

Annex E1.1: 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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Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
	2. PhilHealth ID Number	<input type="text"/> - <input type="text"/> - <input type="text"/>
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	<input type="text"/> - <input type="text"/> - <input type="text"/>

TRANCHE REQUIREMENTS CHECKLIST Colon Cancer Stage I-II (Low Risk) Post-Surgery

	Please Check
1. Tranche Requirements Checklist (Annex E1.1-Colon CA)	
2. Photocopy of approved Pre –Authorization Checklist & Request (Annex A1-Colon CA)	
3. Photocopy of completely accomplished ME FORM (Annex B)	
4. Properly accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF2	
5. Checklist of Mandatory and Other Services (Annex C1.1-Colon CA)	
6. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
7. Photocopy of the Multidisciplinary-interdisciplinary Team (MDT) Plan	
8. Original or certified true copy (CTC) of the Statement of Account (SOA)	
9. Photocopy of accomplished surgical operative report	
10. Photocopy of accomplished anesthesia report	
11. Histopathology result after definitive surgery	
DATE COMPLETED (mm/dd/yyyy)	
DATE FILED (mm/dd/yyyy)	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No. <input type="text"/> - <input type="text"/>	PhilHealth Accreditation No. <input type="text"/> - <input type="text"/>
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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