Case No. _____

Annex "E2 – KT"

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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2)
End Stage Renal Disease requiring Kidney Transplantation (Low Risk)

Requirements	Please Check
1. Transmittal Form (Annex H)	
2. Checklist of Requirements for Reimbursement (Tranche 2) (Annex E2-KT)	
3. Completed PhilHealth Claim Form 2	
4. Monitoring For Recipient And Donor Form (Annex C2-KT) with the following attachment: Immunosuppressive medications	
5. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Nephrologist or Transplant Surgeon	(Printed name and signature) Patient/Parent/Guardian
PhilHealth Accreditation No. ☐☐☐☐–☐☐☐☐☐☐☐–☐	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	