2 0 2 4 (month - day - year)

Indicate date signed

Relationship of the representative to the member/patient: ☐ Spouse ☐ Child ☐ Parent ☐ Sibling ☐ Others, Specify _____

Reason for signing on behalf of the member/patient: ☐ Patient is incapacitated ☐ Other Reasons _____

☐ Patient ☐ Representative

If patient/representative is unable to write, put right thumbmark. Patient/ representative should be assisted by an HCI representative.

PART IV - CERTIFICATION OF CONSUMPTION OF HEALTH CARE INSTITUTION

I certify that services rendered were recorded in the patient's chart and health care institution records and that the herein information given are true and correct.

CARDING DELOS REYES — Signature Over Printed Name of Authorized HCI Representative
RECORDS OFFICER — Official Capacity/Designation
Date Signed: 1 0 - 0 1 - 2 0 2 4 (month - day - year)

Affix signature of HF representative

Annex J.4.2: Sample CF2 for Hormonotherapy Tranche 2

SAMPLE CLAIM FORM 2 FOR HORMONOTHERAPY TRANCHE 2

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PhilHealth *Your Partner in Health*

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 • Trunkline (02) 441-7444
www.philhealth.gov.ph
email: actioncenter@philhealth.gov.ph

CF-2
(Claim Form 2)
Revised September 2018

Series #

IMPORTANT REMINDERS:
PLEASE WRITE IN CAPITAL **LETTERS** AND **CHECK** THE APPROPRIATE BOXES.
This form together with other supporting documents should be filed within sixty (60) calendar days from date of discharge.
All information, fields and trick boxes required in this form are necessary. Claim forms with incomplete information shall not be processed.
FALSE/INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CRIMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.

PART I - HEALTH CARE INSTITUTION (HCI) INFORMATION

1. PhilHealth Accreditation Number (PAN) of Health Care Institution: H 9 3 0 X X X X
2. Name of Health Care Institution: ABCDF Medical Center
3. Address: SHAW BLVD (Building Number and Street Name) PASIG CITY (City/Municipality) (Province)

PART II - PATIENT CONFINEMENT INFORMATION

1. Name of Patient: DELA CRUZ (Last Name) JUANA (First Name) (Name Extension (JR/SR/III)) MAPAGPALA (Middle Name (ex: DELACRUZ JUAN JR SPAG))

2. Was patient referred by another Health Care Institution (HCI)?
☑ NO ☐ YES
Name of referring Health Care Institution | Building Number and Street Name | City/Municipality | Province | Zip code

3. Confinement Period:
a. Date Admitted: 09 (month) 13 (day) 2024 (year) b. Time Admitted: (hour) : (min) ☐ AM ☐ PM
c. Date Discharge: 04 (month) 01 (day) 2025 (year) d. Time Discharge: OUTPATIENT ☐ AM ☐ PM

4. Patient Disposition: (select only 1)
☑ a. Improved
☐ b. Recovered
☐ c. Home/Discharged Against Medical Advise
☐ d. Absconded
☐ e. Expired (month/day/year) Time: (hour : min) ☐ AM ☐ PM
☐ f. Transferred/Referred: Name of Referral Health Care Institution | Building Number and Street Name | City/Municipality | Province | Zip code
Reason/s for referral/transfer:

5. Type of Accomodation: ☐ Private ☐ Non-Private (Charity/Service)

6. Admission Diagnosis/es: Breast Cancer

7. Discharge Diagnosis/es (Use additional CF2 if necessary):

Diagnosis	ICD-10 Code/s	Related Procedure/s (if there's any)	RVS Code	Date of Procedure	Laterality (check applicable box)
a. Breast Cancer		i.			☑ left ☐ right ☐ both
		ii.			☐ left ☐ right ☐ both
		iii.			☐ left ☐ right ☐ both
b.		i.			☐ left ☐ right ☐ both
		ii.			☐ left ☐ right ☐ both
		iii.			☐ left ☐ right ☐ both

MASTER COPY Date: 3/22/24

8. Special Considerations:
a. For the following repetitive procedures, check box that applies and enumerate the procedure/sessions dates (mm-dd-yyyy). For chemotherapy, see guidelines.
☐ Hemodialysis ☐ Blood Transfusion
☐ Peritoneal Dialysis ☐ Brachytherapy
☐ Radiotherapy (LINAC) ☐ Chemotherapy
☐ Radiotherapy (COBALT) ☐ Simple Debridement
b. For Z-Benefit Package **Z-Benefit Package Code:** Z021K2
c. For MCP Package (enumerate four dates [mm-dd-year] of pre-natal check-ups)
1 2 3 4
d. For TB DOTS Package ☐ Intensive Phase ☐ Maintenance Phase
e. For Animal Bite Package (write the dates [mm-dd-year] when the following doses of vaccine were given) **Note: Anti Rabies Vaccine (ARV), Rabies Immunoglobulin (RIG)**
Day 0 ARV **Day 3 ARV** **Day 7 ARV** **RIG** **Others (Specify)**
f. For Newborn Care Package ☐ Essential Newborn Care ☐ Newborn Hearing Screening Test ☐ Newborn Screening Test
For Newborn Screening, *please attach NBS Filter Strip here*
For Essential Newborn Care (check applicable boxes)
☐ Immediate drying of newborn ☐ Timely cord clamping ☐ Weighing of the newborn ☐ BCG vaccination ☐ Hepatitis B vaccination
☐ Early skin-to-skin contact ☐ Eye Prophylaxis ☐ Vitamin K administration ☐ Non-separation of mother/baby for early breastfeeding initiation
g. For Outpatient HIV/AIDS Treatment Package **Laboratory Number:**

9. PhilHealth Benefits:
ICD 10 or RVS Code: a. First Case Rate c. Second Case Rate

Date of the 7th month prescription

Date of the 12th month of prescription or if lost to follow-up or death, indicate the last prescription

Write OUTPATIENT in lieu of time admitted & discharged

Tick YES if the patient was referred by another HF

This is not required, as treatment provided is an out-patient setting

Tick the box for the laterality

Indicate the diagnosis

Indicate the appropriate code for hormonotherapy, as indicated in the Z benefit package code"

This is not required

10. Accreditation Number/Name of Accredited Health Care Professional/Date Signed and Professional Fees/Charges
(Use additional CF2 if necessary):

Accreditation number/Name of Accredited Health Care Professional/Date Signed	Details
Accreditation No.: 1 2 3 4 - 5 6 7 8 9 0 1 2 - [ ] (sgd) MARY DELA ROSAS, MD Signature Over Printed Name Date Signed: month day year	☑ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____
Accreditation No.: [ ] - [ ] Signature Over Printed Name Date Signed: month day year	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____
Accreditation No.: [ ] - [ ] Signature Over Printed Name Date Signed: month day year	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____

Tick this box if patient paid no additional Professional fee

Tick this box if patient paid an additional Professional fee

PART III - CERTIFICATION OF CONSUMPTION OF BENEFITS AND CONSENT TO ACCESS PATIENT RECORD/S

NOTE: Member/Patient should sign only after the applicable charges have been filled-out

A. CERTIFICATION OF CONSUMPTION OF BENEFITS:

☑ PhilHealth benefit is enough to cover HCI and PF Charges.
No purchase of drugs/medicines, supplies, diagnostics, and co-pay for professional fees by the member/patient.

	Total Actual Charges*
Total Health Care Institution Fees	2,700.00
Total Professional Fees	
Grand Total	2,700.00

Tick this box if patient has NO co-payment

☐ ~~The benefit of the member/patient was completely consumed prior to co-pay~~ OR the benefit of the member/patient is not completely consumed BUT with purchases/expenses for drugs/medicines, supplies, diagnostics and others.

Tick this box if patient has a co-payment

a.) The total co-pay for the following are:

	Total Actual Charges*	Amount after Application of Discount (i.e., personal discount, Senior Citizen/PWD)	PhilHealth Benefit	Amount after PhilHealth Deduction
Total Health Care Institution Fees	2,700.00		2,700.00	Amount P 0.00 Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☑ Others (i.e., PCSO, Promissory note, etc.)
Total Professional Fees (for accredited and non-accredited professionals)				Amount P _____ Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☐ Others (i.e., PCSO, Promissory note, etc.)

Indicate the amount if the patient has co-payment, as applicable.

b.) Purchases/Expenses **NOT** included in the Health Care Institution Charges

Total cost of purchase/s for drugs/medicines and/or medical supplies bought by the patient/member within/outside the HCI during confinement	☐ None ☐ Total Amount P _____
Total cost of diagnostic/laboratory examinations paid by the patient/member done within/outside the HCI during confinement	☐ None ☐ Total Amount P _____

*** NOTE:** Total Actual Charges should be based on Statement of Account (SOA)

B. CONSENT TO ACCESS PATIENT RECORD/S:

I hereby consent to the submission and examination of the patient's pertinent medical records for the purpose of verifying the veracity of this claim to effect efficient processing of benefit payment.
I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all legal liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim for reimbursement to/for PhilHealth.

JUANA MAPAGPALA DELA CRUZ
Signature Over Printed Name of Member/Patient/Authorized Representative

Affix signature of the patient/parent /authorized representative

Date Signed: 0 4 - 0 2 - 2 0 2 5
month day year

Indicate date signed

If patient/representative is unable to write, put right thumbmark. Patient/ Representative should be assisted by an HCI representative.

Relationship of the representative to the member/patient: ☐ Spouse ☐ Child ☐ Parent ☐ Sibling ☐ Others, Specify _____

Reason for signing on behalf of the member/patient: ☐ Patient is Incapacitated ☐ Other Reasons _____

☐ Patient ☐ Representative

MASTER COPY
Date 3/22/24
DC: 3rd

PART IV - CERTIFICATION OF CONSUMPTION OF HEALTH CARE INSTITUTION

I certify that services rendered were recorded in the patient's chart and health care institution records and that the herein information given are true and correct.

