



Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION

Citystate Centre Building, 709 Shaw Boulevard, Pasig City
Healthline 441-7444 www.philhealth.gov.ph



Case No. _____

Annex "E1.2 – Cervical CA"

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

Requirements	Please Check
1. Transmittal Form (Annex H)	
2. Checklist of Requirements for Reimbursement (Annex E1.2-Cervical CA)	
3. Photocopy of approved Pre –Authorization Checklist & Request (Annex A-Cervical CA)	
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. Checklist of Mandatory and Other Services (Annex C1.2-Cervical CA)	
7. Photocopy completed Z Satisfaction Questionnaire (Annex D)	
8. 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	
DATE COMPLETED :	
DATE FILED :	

Certified correct by:	Certified correct by:
(Printed name and signature) Gynecologic Oncologist	(Printed name and signature) Radiation Oncologist
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"/>	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"/>
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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