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 "E1 – ALL"

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 INDUCTION PHASE (mm/dd/yyyy)		

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 1)
Acute Lymphocytic/Lymphoblastic Leukemia (Standard Risk)
Induction Phase

Requirements	**Please Check**
1. Checklist of Requirements for Reimbursement (Tranche 1) (Annex E1-ALL)	
2. Photocopy of approved Pre –Authorization Checklist & Request (Annex A-ALL)	
3. Photocopy of completely accomplished ME FORM (Annex B)	
4. *Properly accomplished* PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
5. Checklist of Mandatory and Other Services (Annex C1-ALL)	
6. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
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) Parent/Guardian
PhilHealth Accreditation No. ☐☐☐☐–☐☐☐☐☐☐☐–☐	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	