Annex G: Checklist for Patient Transfer



ADDRESS OF HF

HEALTH FACILITY (HF)

Case No.



Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

♥ Citystate Centre, 709 Shaw Boulevard, Pasig City

७ (02) 8662-2588 ⊕ www.philhealth.gov.ph

PhilHealthOfficial
 X teamphilhealth

A. PATIENT	1. Last Name, First Name, Middle Name, Suffix SEX			SEX
				☐ Male ☐ Female
	2. PhilHealth	ID Number	00-0000	
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	00-0000	10000-0
CHECKLIST FOR PATIENT TRANSFER				
Z Benefits Package for Breast Cancer				
For breast cancer patients enrolled in the Z benefits who will be transferred to a referral				
contracted HF, the following checklist shall be accomplished:				
NAME OF REFERRAL CONTRACTED HF:				
ADDRESS OF REFERRAL CONTRACTED HF:				
Requirements		YES C	ND NO C	ignoture of Dognongible
Requii	ements			ignature of Responsible
			opriate box)	Person
1. Updated Abstract	l Medical			_
1. Updated Abstract 2. Letter o	l Medical f Referral from	(tick appro	opriate box)	Person
1. Updated Abstract 2. Letter of the Attending F	l Medical f Referral from Physician	(tick appro	ppriate box)	_
 Updated Abstract Letter of the Attending F Certified 	d Medical f Referral from Physician d true copy of	(tick appro	ppriate box)	Person Name and Signature
1. Updated Abstract 2. Letter of the Attending F	d Medical f Referral from Physician d true copy of	(tick appro	ppriate box) □ No □ No	Person Name and Signature Attending Physician
1. Updated Abstract 2. Letter of the Attending F 3. Certified the breast cancer.	d Medical f Referral from Physician d true copy of	(tick appro	ppriate box) □ No □ No	Person Name and Signature
1. Updated Abstract 2. Letter of the Attending F 3. Certified the breast cancer passport 4. Letter of	f Referral from Physician d true copy of er treatment	(tick appro	ppriate box) □ No □ No	Person Name and Signature Attending Physician Name and Signature
1. Updated Abstract 2. Letter of the Attending Formula 3. Certified the breast cancerpassport 4. Letter of the patient requirements.	f Referral from Physician d true copy of er treatment f Intent from lesting for	(tick appro	ppriate box) No No No	Person Name and Signature Attending Physician Name and Signature
1. Updated Abstract 2. Letter of the Attending Formula 3. Certified the breast cancerpassport 4. Letter of the patient requirements.	f Referral from Physician d true copy of er treatment	(tick appro	ppriate box) No No No	Name and Signature Attending Physician Name and Signature Z Benefits Coordinator
1. Updated Abstract 2. Letter of the Attending F 3. Certified the breast cancerpassport 4. Letter of the patient requirements to a reference of the patient requirements.	f Referral from Physician I true copy of er treatment f Intent from lesting for Ferral contracted	(tick appro	ppriate box) No No No	Name and Signature Attending Physician Name and Signature Z Benefits Coordinator Name and Signature
1. Updated Abstract 2. Letter of the Attending Formula 3. Certified the breast cancer passport 4. Letter of the patient requirements a refugite HF (Annex I) Certified complements of the patient complements of the patient requirements of the patient req	f Referral from Physician It true copy of er treatment f Intent from lesting for ferral contracted ete by:	(tick appro	Depriate box) No No No No Conforme by:	Name and Signature Attending Physician Name and Signature Z Benefits Coordinator Name and Signature Patient/Parent/Guardian
1. Updated Abstract 2. Letter of the Attending F 3. Certified the breast cancerpassport 4. Letter of the patient requirement requirement requirement requirement (Annex I) Certified complement of the patient requirement (Annex I)	f Referral from Physician I true copy of er treatment f Intent from lesting for erral contracted ete by:	(tick appro	Depriate box) No No No No Conforme by:	Name and Signature Attending Physician Name and Signature Z Benefits Coordinator Name and Signature Patient/Parent/Guardian
1. Updated Abstract 2. Letter of the Attending F 3. Certified the breast cancerpassport 4. Letter of the patient requirement requirement requirement requirement (Annex I) Certified complement of the patient requirement (Annex I)	f Referral from Physician I true copy of er treatment f Intent from lesting for erral contracted ete by: ed name and sign Benefits Coordina	(tick appro	Depriate box) No No No No Conforme by:	Name and Signature Attending Physician Name and Signature Z Benefits Coordinator Name and Signature Patient/Parent/Guardian ame and signature /Parent/Guardian

