**Case No. _____________**

Annex "E1.1 – Rectum 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**

**TRANCHE REQUIREMENTS CHECKLIST**

**Rectum Cancer Stage I (clinical and pathologic stage)**

<table>
<thead>
<tr>
<th>Single Tranche Payment</th>
<th>Please Check</th>
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</thead>
<tbody>
<tr>
<td>1. Transmittal Form (Annex H)</td>
<td></td>
</tr>
<tr>
<td>2. Tranche Requirements Checklist (Annex E1.1-Rectum CA)</td>
<td></td>
</tr>
<tr>
<td>4. Photocopy of completely accomplished ME FORM (Annex B)</td>
<td></td>
</tr>
<tr>
<td>5. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2</td>
<td></td>
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<tr>
<td>6. Checklist of Mandatory and Other Services (Annex C1.1-Rectum CA)</td>
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<tr>
<td>7. Photocopy of completed Z Satisfaction Questionnaire (Annex D)</td>
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<td>8. Operative record</td>
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<tr>
<td>9. Multidisciplinary-interdisciplinary team (MDT) Plan</td>
<td></td>
</tr>
<tr>
<td>10. Histopathology result after definitive surgery</td>
<td></td>
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</tbody>
</table>

**DATE COMPLETED:**

**DATE FILED:**

Certified correct by:

(Printed name and signature)

**Attending Surgeon**

(Date signed (mm/dd/yyyy))

Certified correct by:

(Printed name and signature)

**Attending Medical Oncologist**

(Date signed (mm/dd/yyyy))

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Certified correct by:

(Printed name and signature)

**Attending Radiation Oncologist**

(Date signed (mm/dd/yyyy))

Certified correct by:

(Printed name and signature)

**Patient**

(Date signed (mm/dd/yyyy))

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As of September 2015