Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre Building, 709 Shaw Boulevard, Pasig City
Healthline 441-7444 www.philhealth.gov.ph

Bawat Pilipino MIYEMBRO
Bawat miyembro PROTEKTADO
Kalusugan natin SEGURADO

Case No. _____

Annex "E1.3 – 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 1 REQUIREMENTS CHECKLIST
Rectum cancer pre-treatment clinical stage II - III

Tranche 1 of 3	**Please Check**
1. Transmittal Form (Annex H)	
2. Tranche 1 Requirements Checklist (Annex E1.3-Rectum CA)	
3. Photocopy of Approved Pre –Authorization Checklist & Request (Annex A-Rectum 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. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
7. Checklist of Mandatory and Other Services (Annex C1.3-Rectum CA)	
8. Multidisciplinary-interdisciplinary team (MDT) Plan	
9. Biopsy (after colonoscopy or proctoxcopy)	
10. Copy of Radiation Treatment Summary Form	
11. Copy of Chemotherapy Treatment Summary Form	
DATE COMPLETED : DATE FILED :	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Certified correct by:	Conforme by:
(Printed name and signature) Attending Radiation Oncologist	(Printed name and signature) Patient
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	