



Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION

Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 Trunkline (02) 441-7444
www.philhealth.gov.ph



Case No. _____

Annex "E2.3 – 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-treatment clinical stage II – III

Tranche 2 of 3	Please Check
1. Transmittal Form (Annex H)	
2. Tranche Requirements Checklist (Annex E2.3-Rectum CA)	
3. Completed PhilHealth Claim Form 2	
4. Checklist of Mandatory and Other Services (Annex C2.3-Rectum CA)	
5. Completed Z Satisfaction Questionnaire (Annex D)	
6. Operative Record	
7. Histopathology result after definitive surgery	
DATE COMPLETED :	
DATE FILED :	

Certified correct by:		Conforme by:	
(Printed name and signature) Attending Surgeon		(Printed name and signature) Patient	
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)			