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/mmm)	
DATE (mm/dd/yyyy) PATIENT (Last name, First name, Middle name,	Suffix)
PATIENT (Last name, First name, Middle name	Sumx)
PHILHEALTH ID NUMBER OF PATIENT	
MEMBER (if patient is a dependent) (Last name	e, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER	
LETTER OF INTENT FOR TRANSFER OF P	D 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	
(Name of Referring PD Z Provider)	on (Date of PD Initiation)
(Nume of Referring 1D 21 roomer)	(Dute of 1D Initiation)
I perform exchanges per day	. I would like to request for transfer of PD Care to
(indicate number)	. I would like to request for transfer of TD cure to
(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,	
	the referring PD Z provider to resume my PD care,
referring PD Z provider. In case I decide to return to I will have to abide by the policies set by them as a n	the referring PD Z provider to resume my PD care,
	the referring PD Z provider to resume my PD care,
I will have to abide by the policies set by them as a non- Conforme by:	o the referring PD Z provider to resume my PD care, ew PD patient. Certified correct by:
I will have to abide by the policies set by them as a non- Conforme by: (Printed name and signature)	o the referring PD Z provider to resume my PD care, ew PD patient. Certified correct by: (Printed name and signature)
I will have to abide by the policies set by them as a non- Conforme by:	o the referring PD Z provider to resume my PD care, ew PD patient. Certified correct by: (Printed name and signature) Nephrologist, Referring PD Z Provider
I will have to abide by the policies set by them as a non- Conforme by: (Printed name and signature)	o the referring PD Z provider to resume my PD care, ew PD patient. Certified correct by: (Printed name and signature) Nephrologist, Referring PD Z Provider PhilHealth
I will have to abide by the policies set by them as a non- Conforme by: (Printed name and signature)	o the referring PD Z provider to resume my PD care, ew PD patient. Certified correct by: (Printed name and signature) Nephrologist, Referring PD Z Provider
I will have to abide by the policies set by them as a n Conforme by: (Printed name and signature) Patient/ Parent/ Guardian	o the referring PD Z provider to resume my PD care, ew PD patient. Certified correct by: (Printed name and signature) Nephrologist, Referring PD Z Provider PhilHealth Accreditation
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I will have to abide by the policies set by them as a n Conforme by: (Printed name and signature) Patient/ Parent/ Guardian Certified correct by: (Printed name and signature)	o the referring PD Z provider to resume my PD care, ew PD patient. Certified correct by: (Printed name and signature) Nephrologist, Referring PD Z Provider PhilHealth Accreditation Certified correct by: (Printed name and signature) (Printed name and signature)
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