Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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www.philhealth.gov.ph

UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "E2 – CABG"

HEALTHCARE *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)
Standard Risk Elective Coronary Artery Bypass Graft Surgery (CABG)

Requirements	**Please Check**
1. Checklist of Requirements for Reimbursement (Tranche 2) (Annex E2-CABG)	
2. *Properly accomplished PhilHealth Claim Form 2*	
3. Completed Cardiac Rehabilitation Form	
4. Completed Certificate of OPD Follow-up consultation	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Cardiologist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Certified correct by:	Conforme by:
(Printed name and signature) Authorized Cardiac Rehabilitation Staff	(Printed name and signature) Patient
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)