Case No. _____

Annex "E3.2 – 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 3 REQUIREMENTS CHECKLIST
Rectum cancer pre-operative clinical stage I with post-operative pathologic 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 Services (Annex C3.2-Rectum CA)	
5. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
6. Photocopy of Chemotherapy Treatment Summary Form	
DATE COMPLETED : DATE FILED :	

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