

Annex I.2: Checklist of Requirements For Reimbursement - Living Kidney Donor



Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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 PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH FACILITY (HF)	
ADDRESS OF HF	
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name SEX <input type="checkbox"/> Male <input type="checkbox"/> Female 2. PhilHealth ID Number [] [] - [] [] [] [] [] [] [] [] - []
B. MEMBER <input type="checkbox"/> Same as patient (Answer only if the patient is a dependent)	1. Last Name, First Name, Suffix, Middle Name 2. PhilHealth ID Number [] [] - [] [] [] [] [] [] [] [] - []

Checklist of Requirements for Reimbursement Living Kidney Donor

(Place a ✓ if attached or NA if not applicable)

REQUIREMENTS	Status
1. Transmittal Form (Annex J)	
2. Properly Accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)	
3. Properly Accomplished PhilHealth Claim Form 2 (CF2)	
4. Photocopy of the approved pre-authorization checklist and request form for Living Kidney Donor (Annex A.2.)	
5. Checklist of Essential Health Services - Living Kidney Donor (Annex E.2)	
6. Checklist of Requirements for Reimbursement - Living Kidney Donor (Annex I.2)	
7. 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: <p style="text-align: center;">Printed name and signature Attending Urologist PhilHealth Accreditation No. _____ Date signed (mm/dd/yyyy): _____</p>	Conformed by: <p style="text-align: center;">Printed name and signature <input type="checkbox"/> Patient <input type="checkbox"/> Parent <input type="checkbox"/> Guardian Date signed (mm/dd/yyyy): _____</p>
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