

Annex E.4.2: Checklist of Requirements for Reimbursement – Hormonotherapy Tranche 2



Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
 Citystate Centre, 709 Shaw Boulevard, Pasig City
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 PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
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"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>
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 <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 Breast Cancer – Hormonotherapy Tranche 2

Place a (✓) in the appropriate tick box.

Requirements	Please Check
1. Checklist of Requirements for Reimbursement – Hormonotherapy Tranche 2 (Annex E.4.2)	
2. Photocopy of approved Pre-authorization Checklist and Request (Annex A.2)	
3. Properly accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)	
4. Properly accomplished PhilHealth Claim Form (CF) 2	
5. Photocopy of Member Empowerment Form (Annex B)	
6. Checklist of Mandatory and Other Services (Annex C.4.2)	
7. Completed Z Satisfaction Questionnaire (Annex D)	
8. Breast Cancer Treatment Passport (Annex F)	
9. Transmittal Form (Annex H)	
10. Photocopy of the multidisciplinary – interdisciplinary team (MDT) plan	
11. Original or certified true copy (CTC) of the Statement of Account (SOA) or its equivalent	
DATE COMPLETED (mm/dd/yyyy):	
DATE FILED (mm/dd/yyyy):	

Certified correct by: (Printed name and signature) Attending Oncologist	Conformed by: (Printed name and signature) Patient																				
PhilHealth Accreditation No. <table border="1" style="display: inline-table; border-collapse: collapse; width: 150px; height: 20px;"> <tr> <td style="width: 15px; height: 15px;"></td> <td style="width: 15px; height: 15px;"></td> <td style="width: 15px; height: 15px;"></td> <td style="width: 15px; height: 15px;"></td> <td style="width: 15px; height: 15px;"></td> <td style="width: 15px; height: 15px;"></td> <td style="width: 15px; height: 15px;"></td> <td style="width: 15px; height: 15px;"></td> <td style="width: 15px; height: 15px;"></td> <td style="width: 15px; height: 15px;"></td> <td style="width: 15px; height: 15px;"></td> <td style="width: 15px; height: 15px;"></td> <td style="width: 15px; height: 15px;"></td> <td style="width: 15px; height: 15px;"></td> <td style="width: 15px; height: 15px;"></td> <td style="width: 15px; height: 15px;"></td> <td style="width: 15px; height: 15px;"></td> <td style="width: 15px; height: 15px;"></td> <td style="width: 15px; height: 15px;"></td> <td style="width: 15px; height: 15px;"></td> </tr> </table>																					Date signed (mm/dd/yyyy)
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