

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 "E3.2 –]	Rectum CA"
HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
PATIENT (Last name, First name, Middle name	e, Suffix)	
PHILHEALTH ID NUMBER OF PATIENT		
MEMBER (if patient is a dependent) (Last name	, First name, Middle name, Suff	īx)
PHILHEALTH ID NUMBER OF MEMBER		- 🗆
TRANCHE 3 REQUIF	REMENTS CHECKLIST I with post-operative pathological properties of the control o	gic stage II – III
Tranche 3 of 3		Please Check
1. Transmittal Form (Annex H)		
2. Tranche Requirements Checklist (Annex	E3.2-Rectum CA)	
3. Completed PhilHealth Claim Form 2		
4. Checklist of Mandatory and Other Service		
5. Photocopy of completed Z Satisfaction (Questionnaire (Annex D)	
6. Photocopy of Chemotherapy Treatment	Summary Form	
DATE COMPLETED :	100	
DATE FILED:		
Certified correct by:	Conforme by:	
(Printed name and signature)	(Printed name and signature)	
Attending Medical Oncologist	Patient	
	Patient	ignature)
PhilHealth Accreditation No. Date signed (mm/dd/yyyy)	Patient Date signed (mm/dd/yyyy)	ignature)









