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 only if the patient is a dependent)*	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐☐ - ☐	

Checklist of Requirements for Reimbursement
Kidney Transplantation (Living or Deceased Organ Donor)

(Place a ✔ if attached or NA if not applicable)

REQUIREMENTS	Status
1. Photocopy of completely accomplished pre-authorization checklist and request form (Annex A)	
2. Photocopy of the MDT Plan	
3. Photocopy of properly accomplished Member Empowerment (ME) Form (Annex D)	
4. Properly Accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)	
5. Properly Accomplished PhilHealth Claim Form 2 (CF2)	
6. Properly accomplished Kidney Transplant Data Registry (Annex G)	
7. Completed Z Satisfaction Questionnaire (Annex E)	
8. Checklist of Requirements for Reimbursement (Annex F)	
9. Checklist of Essential Health Services (Annex H) with the attached documents of pre-transplant Evaluation Form for KT Recipient and Donor	
10. Transmittal Form (Annex I)	
11. Original or Certified True Copy (CTC) of the Statement of Account (SOA) or its equivalent	
12. Photocopy of accomplished surgical operative report of recipient and donor or similar documents	
13. Photocopy of Anesthesia Record or similar documents	
Date Completed (mm/dd/yyyy)	
Date Filed (mm/dd/yyyy)	

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