Annex D.4: Checklist of Requirements for Reimbursement (6 to 60 Months Old) – 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

Place a (✓) in the appropriate tick box.

Requirements	Please Check
1. Photocopy of Checklist of Eligibility Criteria for Outpatient Therapeutic Care (OTC) for Severe Acute Malnutrition (SAM) (Annex A)	
2. Checklist of Mandatory and Other Services for 6 to 60 months old (Tranche 2 - Annex B.4)	
3. Properly accomplished Claim Signature Form (CSF)	
4. Checklist of Requirements for Reimbursement – 0 to less than 6 months old (Tranche 2 - Annex D.4)	
5. OTC SAM Satisfaction Questionnaire (Annex E)	
6. Transmittal Form for Claims Application (Annex F)	
7. Photocopy of Ready-To-Use Therapeutic Food (RUTF) Ration Card for 6 to 60 months old (Annex H)	
8. Photocopy of SAM Registration Logbook (Annex I)	
9. Photocopy of OTC Treatment Record/Chart (Annex J)	
10. Statement of Account / Electronic Statements of Account (eSOA)	
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/ Parent/ Guardian
PhilHealth Accreditation No. ☐☐☐☐.☐☐☐☐☐☐☐.	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	