CARDING DELOS REYES
Signature Over Printed Name of Authorized HCI Representative

RECORDS OFFICER
Official Capacity/Designation

Date Signed: 0 4 - 0 3 - 2 0 2 5
month day year

Affix signature of HF representative

SAMPLE CLAIM FORM 2 FOR TARGETED THERAPY TRANCHE 1

PhilHealth
Your Partner in Health

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 • Trunkline (02) 441-7444
www.philhealth.gov.ph
email: actioncenter@philhealth.gov.ph

CF-2
(Claim Form 2)
Revised September 2018

Series #

IMPORTANT REMINDERS:
PLEASE WRITE IN CAPITAL **LETTERS** AND **CHECK** THE APPROPRIATE BOXES.
This form together with other supporting documents should be filled within sixty (60) calendar days from date of discharge.
All information, fields and tick boxes required in this form are necessary. Claim forms with incomplete information shall not be processed.
FALSE/INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CRIMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.

PART I - HEALTH CARE INSTITUTION (HCI) INFORMATION

1. PhilHealth Accreditation Number (PAN) of Health Care Institution: H 9 3 0 0 X X X X
2. Name of Health Care Institution: ABCDF Medical Center
3. Address: SHAW BLVD (Building Number and Street Name) | PASIG CITY (City/Municipality) | (Province)

PART II - PATIENT CONFINEMENT INFORMATION

1. Name of Patient: DELA CRUZ (Last Name) | JUANA (First Name) | (Name Extension (JR/SR/III)) | MAPAGPALA (Middle Name (ex: DELACRUZ JUAN JR SIPAG))

2. Was patient referred by another Health Care Institution (HCI)?
☑ NO ☐ YES
Name of referring Health Care Institution | Building Number and Street Name | City/Municipality | Province | Zip code

3. Confinement Period:
a. Date Admitted: 03 (month) 30 (day) 2024 (year) b. Time Admitted: (hour) : (min) ☐ AM ☐ PM
c. Date Discharge: 06 (month) 31 (day) 2024 (year) d. Time Discharge: OUTPATIENT ☐ AM ☐ PM

4. Patient Disposition: (select only 1)
☑ a. Improved
☐ b. Recovered
☐ c. Home/Discharged Against Medical Advise
☐ d. Absconded
☐ e. Expired (month/day/year) Time: (hour) : (min) ☐ AM ☐ PM
☐ f. Transferred/Referred
Name of Referral Health Care Institution
Building Number and Street Name | City/Municipality | Province | Zip code
Reason/s for referral/transfer:

5. Type of Accomodation: ☐ Private ☐ Non-Private (Charity/Service)

6. Admission Diagnosis/es: Breast Cancer

7. Discharge Diagnosis/es (Use additional CF2 if necessary):

Diagnosis	ICD-10 Code/s	Related Procedure/s (if there's any)	RVS Code	Date of Procedure	Laterality (check applicable box)
a. Breast Cancer		i.			☐ left ☑ right ☐ both
		ii.			☐ left ☐ right ☐ both
		iii.			☐ left ☐ right ☐ both
b.		i.			☐ left ☐ right ☐ both
		ii.			☐ left ☐ right ☐ both
		iii.			☐ left ☐ right ☐ both

MASTER COPY Date: 3/30/24 DO

8. Special Considerations:
a. For the following repetitive procedures, check box that applies and enumerate the procedure/sessions dates (mm-dd-yyyy). For chemotherapy, see guidelines.
☐ Hemodialysis ☐ Blood Transfusion
☐ Peritoneal Dialysis ☐ Brachytherapy
☐ Radiotherapy (LINAC) ☐ Chemotherapy
☐ Radiotherapy (COBALT) ☐ Simple Debridement
b. For Z-Benefit Package **Z-Benefit Package Code:** Z021P1
c. For MCP Package (enumerate four dates (mm-dd-year) of pre-natal check-ups)
1 ____ 2 ____ 3 ____ 4 ____
d. For TB DOTS Package ☐ Intensive Phase ☐ Maintenance Phase
e. For Animal Bite Package (write the dates (mm-dd-year) when the following doses of vaccine were given) **Note: Anti Rabies Vaccine (ARV), Rabies Immunoglobulin (RIG)**
Day 0 ARV ____ **Day 3 ARV** ____ **Day 7 ARV** ____ **RIG** ____ **Others (Specify)** ____
f. For Newborn Care Package ☐ Essential Newborn Care ☐ Newborn Hearing Screening Test ☐ Newborn Screening Test
For Newborn Screening, *please attach NBS Filter Sticker here*
For Essential Newborn Care (check applicable boxes)
☐ Immediate drying of newborn ☐ Timely cord clamping ☐ Weighing of the newborn ☐ BCG vaccination ☐ Hepatitis B vaccination
☐ Early skin-to-skin contact ☐ Eye Prophylaxis ☐ Vitamin K administration ☐ Non-separation of mother/baby for early breastfeeding initiation
g. For Outpatient HIV/AIDS Treatment Package **Laboratory Number:** ____

9. PhilHealth Benefits:
ICD 10 or RVS Code: a. First Case Rate ____ b. Second Case Rate ____

Date of the 1st cycle

Date of the 6th cycle or if lost to follow-up or death, indicate the last cycle provided.

Write OUTPATIENT in lieu of time admitted & discharged

Tick YES if the patient was referred by another HF

This is not required as treatment provided is an out-patient setting

Tick the box for the laterality

Indicate the diagnosis

Indicate the appropriate code for Targeted Therapy, as indicated in the Z benefit package code"

This is not required

10. Accreditation Number/Name of Accredited Health Care Professional/Date Signed and Professional Fees/Charges
(Use additional CF2 if necessary):

Accreditation number/Name of Accredited Health Care Professional/Date Signed	Details
Accreditation No.: 1 2 3 4 - 5 6 7 8 9 0 1 - 2 (sgd) MARY DELA ROSAS, MD Signature Over Printed Name Date Signed: month / day / year	☑ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____
Accreditation No.: Signature Over Printed Name Date Signed: month / day / year	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____
Accreditation No.: Signature Over Printed Name Date Signed: month / day / year	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____

Tick this box if patient paid no additional Professional fee

Tick this box if patient paid an additional Professional fee

PART III - CERTIFICATION OF CONSUMPTION OF BENEFITS AND CONSENT TO ACCESS PATIENT RECORD/S

NOTE: Member/Patient should sign only after the applicable charges have been filled out.

A. CERTIFICATION OF CONSUMPTION OF BENEFITS:

☑ PhilHealth benefit is enough to cover HCI and PF Charges.
No purchase of drugs/medicines, supplies, diagnostics, and co-pay for professional fees by the member/patient.

	Total Actual Charges*
Total Health Care Institution Fees	290,000.00
Total Professional Fees	
Grand Total	290,000.00

Tick this box if patient has NO co-payment

☐ ~~The benefit of the member/patient was completely consumed prior to pay~~ The benefit of the member/patient is not completely consumed BUT with purchases/expenses for drugs/medicines, supplies, diagnostics and others.

Tick this box if patient has a co-payment

a.) The total co-pay for the following are:

	Total Actual Charges*	Amount after Application of Discount (i.e., personal discount, Senior Citizen/PWD)	PhilHealth Benefit	Amount after PhilHealth Deduction
Total Health Care Institution Fees	290,000.0		290,000.00	Amount P 0.00 Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☑ Others (i.e., PCSO, Promissory note, etc.)
Total Professional Fees (for accredited and non-accredited professionals)				Amount P _____ Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☐ Others (i.e., PCSO, Promissory note, etc.)

Co-payment for the targeted therapy is not allowed. The actual amount reflected in the SOA or its equivalent is the bases of payment of PhilHealth that shall not exceed the amount per tranche or per cycle

b.) Purchases/Expenses **NOT** included in the Health Care Institution Charges

Total cost of purchase/s for drugs/medicines and/or medical supplies bought by the patient/member within/outside the HCI during confinement	☐ None ☐ Total Amount P _____
Total cost of diagnostic/laboratory examinations paid by the patient/member done within/outside the HCI during confinement	☐ None ☐ Total Amount P _____

* **NOTE:** Total Actual Charges should be based on Statement of Account (SOA)

B. CONSENT TO ACCESS PATIENT RECORD/S:

I hereby consent to the submission and examination of the patient's pertinent medical records for the purpose of verifying the veracity of this claim to effect efficient processing of benefit payment.
I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all legal liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim for reimbursement before PhilHealth.

JUANA MAPAGPALA DELA CRUZ
Signature Over Printed Name of Member/Patient/Authorized Representative

Affix signature of the patient/parent /authorized representative

Date Signed: 0 6 - 3 1 - 2 0 2 4 (month / day / year)

Indicate date signed

If patient/representative is unable to write, put right thumbmark. Patient/ Representative should be assisted by an HCI representative.

Relationship of the representative to the member/patient: ☐ Spouse ☐ Child ☐ Parent ☐ Sibling ☐ Others, Specify

Reason for signing on behalf of the member/patient: ☐ Patient is incapacitated ☐ Other Reasons

☐ Patient ☐ Representative

MASTER COPY
Date: 12/22
DC

PART IV - CERTIFICATION OF CONSUMPTION OF HEALTH CARE INSTITUTION

I certify that services rendered were recorded in the patient's chart and health care institution records and that the herein information given are true and correct.

CARDING DELOS REYES — Signature Over Printed Name of Authorized HCI Representative
RECORDS OFFICER — Official Capacity/Designation
Date Signed: 0 7 - 0 1 - 2 0 2 4 (month / day / year)

Affix signature of HF representative

SAMPLE CLAIM FORM 2 FOR TARGETED THERAPY

PhilHealth
Your Partner in Health

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 • Trunkline (02) 441-7444
www.philhealth.gov.ph
email: actioncenter@philhealth.gov.ph

CF-2
(Claim Form 2)
Revised September 2018

Series #

IMPORTANT REMINDERS:
PLEASE WRITE IN CAPITAL **LETTERS** AND **CHECK** THE APPROPRIATE BOXES.
This form together with other supporting documents should be filed within sixty (60) calendar days from date of discharge.
All information, fields and trick boxes required in this form are necessary. Claim forms with incomplete information shall not be processed.
FALSE/INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CRIMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.

