Annex E: Letter of Intent for Transfer of PD Care

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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DATE (mm/dd/yyyy)
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐ - ☐
MEMBER *(if patient is a dependent)* (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐ - ☐

LETTER OF INTENT FOR TRANSFER OF PD CARE TO A REFERRAL PD Z PROVIDER

This is to certify that I, _____, born on _____,
(Name of Patient) *(Date of Birth)*
age _____ years old, residing at _____,
(Address)
was diagnosed with CKD Stage 5 and was initiated on peritoneal dialysis at the
_____ on _____.
(Name of Referring PD Z Provider) *(Date of PD Initiation)*

I perform _____ exchanges per day. I would like to request for transfer of PD Care to
(indicate number)
_____ under the care of _____.
(Name of Referral PD Z Provider) *(Name of Nephrologist)*

I understand that upon transfer to a referral PD Z provider, I will have to surrender my PD Passport to the PD Coordinator of my referring PD Z provider as well as waive all my subsequent PD claims in my referring PD Z provider. In case I decide to return to the referring PD Z provider to resume my PD care, I will have to abide by the policies set by them as a new PD patient.

Conforme by:	Certified correct by:
(Printed name and signature) Patient/ Parent/ Guardian	(Printed name and signature) Nephrologist, Referring PD Z Provider
	PhilHealth Accreditation ☐☐☐☐-☐☐☐☐☐☐☐-☐

Certified correct by:	Certified correct by:
(Printed name and signature) Billing Representative, Referring PD Z Provider	(Printed name and signature) PD Coordinator, Referring PD Z Provider

Acknowledged by:	Acknowledged by:
(Printed name and signature) Head/PD Coordinator Referral PD Z Provider	(Printed name and signature) BAS Head/Authorized Representative PhilHealth Regional Office _____ of the Referring Accredited PD Z Provider
	Acknowledged by:
	(Printed name and signature) BAS Head/Authorized Representative PhilHealth Regional Office _____ of the Referral Accredited PD Z Provider