



*Republic of the Philippines*  
**PHILIPPINE HEALTH INSURANCE CORPORATION**

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[www.philhealth.gov.ph](http://www.philhealth.gov.ph)



Case No. \_\_\_\_\_

**Annex "E2.2 – Rectum 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"/>

**TRANCHE 2 REQUIREMENTS CHECKLIST**

**Rectum cancer pre-operative clinical stage I with post-operative pathologic stage II - III**

<b>Tranche 2 of 3</b>	<b>Please Check</b>
1. Transmittal Form (Annex H)	
2. Tranche Requirements Checklist (Annex E2.2-Rectum CA)	
3. Completed PhilHealth Claim Form 2	
4. Checklist of Mandatory and Other Services (Annex C2.2-Rectum CA)	
5. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
6. Photocopy of Radiation Treatment Summary	
7. Photocopy of Chemotherapy Treatment Summary	
DATE COMPLETED :	
DATE FILED :	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Medical Oncologist	(Printed name and signature) Attending 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)