PART I - HEALTH CARE INSTITUTION (HCI) INFORMATION

1. PhilHealth Accreditation Number (PAN) of Health Care Institution: H 9 3 0 0 X X X X

2. Name of Health Care Institution: ABCDF Medical Center

3. Address: SHAW BLVD (Building Number and Street Name) | PASIG CITY (City/Municipality) | (Province)

PART II - PATIENT CONFINEMENT INFORMATION

1. Name of Patient: DELA CRUZ (Last Name) | JUANA (First Name) | (Name Extension (JR/SR/III)) | MAPAGPALA (Middle Name (ex: DELACRUZ JUAN JR SPNS))

2. Was patient referred by another Health Care Institution (HCI)?
☑ NO ☐ YES
Name of referring Health Care Institution | Building Number and Street Name | City/Municipality | Province | Zip code

3. Confinement Period:
a. Date Admitted: 06 (month) 31 (day) 2024 (year) | b. Time Admitted: (hour) (min) ☐ AM ☐ PM
c. Date Discharge: 10 (month) 31 (day) 2024 (year) | d. Time Discharge: (hour) (min) ☐ AM ☐ PM

OUTPATIENT

4. Patient Disposition: (select only 1)
☑ a. Improved
☐ b. Recovered
☐ c. Home/Discharged Against Medical Advice
☐ d. Absconded
☐ e. Expired (month) (day) (year) Time: (hour) (min) ☐ AM ☐ PM
☐ f. Transferred/Referred — Name of Referral Health Care Institution | Building Number and Street Name | City/Municipality | Province | Zip code
Reason/s for referral/transfer:

5. Type of Accomodation: ☐ Private ☐ Non-Private (Charity/Service)

6. Admission Diagnosis/es:
Breast Cancer

7. Discharge Diagnosis/es (Use additional CF2 if necessary):

	Diagnosis	ICD-10 Code/s	Related Procedure/s (if there's any)	RVS Code	Date of Procedure	Laterality (check applicable box)
a.	Breast Cancer	C50.9	Mastectomy	85.41	June 31, 2024	☐ left ☑ right ☐ both
b.						☐ left ☐ right ☐ both
						☐ left ☐ right ☐ both
						☐ left ☐ right ☐ both
						☐ left ☐ right ☐ both
						☐ left ☐ right ☐ both

8. Special Considerations:
a. For the following repetitive procedures, check box that applies and enumerate the procedure/sessions dates (mm-dd-yyyy). For Chemotherapy, see guidelines.
☐ Hemodialysis ☐ Peritoneal Dialysis ☐ Radiotherapy (LINAC) ☐ Radiotherapy (COBALT)
☐ Blood Transfusion ☐ Brachytherapy ☐ Chemotherapy ☐ Simple Debridement
b. For Z-Benefit Package — **Z-Benefit Package Code:** Z021P2
c. For MCP Package (enumerate four dates (mm-dd-year) of pre-natal check-ups)
1 ____ 2 ____ 3 ____ 4 ____
d. For TB DOTS Package ☐ Intensive Phase ☐ Maintenance Phase
e. For Animal Bite Package (write the dates (mm-dd-year) when the following doses of vaccine were given) — **Note: Anti Rabies Vaccine (ARV), Rabies Immunoglobulin (RIG)**
Day 0 ARV ____ **Day 3 ARV** ____ **Day 7 ARV** ____ **RIG** ____ **Others (Specify)** ____
f. For Newborn Care Package ☐ Essential Newborn Care ☐ Newborn Hearing Screening Test ☐ Newborn Screening Test
For Newborn Screening, please attach NBS Filter Sticker here
For Essential Newborn Care (check as applicable boxes)
☐ Immediate drying of newborn ☐ Timely cord clamping ☐ Weighing of the Newborn ☐ BCG vaccination ☐ Hepatitis B vaccination
☐ Early skin-to-skin contact ☐ Eye Prophylaxis ☐ Vitamin K administration ☐ Non-separation of mother/baby for early breastfeeding initiation
g. For Outpatient HIV/AIDS Treatment Package — **Laboratory Number:** ____

9. PhilHealth Benefits:
ICD 10 or RVS Code: a. First Case Rate ____ Second Case Rate ____

Date of the 7th cycle

Date of the 12th cycle or in case of lost to follow-up or death, indicate the last cycle provided.

Write OUTPATIENT in lieu of time admitted & discharged

Tick YES if the patient was referred by another HF

This is not required as treatment provided is an out-patient setting

Tick the box for the laterality

Indicate the diagnosis

Indicate the appropriate code for Targeted Therapy, as indicated in the Z benefit package code"

This is not required

10. Accreditation Number/Name of Accredited Health Care Professional/Date Signed and Professional Fees/Charges
(Use additional CF2 if necessary):

Accreditation number/Name of Accredited Health Care Professional/Date Signed	Details
Accreditation No.: 1 2 3 4 - 5 6 7 8 9 0 1 - 2 (sgd)	☑ No co-pay on top of PhilHealth Benefit
MARY DELA ROSAS, MD — Signature Over Printed Name	☐ With co-pay on top of PhilHealth Benefit P _____
Date Signed: month day year	
Accreditation No.:	☐ No co-pay on top of PhilHealth Benefit
Signature Over Printed Name	☐ With co-pay on top of PhilHealth Benefit P _____
Date Signed: month day year	
Accreditation No.:	☐ No co-pay on top of PhilHealth Benefit
Signature Over Printed Name	☐ With co-pay on top of PhilHealth Benefit P _____
Date Signed: month day year	

Tick this box if patient paid no additional Professional fee

Tick this box if patient paid an additional Professional fee

PART III - CERTIFICATION OF CONSUMPTION OF BENEFITS AND CONSENT TO ACCESS PATIENT RECORD/S

NOTE: Member/Patient should sign only after the applicable charges have been filled out.

A. CERTIFICATION OF CONSUMPTION OF BENEFITS:

☑ PhilHealth benefit is enough to cover HCI and PF Charges.
No purchase of drugs/medicines, supplies, diagnostics, and co-pay for professional fees by the member/patient.

	Total Actual Charges*
Total Health Care Institution Fees	290,000.00
Total Professional Fees	
Grand Total	290,000.00

☐ The benefit of the member/patient was completely consumed prior to pay-off. The benefit of the member/patient is not completely consumed BUT with purchases/expenses for drugs/medicines, supplies, diagnostics and others.

a.) The total co-pay for the following are:

	Total Actual Charges*	Amount after Application of Discount (i.e., personal discount, Senior Citizen/PWD)	PhilHealth Benefit	Amount after PhilHealth Deduction
Total Health Care Institution Fees	290,000.00		290,000.00	Amount P 0.00 Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☑ Others (i.e., PCSO, Promissory note, etc.)
Total Professional Fees (for accredited and non-accredited professionals)				Amount P _____ Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☐ Others (i.e., PCSO, Promissory note, etc.)

b.) Purchases/Expenses **NOT** included in the Health Care Institution Charges:

Total cost of purchase/s for drugs/medicines and/or medical supplies bought by the patient/member within/outside the HCI during confinement	☐ None ☐ Total Amount P _____
Total cost of diagnostic/laboratory examinations paid by the patient/member done within/outside the HCI during confinement	☐ None ☐ Total Amount P _____

* **NOTE:** Total Actual Charges should be based on Statement of Account (SOA)

Tick this box if patient has NO co-payment

Tick this box if patient has a co-payment

Co-payment for the targeted therapy is not allowed. The actual amount reflected in the SOA or its equivalent is the bases of payment of PhilHealth that shall not exceed the amount per tranche or per cycle

B. CONSENT TO ACCESS PATIENT RECORD/S:

I hereby consent to the submission and examination of the patient's pertinent medical records for the purpose of verifying the veracity of this claim to effect efficient processing of benefit payment.
I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all legal liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim for reimbursement before PhilHealth.

JUANA MAPAGPALA DELA CRUZ
Signature Over Printed Name of Member/Patient/Authorized Representative

Date Signed: 10 - 31 - 2024 (month - day - year)

MASTER COPY Date: 3/22/24 C:

If patient/representative is unable to write, put right thumbmark. Patient/ Representative should be assisted by an HCI representative.

Relationship of the representative to the member/patient: ☐ Spouse ☐ Child ☐ Parent ☐ Sibling ☐ Others, Specify

Reason for signing on behalf of the member/patient: ☐ Patient is incapacitated ☐ Other Reasons

☐ Patient ☐ Representative

Affix signature of the patient/parent /authorized representative

Indicate the date signed

PART IV - CERTIFICATION OF CONSUMPTION OF HEALTH CARE INSTITUTION

I certify that services rendered were recorded in the patient's chart and health care institution records and that the herein information given are true and correct.

CARDING DELOS REYES — Signature Over Printed Name of Authorized HCI Representative

RECORDS OFFICER — Official Capacity/Designation

Date Signed: 11 - 01 - 2024 (month - day - year)

Affix signature of HF representative

SAMPLE CLAIM FORM 2 FOR TARGETED THERAPY TRANCHE 3

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 • Trunkline (02) 441-7444
www.philhealth.gov.ph
email: actioncenter@philhealth.gov.ph

PhilHealth
Your Partner in Health

CF-2
(Claim Form 2)
Revised September 2018

Series #

IMPORTANT REMINDERS:
PLEASE WRITE IN CAPITAL **LETTERS** AND **CHECK** THE APPROPRIATE BOXES.
This form together with other supporting documents should be filed within sixty (60) calendar days from date of discharge.
All information, fields and tick boxes required in this form are necessary. Claim forms with incomplete information shall not be processed.
FALSE/INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CRIMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.

