Case No. ________________

Annex "E3.3 – Rectum CA"

<table>
<thead>
<tr>
<th>HEALTH CARE INSTITUTION (HCI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS OF HCI</td>
</tr>
<tr>
<td>PATIENT (Last name, First name, Middle name, Suffix)</td>
</tr>
<tr>
<td>PHILHEALTH ID NUMBER OF PATIENT</td>
</tr>
<tr>
<td>MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)</td>
</tr>
<tr>
<td>PHILHEALTH ID NUMBER OF MEMBER</td>
</tr>
</tbody>
</table>

**TRANCHE 3 REQUIREMENTS CHECKLIST**  
Rectum cancer pre-treatment clinical stage II – II

**Tranche 3 of 3**  
1. Transmittal Form (Annex H)  
2. Tranche Requirements Checklist (Annex E3.3-Rectum CA)  
3. Completed PhilHealth Claim Form 2  
4. Checklist of Mandatory and Other Services (Annex C3.3-Rectum CA)  
5. Photocopy of completed Z Satisfaction Questionnaire (Annex D)  
6. Photocopy of Chemotherapy Treatment Summary Form  

**Please Check**

**Certified correct by:**  
(Printed name and signature)  
Attending Medical Oncologist  
PhilHealth Accreditation No. | ~ | ~ | ~ | ~ | ~ | ~  
Date signed (mm/dd/yyyy)  

**Conforme by:**  
(Printed name and signature)  
Patient  
Date signed (mm/dd/yyyy)