Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center: (02) 8441-7442 | Trunkline: (02) 8441-7444
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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "E2 – Breast CA"

HEALTH CARE *PROVIDER (HCP)*		
ADDRESS OF *HCP*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	*SEX* ☐ *Male* ☐ *Female*
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	☐ *Same as patient* *(Answer the following only if the patient is a dependent)* 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2)
Upon completion of one (1) month hormonotherapy or last cycle of chemotherapy for stages I-IIIA and upon completion of surgery for stage 0-*IA not requiring chemotherapy*

Requirements	**Please Check**
1. Checklist of Requirements for Reimbursement (Tranche 2) (Annex E2-Breast CA)	
2. *Properly accomplished* PhilHealth Claim Form 2	
3. Checklist of Mandatory and Other Services (Annex C2-Breast CA)	
4. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
5. Photocopy of Breast Cancer Medical Records Summary Form (Annex O)	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient
Date signed (mm/dd/yyyy)