PART I - HEALTH CARE INSTITUTION (HCI) INFORMATION

1. PhilHealth Accreditation Number (PAN) of Health Care Institution: H 9 3 0 0 X X X X

2. Name of Health Care Institution: ABCDF Medical Center

3. Address: SHAW BLVD (Building Number and Street Name) | PASIG CITY (City/Municipality) | (Province)

PART II - PATIENT CONFINEMENT INFORMATION

1. Name of Patient: DELA CRUZ (Last Name) | JUANA (First Name) | (Name Extension (JR/SR/III)) | MAPAGPALA (Middle Name (ex: DELACRUZ JUAN JR SPAG))

2. Was patient referred by another Health Care Institution (HCI)?
☑ NO ☐ YES
Name of referring Health Care Institution | Building Number and Street Name | City/Municipality | Province | Zip code

3. Confinement Period:
a. Date Admitted: 1 0 - 3 1 - 2 0 2 4 (month - day - year) b. Time Admitted: (hour : min) ☐ AM ☐ PM
c. Date Discharge: 0 2 - 2 8 - 2 0 2 5 (month - day - year) d. Time Discharge: OUTPATIENT ☐ AM ☐ PM

4. Patient Disposition: (select only 1)
☑ a. Improved
☐ b. Recovered
☐ c. Home/Discharged Against Medical Advise
☐ d. Absconded
☐ e. Expired (month day year) Time: (hour min) ☐ AM ☐ PM
☐ f. Transferred/Referred — Name of Referral Health Care Institution | Building Number and Street Name | City/Municipality | Province | Zip code
Reason/s for referral/transfer:

5. Type of Accomodation: ☐ Private ☐ Non-Private (Charity/Service)

6. Admission Diagnosis/es: Breast Cancer

7. Discharge Diagnosis/es (Use additional CF2 if necessary):

	Diagnosis	ICD-10 Code/s	Related Procedure/s (if there's any)	RVS Code	Date of Procedure	Laterality (check applicable box)
a.	Breast Cancer		i.			☐ left ☐ right ☐ both
			ii.			☐ left ☐ right ☐ both
			iii.			☐ left ☐ right ☐ both
b.			i.			☐ left ☐ right ☐ both
			ii.			☐ left ☐ right ☐ both
			iii.			☐ left ☐ right ☐ both

MASTER COPY Date: 3/2021

8. Special Considerations:
a. For the following repetitive procedures, check box that applies and enumerate the procedure/sessions dates (mm-dd-yyyy). For chemotherapy, see guidelines.
☐ Hemodialysis ☐ Peritoneal Dialysis ☐ Radiotherapy (LINAC) ☐ Radiotherapy (COBALT)
☐ Blood Transfusion ☐ Brachytherapy ☐ Chemotherapy ☐ Simple Debridement
b. For Z-Benefit Package — **Z-Benefit Package Code:** Z021P3
c. For MCP Package (enumerate four dates [mm-dd-year] of pre-natal check-ups)
1 ____ 2 ____ 3 ____ 4 ____
d. For TB DOTS Package ☐ Intensive Phase ☐ Maintenance Phase
e. For Animal Bite Package (write the dates [mm-dd-year] when the following doses of vaccine were given) **Note: Anti Rabies Vaccine (ARV), Rabies Immunoglobulin (RIG)**
Day 0 ARV ____ **Day 3 ARV** ____ **Day 7 ARV** ____ **RIG** ____ **Others (Specify)** ____
f. For Newborn Care Package ☐ Essential Newborn Care ☐ Newborn Hearing Screening Test ☐ Newborn Screening Test
For Newborn Screening, *please attach NBS Filer Sticker here*
For Essential Newborn Care (check applicable boxes)
☐ Immediate drying of newborn ☐ Early skin-to-skin contact ☐ Timely cord clamping ☐ Eye Prophylaxis ☐ Weighing of the newborn ☐ Vitamin K administration ☐ BCG vaccination ☐ Non-separation of mother/baby for early breastfeeding initiation ☐ Hepatitis B vaccination
g. For Outpatient HIV/AIDS Treatment Package — **Laboratory Number:** ____

9. PhilHealth Benefits:
ICD 10 or RVS Code: a. First Case Rate ____ b. Second Case Rate ____

Date of the 13th cycle

Date of the 18th cycle or in case of lost to follow-up or death, indicate the date of the last cycle given.

Write OUTPATIENT in lieu of time admitted & discharged

Tick YES if the patient was referred by another HF

This is not required as treatment provided is an out-patient setting

Tick the box for the laterality

Indicate the diagnosis

Indicate the appropriate code for Targeted Therapy, as indicated in the Z benefit package code"

This is not required

10. Accreditation Number/Name of Accredited Health Care Professional/Date Signed and Professional Fees/Charges
(Use additional CF2 if necessary):

Accreditation number/Name of Accredited Health Care Professional/Date Signed	Details
Accreditation No.: 1 2 3 4 - 5 6 7 8 9 0 1 - 2 (sgd) MARY DELA ROSAS, MD Signature Over Printed Name Date Signed: month / day / year	☑ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____
Accreditation No.: _____ Signature Over Printed Name Date Signed: month / day / year	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____
Accreditation No.: _____ Signature Over Printed Name Date Signed: month / day / year	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____

Tick this box if patient paid no additional Professional fee

Tick this box if patient paid an additional Professional fee

PART III - CERTIFICATION OF CONSUMPTION OF BENEFITS AND CONSENT TO ACCESS PATIENT RECORD/S

NOTE: Member/Patient should sign only after the applicable charges have been filled out.

A. CERTIFICATION OF CONSUMPTION OF BENEFITS:

☑ PhilHealth benefit is enough to cover HCI and PF Charges.
No purchase of drugs/medicines, supplies, diagnostics, and co-pay for professional fees by the member/patient.

	Total Actual Charges*
Total Health Care Institution Fees	290,000.00
Total Professional Fees	
Grand Total	290,000.00

☐ The benefit of the member/patient was completely consumed but there is co-pay OR the benefit of the member/patient is not completely consumed BUT with purchases/expenses for drugs/medicines, supplies, diagnostics and others.

a.) The total co-pay for the following are:

	Total Actual Charges*	Amount after Application of Discount (i.e., personal discount, Senior Citizen/PWD)	PhilHealth Benefit	Amount after PhilHealth Deduction
Total Health Care Institution Fees	290,000.00		290,000.00	Amount P 0.00 Paid by (check all that applies): ☑ Member/Patient ☐ HMO ☑ Others (i.e., PCSO, Promissory note, etc.)
Total Professional Fees (for accredited and non-accredited professionals)				Amount P _____ Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☐ Others (i.e., PCSO, Promissory note, etc.)

b.) Purchases/Expenses **NOT** included in the Health Care Institution Charges

Total cost of purchase/s for drugs/medicines and/or medical supplies bought by the patient/member within/outside the HCI during confinement	☐ None ☐ Total Amount P _____
Total cost of diagnostic/laboratory examinations paid by the patient/member done within/outside the HCI during confinement	☐ None ☐ Total Amount P _____

*** NOTE:** Total Actual Charges should be based on Statement of Account (SOA)

Tick this box if patient has NO co-payment

Tick this box if patient has a co-payment

Co-payment for the targeted therapy is not allowed. The actual amount reflected in the SOA or its equivalent is the bases of payment of PhilHealth that shall not exceed the amount per tranche or per cycle

B. CONSENT TO ACCESS PATIENT RECORD/S:

I hereby consent to the submission and examination of the patient's pertinent medical records for the purpose of verifying the veracity of this claim to effect efficient processing of benefit payment.
I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all legal liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim for reimbursement before PhilHealth.

JUANA MAPAGPALA DELA CRUZ
Signature Over Printed Name of Member/Patient/Authorized Representative

Date Signed: 0 2 - 2 8 - 2 0 2 5 (month / day / year)

If patient/representative is unable to write, put right thumbmark. Patient/ Representative should be assisted by an HCI representative.

Relationship of the representative to the member/patient: ☐ Spouse ☐ Child ☐ Parent ☐ Sibling ☐ Others, Specify _____

Reason for signing on behalf of the member/patient: ☐ Patient is Incapacitated ☐ Other Reasons _____

☐ Patient ☐ Representative

MASTER COPY
Date: 02/28/25
DC: [signature]

Affix signature of the patient/parent /authorized representative

Indicate date signed

PART IV - CERTIFICATION OF CONSUMPTION OF HEALTH CARE INSTITUTION

I certify that services rendered were recorded in the patient's chart and health care institution records and that the herein information given are true and correct.

CARDING DELOS REYES — Signature Over Printed Name of Authorized HCI Representative
RECORDS OFFICER — Official Capacity/Designation
Date Signed: 0 3 - 0 1 - 2 0 2 5 (month / day / year)

Affix signature of HF representative

SAMPLE CLAIM FORM 2 FOR SURVEILLANCE

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Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 • Trunkline (02) 441-7444
www.philhealth.gov.ph
email: actioncenter@philhealth.gov.ph

CF-2
(Claim Form 2)
Revised September 2018

Series #

IMPORTANT REMINDERS:
PLEASE WRITE IN CAPITAL **LETTERS** AND **CHECK** THE APPROPRIATE BOXES.
This form together with other supporting documents should be filed within sixty (60) calendar days from date of discharge.
All information, fields and tick boxes required in this form are necessary. Claim forms with incomplete information shall not be processed.
FALSE/INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CRIMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.

