

Annex D: Peritoneal Dialysis (PD) Passport



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)	DATE OF CONSULTATION (mm/dd/yyyy)
ADDRESS OF HF	
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name SEX <input type="checkbox"/> Male <input type="checkbox"/> Female 2. PhilHealth ID Number [] [] - [] [] [] [] [] [] [] [] - []
B. MEMBER <input type="checkbox"/> Same as patient (Answer only if the patient is a dependent)	1. Last Name, First Name, Suffix, Middle Name 2. PhilHealth ID Number [] [] - [] [] [] [] [] [] [] [] - []

PD PASSPORT

The PD Coordinator should countersign the availment of the PD bags opposite the inclusive dates.

Claim No.	Date of PD dispensing	Inclusive dates	No. of issued bags/day	Pharmacist's signature	Date of next claim	Patient's signature	Attending Physician's signature
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
		PD transfer set given*	<input type="checkbox"/> Date (mm/dd/yyyy) _____ <input type="checkbox"/> Date (mm/dd/yyyy) _____				

* Quantity: 2 per calendar year, every six (6) months only

Medications as indicated (Attach additional sheets as necessary)

Name of medicine	Dosage	Preparation	Date given	Patient's/ parent/ guardian's signature	Attending Physician's signature

