Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "E1.3 – 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 Linear Accelerator and Brachytherapy (Low/High Dose) for Cervical Cancer

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E1.3-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 C1.3-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)