



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 "E3 – ALL"

HEALTH CARE PROVIDER (HCP)		
ADDRESS OF HCP		
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	<input type="checkbox"/> 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	<input type="text"/> - <input type="text"/> - <input type="text"/>
DATE OF END OF 6 th MAINTENANCE CYCLE (mm/dd/yyyy)		

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 3)
Acute Lymphocytic/Lymphoblastic Leukemia (Standard Risk)
After 6th Maintenance Cycle

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Tranche 3) (Annex E3-ALL)	
2. Properly accomplished PhilHealth Claim Form 2	
3. Checklist of Mandatory and Other Services (Annex C3-ALL)	
4. 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. <input type="text"/> - <input type="text"/>	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

