



*Republic of the Philippines*  
**PHILIPPINE HEALTH INSURANCE CORPORATION**

Citystate Centre, 709 Shaw Boulevard, Pasig City  
Call Center (02) 441-7442 Trunkline (02) 441-7444  
[www.philhealth.gov.ph](http://www.philhealth.gov.ph)



Case No. \_\_\_\_\_

**Annex "E1- CABG"**

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT <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"/> <input type="text"/> <input type="text"/> - <input type="text"/>
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER <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"/> <input type="text"/> <input type="text"/> - <input type="text"/>

**CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 1)**  
**Standard Risk Elective Coronary Artery Bypass Graft Surgery (CABG)**

Requirements	Please Check
1. Transmittal Form (Annex H)	
2. Checklist of Requirements for Reimbursement (Tranche 1) (Annex E-CABG)	
3. Photocopy of approved Pre –Authorization Checklist & Request (Annex A-CABG)	
4. Photocopy of completely accomplished ME FORM (Annex B)	
5. Completed PhilHealth Claim Form (CF) 1 OR PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
6. Completed Checklist of Mandatory and Other Services (Annex C-CABG) (Pre-claims Assessment Checklist of Mandatory and Other Services)	
7. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
8. Accomplished Surgical Operative Report	
9. Accomplished Anaesthesia Report	
10. Discharge Summary Signed by Attending Physician	
DATE COMPLETED :	
DATE FILED :	

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. <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"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	PhilHealth Accreditation No. <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"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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