PART I - HEALTH CARE INSTITUTION (HCI) INFORMATION

1. PhilHealth Accreditation Number (PAN) of Health Care Institution: H 9 3 0 0 X X X X
2. Name of Health Care Institution: ABCDF Medical Center
3. Address: SHAW BLVD (Building Number and Street Name) | PASIG CITY (City/Municipality) | (Province)

PART II - PATIENT CONFINEMENT INFORMATION

1. Name of Patient: DELA CRUZ (Last Name) | JUANA (First Name) | (Name Extension (JR/SR/III)) | MAPAGPALA (Middle Name (ex. DELACRUZ JUAN JR SHNG))

2. Was patient referred by another Health Care Institution (HCI)?
☑ NO ☐ YES
Name of referring Health Care Institution | Building Number and Street Name | City/Municipality | Province | Zip code

3. Confinement Period:
a. Date Admitted: 08 (month) - 30 (day) - 2024 (year) b. Time Admitted: (hour) : (min) ☐ AM ☐ PM
c. Date Discharge: 08 (month) - 30 (day) - 2024 (year) d. Time Discharge: OUTPATIENT ☐ AM ☐ PM

4. Patient Disposition: (select only 1)
☑ a. Improved
☐ b. Recovered
☐ c. Home/Discharged Against Medical Advise
☐ d. Absconded
☐ e. Expired — Date: (month) (day) (year) Time: (hour) : (min) ☐ AM ☐ PM
☐ f. Transferred/Referred — Name of Referral Health Care Institution | Building Number and Street Name | City/Municipality | Province | Zip code
Reason/s for referral/transfer:

5. Type of Accomodation: ☐ Private ☐ Non-Private (Charity/Service)

6. Admission Diagnosis/es: Breast Cancer

7. Discharge Diagnosis/es (Use additional CF2 if necessary):

Diagnosis	ICD-10 Code/s	Related Procedure/s (if there's any)	RVS Code	Date of Procedure	Laterality (check applicable box)
a. Breast Cancer		i.			☑ left ☐ right ☐ both
		ii.			☐ left ☐ right ☐ both
		iii.			☐ left ☐ right ☐ both
b.		i.			☐ left ☐ right ☐ both
		ii.			☐ left ☐ right ☐ both
		iii.			☐ left ☐ right ☐ both

MASTER COPY Date: 31/Jan/24

8. Special Considerations:
a. For the following repetitive procedures, check box that applies and enumerate the procedure/sessions dates (mm-dd-yyyy). For chemotherapy, see guidelines.
☐ Hemodialysis ☐ Blood Transfusion
☐ Peritoneal Dialysis ☐ Brachytherapy
☐ Radiotherapy (LINAC) ☐ Chemotherapy
☐ Radiotherapy (COBALT) ☐ Simple Debridement
b. For Z-Benefit Package — **Z-Benefit Package Code:** Z021Q1
c. For MCP Package (enumerate four dates (mm-dd-yyyy) of pre-natal check-ups)
1 ____ 2 ____ 3 ____ 4 ____
d. For TB DOTS Package ☐ Intensive Phase ☐ Maintenance Phase
e. For Animal Bite Package (write the dates (mm-dd-year) when the following doses of vaccine were given) **Note: Anti Rabies Vaccine (ARV), Rabies Immunoglobulin (RIG)**
Day 0 ARV ____ **Day 3 ARV** ____ **Day 7 ARV** ____ **RIG** ____ **Others (Specify)** ____
f. For Newborn Care Package ☐ Essential Newborn Care ☐ Newborn Hearing Screening Test ☐ Newborn Screening Test — For Newborn Screening, *please attach NBS Filter Sticker here*
For Essential Newborn Care (check applicable boxes)
☐ Immediate drying of newborn ☐ Timely cord clamping ☐ Weighing of the newborn ☐ BCG vaccination ☐ Hepatitis B vaccination
☐ Early skin-to-skin contact ☐ Eye Prophylaxis ☐ Vitamin K administration ☐ Non-separation of mother/baby for early breastfeeding initiation
g. For Outpatient HIV/AIDS Treatment Package **Laboratory Number:** ____

9. PhilHealth Benefits:
ICD 10 or RVS Code: a. First Case Rate ____ b. Second Case Rate ____

Indicate the date of the procedure was done

Write OUTPATIENT in lieu of time admitted & discharged

Tick YES if the patient was referred by another HF

This is not required as treatment provided is an out-patient setting

Tick the box for the laterality

Indicate the diagnosis

Indicate the appropriate "Z benefit package code"

This is not required

10. Accreditation Number/Name of Accredited Health Care Professional/Date Signed and Professional Fees/Charges
(Use additional CF3 if necessary)

Accreditation number/Name of Accredited Health Care Professional/Date Signed	Details
Accreditation No.: 1 2 3 4 - 5 6 7 8 9 0 1 2 (sgd) MARY DELA ROSAS, MD Signature Over Printed Name Date Signed: month / day / year	☑ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____
Accreditation No.: Signature Over Printed Name Date Signed: month / day / year	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____
Accreditation No.: Signature Over Printed Name Date Signed: month / day / year	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____

Tick this box if patient paid no additional Professional fee

Tick this box if patient paid an additional Professional fee

PART III - CERTIFICATION OF CONSUMPTION OF BENEFITS AND CONSENT TO ACCESS PATIENT RECORD/S

NOTE: Member/Patient should sign only after the applicable charges have been filled out

A. CERTIFICATION OF CONSUMPTION OF BENEFITS:

☑ PhilHealth benefit is enough to cover HCI and PF Charges.
No purchase of drugs/medicines, supplies, diagnostics, and co-pay for professional fees by the member/patient.

	Total Actual Charges*
Total Health Care Institution Fees	2,700.00
Total Professional Fees	
Grand Total	2,700.00

Tick this box if patient has No co-payment

☐ ~~The benefit of the member/patient was completely consumed prior to co-pay OR~~ the benefit of the member/patient is not completely consumed BUT with purchases/expenses for drugs/medicines, supplies, diagnostics and others.

a.) The total co-pay for the following are:

	Total Actual Charges*	Amount after Application of Discount (i.e., personal discount, Senior Citizen/PWD)	PhilHealth Benefit	Amount after PhilHealth Deduction
Total Health Care Institution Fees	2,700.00		2,500.00	Amount P 0.00 Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☑ Others (i.e., PCSO, Promissory note, etc.)
Total Professional Fees (for accredited and non-accredited professionals)				Amount P _____ Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☐ Others (i.e., PCSO, Promissory note, etc.)

Tick this box if patient has a co-payment

Indicate the amount if the patient has co-payment, as applicable

b.) Purchases/Expenses **NOT** included in the Health Care Institution Charges

Total cost of purchase/s for drugs/medicines and/or medical supplies bought by the patient/member within/outside the HCI during confinement	☐ None ☐ Total Amount P _____
Total cost of diagnostic/laboratory examinations paid by the patient/member done within/outside the HCI during confinement	☐ None ☐ Total Amount P _____

*** NOTE:** Total Actual Charges should be based on Statement of Account (SOA)

B. CONSENT TO ACCESS PATIENT RECORD/S:

I hereby consent to the submission and examination of the patient's pertinent medical records for the purpose of verifying the veracity of this claim to effect efficient processing of benefit payment.
I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all legal liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim for reimbursement before PhilHealth.

JUANA MAPAGPALA DELA CRUZ
Signature Over Printed Name of Member/Patient/Authorized Representative

Affix signature of the patient/parent /authorized representative

Date Signed: 0 8 - 3 0 - 2 0 2 4
month / day / year

Indicate date signed

Relationship of the representative to the member/patient: ☐ Spouse ☐ Child ☐ Parent ☐ Sibling ☐ Others, Specify _____

Reason for signing on behalf of the member/patient: ☐ Patient is Incapacitated ☐ Other Reasons: _____

If patient/representative is unable to write, put right thumbmark. Patient/ Representative should be assisted by an HCI representative.

☐ Patient ☐ Representative

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Date: 08/30/24

DD:

PART IV - CERTIFICATION OF CONSUMPTION OF HEALTH CARE INSTITUTION

I certify that services rendered were recorded in the patient's chart and health care institution records and that the herein information given are true and correct.

CARDING DELOS REYES — Signature Over Printed Name of Authorized HCI Representative
RECORDS OFFICER — Official Capacity/Designation
Date Signed: 0 9 - 0 1 - 2 0 2 4 (month / day / year)

