Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center: (02) 8441-7442 Trunkline: (02) 8441-7444
www.philhealth.gov.ph

UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "C2 – ALL"

CHECKLIST OF MANDATORY AND OTHER SERVICES
Acute Lymphocytic/Lymphoblastic Leukemia (Standard Risk)
Consolidation, Interim Maintenance and Delayed Intensification Phase

Tranche 2

HEALTH CARE *PROVIDER (HCP)*		
ADDRESS OF *HCP*		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	*SEX* ☐ *Male* ☐ *Female*
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	☐ *Same as patient* *(Answer the following only if the patient is a dependent)*	
	1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
DATE OF END OF INTENSIFICATION OR RE-INDUCTION PHASE (mm/dd/yyyy)		

Place a (✓) in the appropriate tick box if *the service is* given.

MANDATORY SERVICES	OTHER SERVICES (As needed/ as indicated)
A. **Diagnostics**	
☐ CSF Analysis WBC differential count	☐ Bone marrow aspirate examination
☐ CBC with platelet count	☐ Alanine aminotransferase (ALT)
☐ Creatinine	☐ PT/PTT
☐ Bilirubin	
B. Complete list of medicines given	
Chemotherapy	
☐ Systemic	
☐ prednisone *or dexamethasone*	☐ doxorubicin
☐ vincristine	☐ L-asparaginase
☐ cytarabine	
☐ cyclophosphamide	
☐ methotrexate (IV and oral)	
☐ 6-mercaptopurine	
☐ Intrathecal	
☐ Single (methotrexate) OR	
☐ Triple (methotrexate, cytarabine, hydrocortisone)	

Place a (✓) in the appropriate tick box if *the service is* given.

MANDATORY SERVICES	OTHER SERVICES (As needed/ as indicated)
	Other drugs
	☐ MESNA
	☐ hydrocortisone
	Anti-emetics
	☐ ondansetron
	☐ metoclopramide
	Antimicrobials
	☐ cotrimoxazole
	☐ ceftriaxone
	☐ ceftazidime
	☐ amikacin
	☐ *antifungal (oral), specify*
	☐ Other *antimicrobials* based on hospital antibiogram Specify: _____ _____
	☐ Blood products

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physician	(Printed name and signature) Parent/Guardian
PhilHealth Accreditation No. _____ – _____ – _____	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	