Annex C1.1: Colon Cancer Stage I to II (low risk) – Post-surgery

Revised as of December 2022

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")*** 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF MANDATORY AND OTHER SERVICES
Colon Cancer Stage I-II (Low Risk)
Post-Surgery

Place a (✓) in the appropriate tick box if *the service is* done or *given*

MANDATORY SERVICES	OTHER SERVICES as needed/as indicated
Procedure:	
☐ Colonoscopy[a]	☐ Surgery for closure of colostomy/ ileostomy[b]
☐ Histopathology	
☐ Surgery (definitive)	
Diagnostics:	
☐ Chest CT or Chest x-ray (PA-L)[a]	☐ ECG
☐ CT scan of whole abdomen *preferably with contrast*[a, c]	☐ CP clearance
☐ Fasting blood sugar (FBS)	☐ SGPT
☐ Carcinoembryonic antigen (CEA), as baseline	☐ Prothrombin time
	☐ Alkaline phosphatase
☐ Complete blood count	☐ CEA for monitoring
☐ Blood typing	☐ SGPT for monitoring
☐ Albumin	☐ Creatinine for monitoring
☐ Creatinine	Medicine
[a] *should be done within 60 calendar days before the date of submission of the pre-authorization checklist and request.to PhilHealth*	☐ *Antimicrobials*, specify
[b] *shall be covered under the Z Benefits within two (2) years from the date of surgery; patients may be charged co-payment within the allowable limit as indicated in the contract of the HF*	☐ Pain relievers, specify
[c] *PET scan may be accepted in place of CT scan*	Others
	☐ Blood support, such as cross-matching, screening, and processing

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	**(Answer only if the patient is a dependent; otherwise, write, "same as above")** 1. Last Name, First Name, Suffix, Middle Name	
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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)