Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

CHECKLIST FOR PATIENT TRANSFER – PD Z Benefits

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

For HF PD patients* who will be transferred to a referral PD Z Provider, the following checklist shall be accomplished:

NAME OF REFERRAL PD Z PROVIDER:
ADDRESS OF REFERRAL PD Z PROVIDER:

Requirements	Yes OR No (tick appropriate box)	Signature of Responsible Person
1. Updated Medical Abstract	☐ Yes ☐ No	Name & signature Attending Nephrologist
2. Updated PD Prescription for one (1) month	☐ Yes ☐ No	
3. Letter of Referral from Attending Nephrologist/ Fellow	☐ Yes ☐ No	
4. Clearance from PD Z Provider re: status of utilization of PhilHealth PD First Z Benefits Claims	☐ Yes ☐ No	Name & signature Billing Personnel
5. Letter of Intent from Patient requesting for transfer to a referral PD Z Provider (Annex E)	☐ Yes ☐ No	Name & signature Patient/Parent/Guardian
6. Submission of PD Passport (Annex D) to Provider	☐ Yes ☐ No	Name & signature PD Coordinator

*HF PD Patients are those who had their PD initiation and subsequent follow-ups in the referring PD Z Provider. They claim their PD First Z Benefits from the referring HF.

Certified complete by: _____ Printed name and signature PD Coordinator	Conforme by: _____ Printed name and signature Patient/Parent/Guardian
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)