Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

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	☐ Same as patient (Answer the following only if the patient is a dependent) 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT FOR HEART VALVE REPAIR AND/OR REPLACEMENT FOR VALVULAR HEART DISEASE

Requirements	Remarks
1. Transmittal Form (Annex G)	
2. Checklist of Requirements for Reimbursement (Annex F)	
3. Photocopy of approved Pre –Authorization Checklist & Request ☐ Annex A.1: Pre-authorization Checklist and Request Form for Heart Valve Replacement for Valvular Heart Disease (Adult) ☐ Annex A.2: Pre-authorization Checklist and Request Form Heart Valve Repair and/or Replacement for Valvular Heart Disease (Pedia)	
4. Photocopy of completely accomplished ME Form (Annex D)	
5. Properly accomplished PhilHealth Claim Form (CF) 1 OR PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
6. Completed Checklist of Essential Health Services (Annex H)	
7. Photocopy of completed Z Satisfaction Questionnaire (Annex E)	
8. Original or Certified true copy of Statement of Account (SOA)	
9. Photocopy of accomplished surgical operative report	
10. Photocopy of accomplished anesthesia report	
Date Filed (mm/dd/yyyy):	

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
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B. MEMBER	☐ Same as patient (Answer the following only if the patient is a dependent) 1. Last Name, First Name, Suffix, Middle Name	
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Certified correct by:	Certified correct by:
(Printed name and signature) Attending Cardiologist (Adult or Pediatric)	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
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)