Annex E.1: Checklist of Requirements for Reimbursement – Diagnostic Test and Prognostication

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX □ Male □ Female
	2. PhilHealth ID Number □□-□□□□□□□□□-□	
B. MEMBER	**(Answer only if the patient is a dependent; otherwise, write, "same as above")** 1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number □□-□□□□□□□□□-□	

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT
Breast Cancer - Diagnostic Test and Prognostication

Place a (✔) in the appropriate tick box.

Requirements	Please Check
1. Checklist of Requirements for Reimbursement – Diagnostic Test (Annex E.1)	
2. Photocopy of completely accomplished Eligibility Criteria for Diagnostic Test (Annex A.1)	
3. Properly accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)	
4. Properly accomplished PhilHealth Claim Form (CF) 2	
5. Checklist of Mandatory and Other Services (Annex C.1-Diagnostic Test Breast CA)	
6. Completed Z Satisfaction Questionnaire (Annex D)	
7. Original or certified true copy (CTC) of the Statement of Account (SOA) or its equivalent	
8. Transmittal Form (Annex H)	
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) Patient
PhilHealth Accreditation No. □□□□-□□□□□□-□	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	