



Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION

Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 Trunkline (02) 441-7444
www.philhealth.gov.ph



Case No. _____

Annex "E2 – ALL"

HEALTH CARE INSTITUTION (HCI)	
ADDRESS OF HCI	
PATIENT (Last name, First name, Middle name, Suffix)	
PHILHEALTH ID NUMBER OF PATIENT	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)	
PHILHEALTH ID NUMBER OF MEMBER	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2)
Acute Lymphocytic/Lymphoblastic Leukemia (Standard Risk)
Consolidation, Interim, Maintenance and Delayed Intensification Phase

Requirements	Please Check
1. Transmittal Form (Annex H)	
2. Checklist of Requirements for Reimbursement (Tranche 2) (Annex E2-ALL)	
3. Completed PhilHealth Claim Form 2	
4. Checklist of Mandatory and Other Services (Annex C2-ALL)	
5. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
DATE COMPLETED :	
DATE FILED :	

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"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	