# Annex C1.2: Colon Cancer Stage II (high risk) to III – 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 II (High Risk) *to* III
## 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] |
| ☐ *Biopsy with* 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 |
| | ☐ SGPT |
| ☐ Fasting blood sugar (FBS) | ☐ Prothrombin time |
| ☐ Carcinoembryonic antigen (CEA), as baseline | ☐ Alkaline phosphatase |
| | ☐ CEA for monitoring |
| ☐ Complete blood count | ☐ SGPT for monitoring |
| ☐ Blood typing | ☐ Creatinine for monitoring |
| ☐ Albumin | Medicines |
| ☐ Creatinine | ☐ *Antimicrobials,* specify |
| [a] *should be done within 60 calendar days before the date of submission of the pre-authorization checklist and request to PhilHealth* | ☐ *Antiemetics*, specify |
| | ☐ Pain relievers, 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* | Others |
| [c] *PET scan may be accepted in place of CT scan* | ☐ Blood support, such as cross-matching, screening, and processing |

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|---|---|---|
| HEALTH *FACILITY (HF)* | | |
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| | 2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐ | |
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|---|---|
| Certified correct by: | Certified correct by: |
| (Printed name and signature)<br>Attending Surgeon | (Printed name and signature)<br>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)<br>Patient |
| Date signed (mm/dd/yyyy) |