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)

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

Certified correct by:  
(Printed name and signature)  
Attending Nephrologist or Transplant Surgeon  
PhilHealth Accreditation No.  -  -  -  -  -  -  -  -  -  -  -  -  -  -

Date signed (mm/dd/yyyy)

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