Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center: (02) 8441-7442 | Trunkline: (02) 8441-7444
www.philhealth.gov.ph

UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "E1.2 – Cervical CA"

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
Chemoradiation with Cobalt and Brachytherapy (Low Dose) for Cervical Cancer

Requirements	**Please Check**
1. Checklist of Requirements for Reimbursement (Annex E1.2-Cervical CA)	
2. Photocopy of approved Pre –Authorization Checklist & Request (Annex A-Cervical CA)	
3. Photocopy of completely accomplished ME FORM (Annex B)	
4. *Properly accomplished* PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
5. Checklist of Mandatory and Other Services (Annex C1.2-Cervical CA)	
6. Photocopy completed Z Satisfaction Questionnaire (Annex D)	
7. *Original copy of* medical certificate of Out-Patient Follow up Consultation (within 2 weeks post-procedure) with written request for out-patient pap smear 3 months post-procedure	

Certified correct by:	Certified correct by:
(Printed name and signature) Gynecologic Oncologist	(Printed name and signature) Radiation 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)