



Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "E2 – KT"

HEALTH CARE PROVIDER (HCP)		
ADDRESS OF HCP		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
	2. PhilHealth ID Number	<input type="text"/> - <input type="text"/> - <input type="text"/>
B. MEMBER	<input type="checkbox"/> 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	<input type="text"/> - <input type="text"/> - <input type="text"/>

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

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Tranche 2) (Annex E2-KT)	
2. Properly accomplished PhilHealth Claim Form 2	
3. Monitoring For Recipient And Donor Form (Annex C2-KT) with the following attachment: Immunosuppressive medications	
4. 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. <input type="text"/> - <input type="text"/>	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

