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

Checklist of Health Essential Services for Post-Cardiac Services

Place a check (✓) on the appropriate answer

Type of Surgery Performed	Date of Procedure (mm/dd/yyyy)
☐ Coronary Artery Bypass Graft (CABG) Closure of Ventricular Septal Defect ☐ Without Special Conditions ☐ With Special Conditions ☐ With Severe Pulmonary Stenosis ☐ Repair of Tetralogy of Fallot (TOF)	

A. Cardiac Rehabilitation Sessions*

Date Performed (mm/dd/yyyy)	Indicate the health professionals (e.g. Physical Therapist, Occupational Therapist)
1.	
2.	
3.	
4.	
5.	
6.	

*Maximum sessions covered:
Six (6) – CABG
Four (4) – VSD and TOF

B. Ancillary Services for post-CABG Surgery

Essential Health Services	Date Conducted/Dispensed (mm/dd/yyyy)
Laboratory and Diagnostics	
☐ Electrocardiogram (ECG)	
As indicated/needed:	
☐ Cardiac Stress Test	
☐ Complete blood count (CBC)	
☐ Fasting blood sugar (FBS)	
☐ Blood Urea Nitrogen (BUN)	
☐ Serum Creatinine	
Electrolytes: ☐ Sodium ☐ Potassium ☐ Magnesium ☐ Ionized Calcium	
Drugs/ Medicines	
☐ Antiplatelet Specify:_____	
☐ Statins Specify: _____	
As indicated/needed:	
☐ Beta blockers Specify:_____	
☐ Calcium channel blockers Specify:_____	
☐ Nitrates Specify: _____	
☐ Antiplatelet agents Specify: _____	
☐ Angiotensin receptors blockers Specify: _____	
Consultations	
☐ Follow-up visit (Cardiologist or other Specialists)	Date of Visit (mm/dd/yyyy):

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Cardiologist (Adult or Pediatric)	(Printed name and signature) Cardiac Rehabilitation Specialist or Physical Medicine and Rehabilitation Specialist
PhilHealth Accreditation No. ____-____-____	PhilHealth Accreditation No. ____-____-____
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient
Date signed (mm/dd/yyyy)