Annex E.6: Checklist of Requirements for Reimbursement – Surveillance

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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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 ☐ 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 - Surveillance

Place a (√) in the appropriate tick box.

Requirements	Please Check
1. Checklist of Requirements for Reimbursement – Surveillance 2. (Annex E.6)	
3. Photocopy of approved Pre-authorization Checklist and Request (Annex A.2)	
4. Photocopy of Member Empowerment Form (Annex B)	
5. Properly accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)	
6. Properly accomplished PhilHealth Claim Form (CF) 2	
7. Checklist of Mandatory and Other Services (Annex C.6)	
8. Completed Z Satisfaction Questionnaire (Annex D)	
9. Original or certified true copy (CTC) of the Statement of Account (SOA) or its equivalent	
10. 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)	