

Annex I.2: Checklist of Requirements 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 <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> |
| B. MEMBER | 1. Last Name, First Name, Suffix, Middle Name |
| <input type="checkbox"/> Same as patient (Answer only if the patient is a dependent) | 2. PhilHealth ID Number <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> |

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: | Conformed by: |
| Printed name and signature Attending Nephrologist PhilHealth Accreditation No. _____ Date signed (mm/dd/yyyy): _____ | Printed name and signature <input type="checkbox"/> Patient <input type="checkbox"/> Parent <input type="checkbox"/> Guardian Date signed (mm/dd/yyyy): _____ |

