

Annex F: Checklist for Patient Transfer

As of October 2023



Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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Case No. _____

HEALTH FACILITY (HF)	
ADDRESS OF HF	
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
	2. PhilHealth ID Number <input type="text"/> - <input type="text"/> - <input type="text"/>
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 <input type="text"/> - <input type="text"/> - <input type="text"/>

CHECKLIST FOR PATIENT TRANSFER Mental Health

For Mental Health patients who will be transferred to a referral MH provider, the following checklist shall be accomplished:

NAME OF REFERRAL MH PROVIDER
ADDRESS OF REFERRAL MH PROVIDER

Requirements	YES OR NO (tick appropriate box)	Signature of Responsible Person
1. Photocopy of accomplished MH Passport	<input type="checkbox"/> Yes <input type="checkbox"/> No	<hr style="width: 80%; margin: 0 auto;"/> Name and Signature Attending Physician
2. Letter of Intent from patient requesting for transfer to a referral MH provider (Annex J)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<hr style="width: 80%; margin: 0 auto;"/> Name and Signature Patient/Parent/Guardian

Certified complete by: <hr style="width: 80%; margin: 0 auto;"/> Printed name and signature MH Coordinator	Conformed by: <hr style="width: 80%; margin: 0 auto;"/> Printed name and signature Patient/Parent/Guardian
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)