Case No. _____

Annex "E1 – KT"

HEALTH CARE *PROVIDER (HCP)*		
ADDRESS OF *HCP*		
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 (TRANCHE 1)
End Stage Renal Disease requiring Kidney Transplantation (Low Risk)

Requirements	**Please Check**
1. Checklist of Requirements for Reimbursement (Tranche 1) (Annex E1-KT)	
2. Photocopy of approved Pre –Authorization Checklist & Request (Annex A-KT)	
3. Photocopy of completely accomplished ME FORM (Annex B)	
4. *Properly accomplished* PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
5. Checklist of Mandatory and Other Services (Annex C1-KT) with the following attachments: a. Pre-Transplant Evaluation Form For Kidney Transplant Recipient b. Pre-Transplant Evaluation Form For Kidney Transplant Donor	
6. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
7. Photocopy of accomplished surgical operative report of recipient and donor	
8. Photocopy of accomplished anesthesia report of recipient and donor	

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)	