

## Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION Citystate Centre, 709 Shaw Boulevard, Pasig City Call Center (02) 441-7442 Trunkline (02) 441-7444 www.philhealth.gov.ph



Case No.

Annex "C3.2- Rectum CA"

## CHECKLIST OF MANDATORY AND OTHER SERVICES Rectum cancer pre-operative clinical stage I with post-operative pathologic stage II - III

Tranche 3 of 3

HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
PATIENT (Last name, First name, Middle name, Suffix)		
TATIENT (Last name, Thist name, Whethe name, Suthx)		
PHILHEALTH ID NUMBER OF PATIENT		
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)		
HEMDER ( <i>j puttin is a appravni</i> ) (East name, 1 list name, Wieder name, Suthx)		
PHILHEALTH ID NUMBER OF MEMBER		

Place a ( $\checkmark$ ) if DONE or NA if not applicable in the status column.

	MANDATORY AND OTHER SERVICES	Status	
Procedure:			
1.	Proctoscopy, as indicated		
2.	Surgery for closure of colostomy/ileostomy, if needed		
Diagno	ostics:		
1.	Complete blood count		
2.	Creatinine		
3.	Chest x-ray, as needed		
4.	Chest CT, as needed		
5.	ECG, as needed		
6.	Prothrombin time, as needed		
7.	Alkaline phosphatase, as needed		
8.	Bilirubin, as needed		
9.	CEA for monitoring, as needed		
10.	SGPT for monitoring, as needed		
11.	Creatinine for monitoring, as needed		

As of September 2015

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MANDATORY AND OTHER SERVICES	Status	
Medicines		
A. Any of the following protocols:		
1. Capecitabine-Oxaliplatin (CapeOX)		
2. Fluorouracil-Folinic acid-Oxaliplatin (FOLFOX 4)		
3. Fluorouracil-Folinic acid-Oxaliplatin (mFOLFOX 6)		
B. Antiemetics, specify (as indicated)		
C. Antibiotics, specify (as indicated)		
D. Pain relievers, specify (as indicated)		
Others: Blood support, as needed	2	

Certified correct by:	Certified correct by:
(Printed name and signature)	(Printed name and signature)
Attending Surgeon	Attending Medical Oncologist
PhilHealth Accreditation No.	PhilHealth Accreditation No.
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Certified correct by:	Conforme by:
(Printed name and signature)	(Printed name and signature)
Attending Radiation Oncologist	Patient
PhilHealth Accreditation No.	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

As of September 2015

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