Affix signature of HF representative

Annex K: Pathway of the Benefits Availment of the Z Benefits for Breast Cancer

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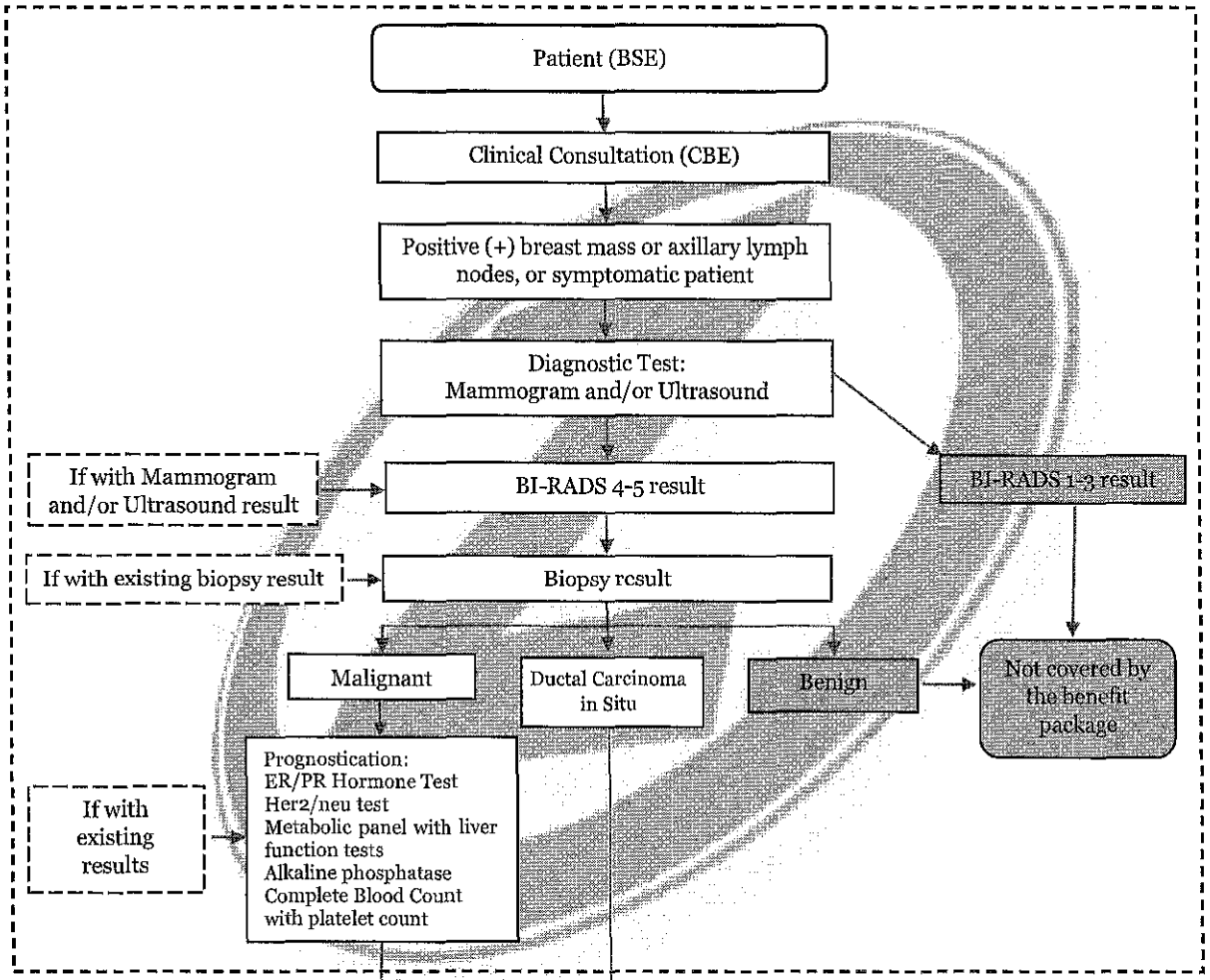
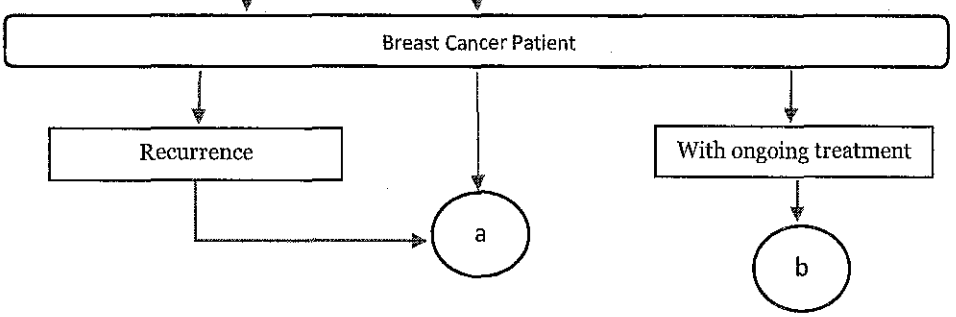
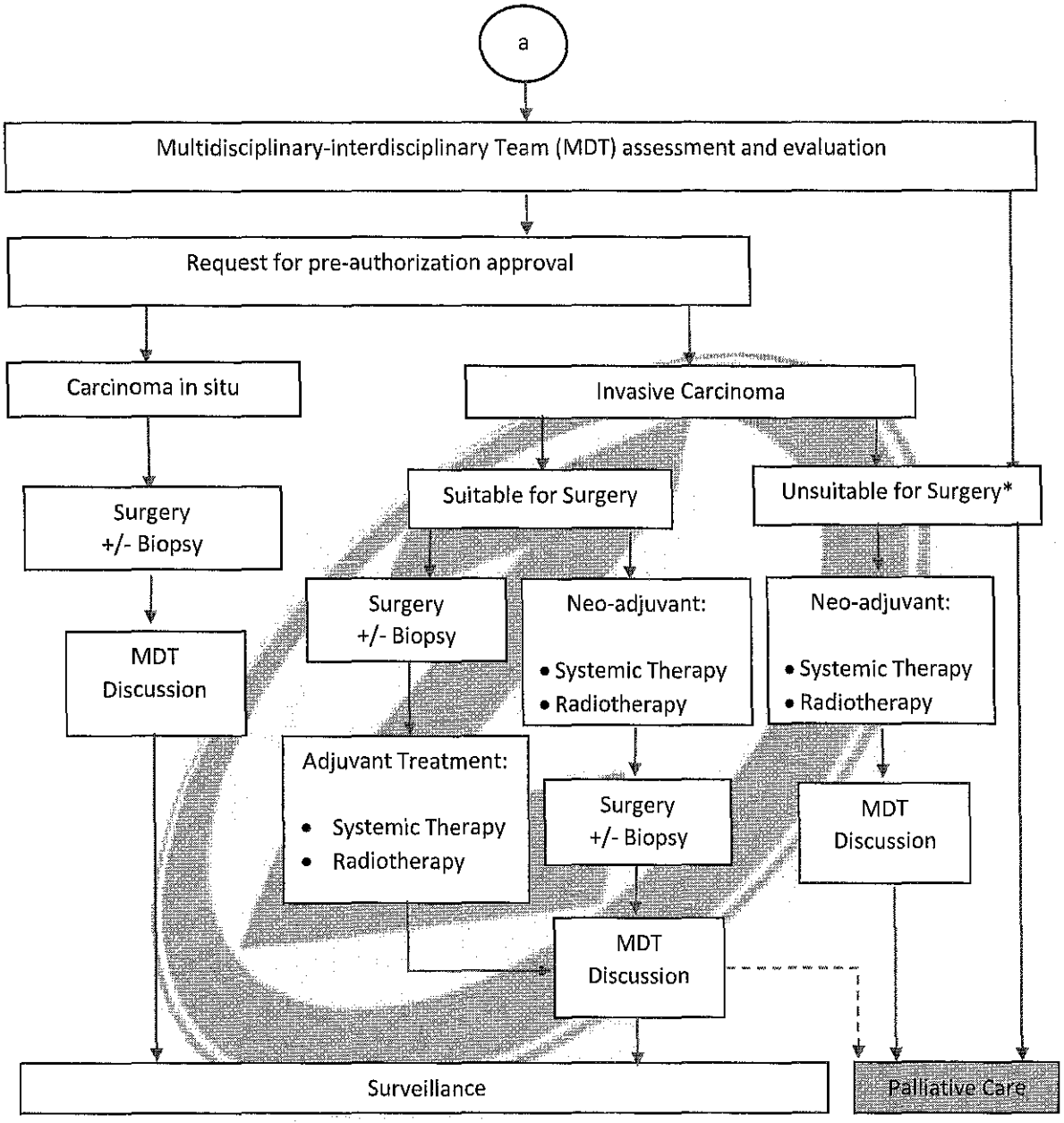
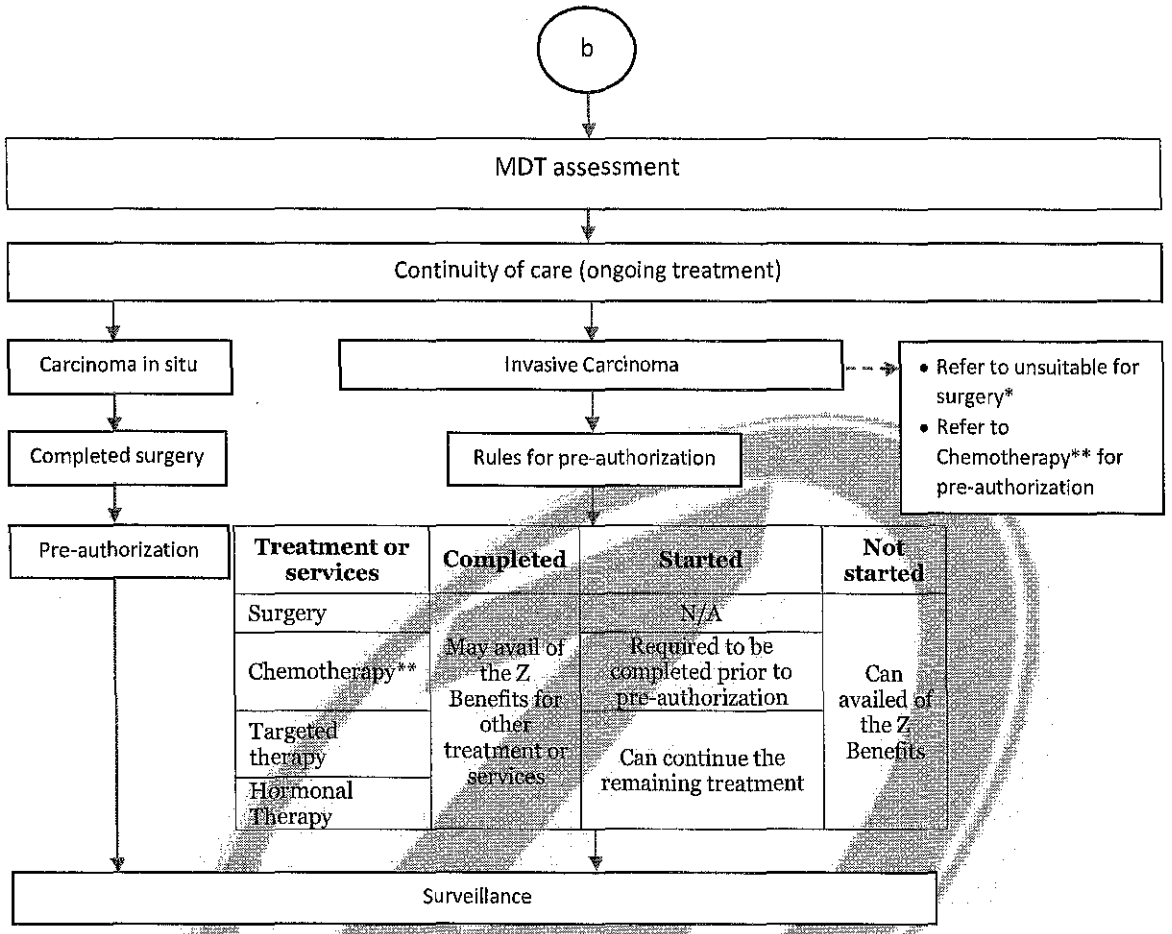
Pathway of the Benefits Availment of the Z Benefits for Breast Cancer









