

Annex H: Checklist for Patient Transfer to a Contracted HF



Republic of the Philippines
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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 TO A CONTRACTED HF Z Benefits Package for Post-Kidney Transplantation Services

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	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ Name and Signature Attending Physician
2. Letter of Referral from Attending Physician	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Certified true copy of the post-kt passport	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ Name and Signature Z Benefits Coordinator
4. Letter of Intent from patient requesting for transfer to a referral contracted HF (Annex G)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ Name and Signature Patient/Parent/Guardian

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

