

Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION

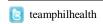
Citystate Centre Building, 709 Shaw Boulevard, Pasig City Healthline 441-7444 www.philhealth.gov.ph



Case No. Annex "E1.2 - 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 1 REQUIREMENTS CHECKLIST **Colon Cancer** Post-Surgery Stage II (High Risk) - III Tranche 1 of 2 Please Check Transmittal Form (Annex H) 2. Tranche 1 Requirements Checklist (Annex E1.2-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. Photocopy of completed Z Satisfaction Questionnaire (Annex D) 7. Checklist of Mandatory and Other Services (Annex C1.2-Colon CA) 8. Operative record 9. Histopathology result after definitive surgery DATE COMPLETED: DATE FILED: Certified correct by: Certified correct by: (Printed name and signature) (Printed name and signature) Attending Surgeon Attending Medical Oncologist PhilHealth PhilHealth Accreditation No. Accreditation No. Date signed (mm/dd/yyyy) Date signed (mm/dd/yyyy) Conforme by: (Printed name and signature)

As of September 2015

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Patient

Date signed (mm/dd/yyyy)