Disclaimer: The algorithm may change in accordance with the updates on the Clinical Practice Guidelines. The Z Benefits for Breast cancers covers treatments and services that are included in the benefits package. Other rules are indicated in the PhilHealth Circular

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Breast Cancer Treatment Protocols

Legend:

A – Doxorubicin	T – Docetaxel
C – Cyclophosphamide	Pacli – Paclitaxel
H – Trastuzumab	Cb – Carboplatin
Tamox – Tamoxifen	Anas – Anastrozole
Zola – Goserelin	Letro – Letrozole

1. For Stage IA and above: hormone receptor (ER/PR) positive and HER2 positive BRCA

PREMENOPAUSAL	
OPTIONS	REGIMEN
A	AC x 4 cycles → TH x 4 cycles → H x 14 cycles → Tamox +/- Zola x 5 years
B	AC x 4 cycles → Pacli x 12 weeks + H x 18 cycles → Tamox +/- Zola x 5 years
C	TCbH x 6 cycles → Tamox +/- Zola x 5 years

POSTMENOPAUSAL	
OPTIONS	REGIMEN
D	AC x 4 cycles → TH x 4 cycles → H x 14 cycles → Anas/Letro x 5 years
E	AC x 4 cycles → Pacli x 12 weeks + H x 18 cycles → Anas/Letro x 5 years
F	TCbH x 6 cycles → Tamox +/- Zola x 5 years

2. For Stage IA with tumor </= 0.5cm → hormone receptor (ER/PR) positive and HER2 negative BRCA

PREMENOPAUSAL	
OPTION	REGIMEN
G	Tamox +/- Zola x 5 years

POSTMENOPAUSAL	
OPTION	REGIMEN
H	Anas/Letro x 5 years

3. For Stage IA and above with tumor > 0.5cm → hormone receptor (ER/PR) positive and HER2 negative BRCA

PREMENOPAUSAL	
OPTIONS	REGIMEN
I	AC x 4 cycles → T x 4 cycles → Tamox +/- Zola x 5 years
J	AC x 4 cycles → Pacli x 12 weeks → Tamox +/- Zola x 5 years

POSTMENOPAUSAL	
OPTIONS	REGIMEN
K	AC x 4 cycles → T x 4 cycles → Anas/Letro x 5 years
L	AC x 4 cycles → Pacli x 12 weeks → Anas/Letro x 5 years

4. For Stage IA and above → hormone receptor (ER/PR) negative and HER2 positive BRCA

OPTIONS	REGIMEN
M	AC x 4 cycles → TH x 4 cycles → H x 14 cycles
N	AC x 4 cycles → Pacli x 12 weeks + H x 18 cycles
O	TCbH x 6 cycles

5. For Stage IA and above with tumor >0.5cm → hormone receptor (ER/PR) negative and HER2 negative BRCA

OPTIONS	REGIMEN
P	AC x 4 cycles → T x 4 cycles
Q	AC x 4 cycles → Pacli x 12 weeks

Disclaimer: The Breast Cancer Treatment Protocols are based on the Clinical Practice Guidelines that may be subjected to changes or updates. The Z Benefits for Breast Cancer covers treatments and services as defined in the mandatory services of the benefits package.

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HEALTH FACILITIES (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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 ☐☐ - ☐☐☐☐☐☐☐☐☐☐ - ☐	

BREAST CANCER MEDICAL RECORDS SUMMARY FORM

Instructions: This form is required for all breast cancer mortalities and "lost to follow-up[1]" patients in contracted health facilities. Completely fill-out all required items. Submit this form as attachment to claims for the specific treatment phase, as applicable.

I. Breast Cancer Disease Profile

Laterality of breast cancer (Choose one by ticking the appropriate box)	☐ Right
	☐ Left
	☐ Both
	☐ Not recorded in the chart
Biopsy Histological Diagnosis (Verbatim from histopathology report)	
Date of biopsy	Date (mm/dd/yyyy)
Clinical Cancer Stage at pre-authorization (Choose one by ticking the appropriate box)	☐ cStage 0
	☐ cStage IA
	☐ cStage IB
	☐ cStage IIA
	☐ cStage IIB
	☐ cStage IIIA
	☐ cStage IIIB
	☐ cStage IIIC
	☐ cStage IV
	☐ Not recorded in the chart

DC: Date: 3/22/24

TNM (Choose one by ticking the appropriate box)	☐ With data ☐ Not recorded in the chart
If with data on TNM:	What is T? What is N? What is M?
Widest diameter size of primary tumor	(cm) or _____ (mm) Not recorded in the chart
Skin ulceration (Choose one by checking the appropriate box)	☐ Yes ☐ No ☐ Not recorded in the chart
Skin satellite lesion/s (Choose one by checking the appropriate box)	☐ Yes ☐ No ☐ Not recorded in the chart
Multifocal carcinomata (Choose one by checking the appropriate box)	☐ Yes ☐ No ☐ Not recorded in the chart
Regional lymph node involvement (Choose one by checking the appropriate box)	☐ Yes ☐ No ☐ Not recorded in the chart
Distant metastasis (Choose one by checking the appropriate box)	☐ Yes ☐ No ☐ Not recorded in the chart
If yes, when did first metastasis happen?	☐ Date (mm/dd/yyyy) ☐ Not recorded in the chart
If yes, which organ site/s? (Can choose more than one by checking the appropriate box/es)	☐ Regional lymph nodes ☐ Brain ☐ Skin ☐ Lung ☐ Pleura ☐ Liver ☐ Adrenal ☐ Bone ☐ Peritoneum ☐ Pelvic ☐ Adjacent Organ/s (Specify): ☐ Others (Specify):
Post-surgical histological diagnosis (Verbatim from pathological report)	

Date of post-surgical histopathologic report	(mm/dd/yyyy)
Histological/nuclear grade (Choose one by checking the appropriate box)	☐ GX: Grade cannot be assessed (undetermined grade)
	☐ G1: well-differentiated (low grade)
	☐ G2: moderately differentiated (intermediate grade
	☐ G3: poorly differentiated (high grade)
	☐ G4: undifferentiated (high grade)
	☐ Not recorded in the chart
Pathological Cancer Stage (Choose one by checking the appropriate box)	☐ cStage 0
	☐ cStage IA
	☐ cStage IB
	☐ cStage IIA
	☐ cStage IIB
	☐ cStage IIIA
	☐ cStage IIIB
	☐ cStage IIIC
	☐ cStage IV
	☐ Not recorded in the chart
Provide the appropriate information for TNM	What is T?
	What is N?
	What is M?
	☐ Not recorded in the chart
Widest diameter of primary tumor	_____ (cm) or _____ (mm)
	☐ Not recorded in the chart
Number of positive lymph nodes/TLNs harvested	__ positive lymph nodes __ TLNs
	☐ Not recorded in the chart
Lymphovascular invasion (Choose one by checking the appropriate box)	☐ Negative
	☐ Positive
	☐ Not recorded in the chart
Perineural invasion (Choose one by checking the appropriate box)	☐ Negative
	☐ Positive
	☐ Not recorded in the chart
Surgical margin involvement (Choose one by checking the appropriate box)	☐ Negative
	☐ Positive
	☐ Not recorded in the chart
Were tumor markers done? (Choose one by checking the appropriate box)	☐ Yes
	☐ No
	☐ Not recorded in the chart
ER (Choose one by checking the appropriate box)	☐ Negative
	☐ Positive: _% (1% to 100%); Alfred score __
	☐ Not recorded in the chart
PR (Choose one by checking the appropriate box)	☐ Negative
	☐ Positive: _% (1% to 100%); Alfred score __
	☐ Not recorded in the chart

Her2neu IHC staining intensity (Choose one by checking the appropriate box)	☐ Negative
	☐ Positive
	☐ Equivocal
	☐ Not recorded in the chart
Her2neu gene amplification (Choose one by checking the appropriate box)	☐ Non-amplified
	☐ Amplified
	☐ Not recorded in the chart

II. **Breast Cancer Treatment Profile**

Was definitive surgery done? (Choose one by checking the appropriate box)	☐ Yes
	☐ No
	☐ No operative record in the chart
If yes, what is the name of the surgical procedure?	
Was chemotherapy given in the contracted health facilities? (Choose one by checking the appropriate box)	☐ Yes
	☐ No
	☐ No record found in the contracted health care institution
	☐ Chemotherapy was given by another healthcare provider
If answer to previous question is "no," check the appropriate box and must provide details.	☐ Patient preference ☐ Advised by healthcare provider ☐ Patient is "lost to follow-up[1]"
If answer is "yes," specify the drug regimen used.	
Specify the total dose per cycle for the drug regimen used (Choose one by checking the appropriate box)	☐ Total dose per cycle: _____ ☐ Not recorded in the chart
If chemotherapy was given, provide the date when chemotherapy started (Choose one by checking the appropriate box)	☐ mm/dd/yyyy _____ ☐ Not recorded in the chart ☐ NA, chemotherapy was not given
If chemotherapy was given, how many cycles were given? (Choose one by checking the appropriate box)	☐ ____ ☐ NA, chemotherapy was not given

