Case No. _____

Annex "E1.3 – Cervical CA"

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT
Chemoradiation with Linear Accelerator and Brachytherapy (Low/High Dose) for Cervical Cancer

Requirements	**Please Check**
1. Transmittal Form (Annex H)	
2. Checklist of Requirements for Reimbursement (Annex E1.3-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 C1.3-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. ☐☐☐☐–☐☐☐☐☐☐☐–☐	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)