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)

Single Tranche Payment	**Please Check**
1. Transmittal Form (Annex H)	
2. Tranche Requirements Checklist (Annex E1.1-Colon CA)	
3. Photocopy of approved Pre –Authorization Checklist & Request (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 :	

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

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