

## Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION

Citystate Centre Building, 709 Shaw Boulevard, Pasig City Healthline 441-7444 www.philhealth.gov.ph



Case No.	Annex "E1,1	- Colon 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 REQUIREMENTS CHECKLIST		
Colon Cancer Post-Surgery Stage I-II (Low Risk)		
	ige I-II (Low Risk)	Diagon Charle
Single Tranche Payment		Please Check
Transmittal Form (Annex H)     Tranche Requirements Checklist (Annex E1.1-Colon CA)		
<ol> <li>Tranche Requirements Checklist (Annex E1.1-Colon CA)</li> <li>Photocopy of approved Pre –Authorization Checklist &amp; Request</li> </ol>		
(Annex A-Colon CA)		
4. Photocopy of completely accomplished ME FORM (Annex B)		
5. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit		
Eligibility Form (PBEF) and CF 2		
6. Checklist of Mandatory and Other Services (Annex C1.1-Colon CA)		
7. Photocopy of completed Z Satisfaction Questionnaire (Annex D)		
8. Operative record		
9. Histopathology result after definitive surgery		
DATE COMPLETED:		
DATE FILED:		
		1
Certified correct by:	Certified correct by:	
(Printed name and signature)	(Printed name and sign	ature)
Attending Surgeon	Attending Medical Oncologist	
PhilHealth	PhilHealth	
Accreditation No.	Accreditation No.	
Date signed (mm/dd/yyyy)	/yyyy) Date signed (mm/dd/yyyy)	
	Conforme by:	
	(Printed name and signature)	
	Patient	
Date signed (mm/dd/yyyy)		

As of September 2015

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