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DC: ___ Date: 3/29/19

What is the purpose of chemotherapy? (Choose one by checking the appropriate box)	☐ Adjuvant ☐ Neo-adjuvant ☐ NA, chemotherapy was not given
What is tumor response to chemotherapy? (Choose one by checking the appropriate box)	☐ NED (no evidence of disease progression) ☐ CR ☐ PR ☐ SD ☐ PD (progressive disease) ☐ Not recorded in the chart ☐ NA, chemotherapy was not given
Was the chemotherapy regimen ever changed?	☐ Yes ☐ No ☐ Not recorded in the chart ☐ NA, chemotherapy was not given
What is reason for chemotherapy regimen is changed?	☐ Adverse event to former chemotherapy. Specify adverse event: _____ ☐ PD ☐ Patient preference ☐ Other (Specify): _____ ☐ Not recorded in the chart ☐ NA, chemotherapy was not given
What drug/s were used in this new chemotherapy regimen?	
Specify the total dose per drug per cycle for this new drug regimen used	☐ Total dose per drug per cycle: _____ ☐ Not recorded in the chart
What is the start date for this new chemotherapy regimen?	mm/dd/yyyy
How many cycles were given for this new chemotherapy regimen?	
What is the purpose for this new chemotherapy regimen?	☐ Adjuvant ☐ Neo-adjuvant ☐ Palliative ☐ Not recorded in the chart
What is tumor response for this new chemotherapy regimen? (Choose one by checking the appropriate box)	☐ NED ☐ CR ☐ PR ☐ SD ☐ PD ☐ Not recorded in the chart
Was radiotherapy advised?	☐ Yes, it is recorded in the chart ☐ No, it is recorded in the chart ☐ It is not documented in the chart

If RT was advised, was radiotherapy given?	☐ Yes, it is recorded in the chart ☐ No, it is recorded in the chart ☐ It is not documented in the chart
Was supportive care given?	☐ Yes, it is recorded in the chart ☐ No, it is recorded in the chart ☐ It is not documented in the chart
If answer is "yes," specify supportive care (May choose more than one)	☐ Pain control (Specify): _____ ☐ Nutrition build-up ☐ Rehabilitation from a sequela of the treatment ☐ Psychological counseling ☐ Psychiatric intervention ☐ Religious/faith counseling ☐ Referral to Civil Society Organization ☐ NA, supportive care was not given ☐ NA, it is not documented in the chart
Was the hormonotherapy given to the contracted health facilities? (Choose one by checking the appropriate box)	☐ Yes ☐ No ☐ No record was found in the contracted health facility ☐ Hormonotherapy was given by another healthcare provider
If the answer to the previous question is "no," check the appropriate box and must provide details.	☐ Patient preference ☐ Advised by a healthcare provider ☐ Patient is "lost to follow-up[1]"
If the answer is "yes," specify the drug regimen used.	
Specify the total number of prescriptions for the drug regimen used (Choose one by checking the appropriate box)	☐ Total prescription: _____ ☐ Not recorded in the chart
If hormonotherapy was given, provide the date when it was started (Choose one by checking the appropriate box)	☐ mm/dd/yyyy _____ ☐ Not recorded in the chart ☐ NA, hormonotherapy was not given
What is the purpose of hormonotherapy? (Choose one by checking the appropriate box)	☐ Premenopausal ☐ Postmenopausal ☐ NA, hormonotherapy was not given
Was the targeted therapy given to the contracted health facilities? (Choose one by checking the appropriate box)	☐ Yes ☐ No ☐ No record found in the contracted health facility

	☐ Targeted therapy was given by Another healthcare provider
If answer to previous question is "no," check the appropriate box and must provide details.	☐ Patient preference ☐ Advised by healthcare provider ☐ Patient is "lost to follow-up[1]"
If answer is "yes," specify the drug regimen used.	
Specify the total dose per cycle for the drug regimen used (Choose one by checking the appropriate box)	☐ Total dose per cycle: _____ ☐ Not recorded in the chart
If targeted therapy was given, provide the date when it was started (Choose one by checking the appropriate box)	☐ mm/dd/yyyy _____ ☐ Not recorded in the chart ☐ NA, targeted therapy was not given
If targeted therapy was given, how many cycles were given? (Choose one by checking the appropriate box)	☐ ____ ☐ NA, targeted therapy was not given

III. Breast Cancer Survival Status

Date of survival assessment	mm/dd/yyyy
What is the status of this patient at this date	☐ Alive ☐ Died ☐ Lost to follow-up[1] ☐ Not recorded in the chart
When was date of last follow-up?	☐ mm/dd/yyyy ☐ Not recorded in the chart
What is the status of this patient at this last follow-up date?	☐ Alive, NED ☐ Alive with residual small lesions, on definitive treatment ☐ Alive with residual small lesions, without definitive treatment ☐ Alive with residual big lesions, on definitive treatment ☐ Alive with residual big lesions, without definitive treatment ☐ Alive with terminal disease, only on supportive treatment ☐ Not recorded in the chart
If died, when was date of death?	☐ mm/dd/yyyy ☐ Not recorded in the chart
If died, what is cause of death?	☐ Breast cancer-related ☐ Not cancer-related ☐ Not recorded in the chart

1 Lost to follow-up refers to a term used to characterize a breast cancer patient who has not returned to or followed up at a contracted health facility after sixty (60) calendar days from the scheduled visit or treatment, as advised.

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OUTCOME INDICATORS FOR BREAST CANCER

I. Cancer detection rate

A. Clinical Breast Examination
   1. Interval palpable breast mass found

B. Mammography
   1. Interval BIRADS 4-5 breast lesion found

C. Breast Ultrasound
   1. Interval BIRADS 4-5 breast lesion found

D. Biopsy
   1. Confirmed breast cancer (n)
   2. Cancer detection rate (%)
   3. Time interval from Screen to Biopsy at initial diagnosis

II. Cancer Stage at Diagnosis (defines prognosis)

III. Molecular Profile at Diagnosis (defines prognosis)

A. ER+ (%)
B. PR+ (%)
C. HER2neu+ (%)

IV. Time interval from confirmed breast cancer to start of

A. Neoadjuvant anti-cancer drug treatment
B. Definitive surgery (e.g.Mastectomy)
C. Adjuvant anti-cancer drug treatment
D. Radiotherapy

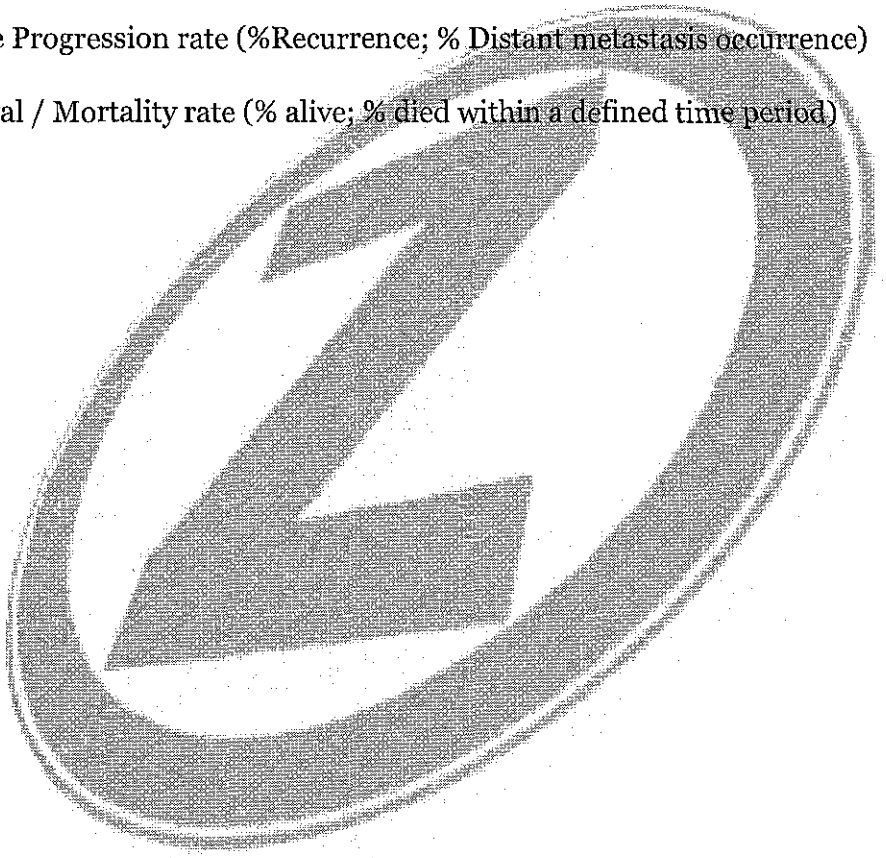
V. Anti-cancer Treatment Complication (surgery complication, anti-cancer drug adverse effect, radiotherapy adverse effect, worsening of comorbidity)

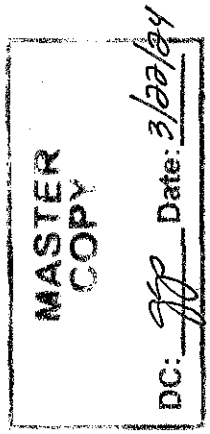
VI. Compliance rate (%) (Completed, deferred due adverse effect, lost to follow-up/ abandonment)

A. Surgery
B. Cytotoxic drug therapy
C. Targeted drug therapy
D. Radiotherapy
E. Hormonal drug therapy

VII. Disease Progression rate (%Recurrence; % Distant metastasis occurrence)

VIII. Survival / Mortality rate (% alive; % died within a defined time period)





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Guide on Co-payment Proposal of the Z Benefits Package for Breast Cancer

At Point of Services	Co-payment Rules
Diagnostic Tests and Prognostication	Not to exceed the line item equivalent of the package rate
Surgery	Not to exceed the package rate; No co-payment in basic or ward accommodation
Chemotherapy	Not to exceed the package rate per cycle
Hormonotherapy (2) Tranches	Not to exceed the package rate per monthly prescription
Targeted Therapy (3) Tranches	No co-payment
Surveillance	Not to exceed the line item equivalent of the package rate

Note: The co-payment proposal for each of the services or treatment phases of the Z Benefits package for breast cancer is subject to negotiation and approval of PhilHealth. The negotiated co-payment shall be stipulated in the contract of the health facility.