**Case No. _____**

**Annex "E2 – KT"**

| | | |
|---|---|---|
| HEALTH CARE *PROVIDER* (*HCP*) | | |
| ADDRESS OF *HCP* | | |
| A. PATIENT | 1. Last Name, First Name, Suffix, Middle Name | *SEX*<br>☐ *Male* ☐ *Female* |
| | 2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐ | |
| B. MEMBER | ☐ *Same as patient* *(Answer the following only if the patient is a dependent)*<br>1. Last Name, First Name, Suffix, Middle Name | |
| | 2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐ | |

## 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:<br>Immunosuppressive medications | |
| 4. Photocopy of completed Z Satisfaction Questionnaire (Annex D) | |

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