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

Checklist of Requirements for Reimbursement Using CAPD - PD Bags for Pediatric Patients

(Place a ✓ if attached or NA if not applicable)

REQUIREMENTS	Status
I. Upon filing of claims for the 1st tranche	
A. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF2	
B. Photocopy of the completely accomplished Checklist of Eligibility Criteria (Annex A.2)	
C. Photocopy of completely accomplished Member Empowerment (ME) Form (Annex C)	
II. To be submitted every filing of tranche (every 28 days)	
A. Transmittal Form (Annex K)	
B. Photocopy of PD passport (Annex D)	
C. Accomplished Checklist of Requirements for Reimbursement (Annex G.2A)	
D. Accomplished Checklist of Essential Health Services Using CAPD - PD Bags (Annex I.2A)	
E. Original or Certified true copy (CTC) of the Statement of Account (SOA)	
III. To be submitted along with the claims for the 13th tranche	
Z Satisfaction Questionnaire (Annex H)	
Date Completed (mm/dd/yyyy)	
Date Filed (mm/dd/yyyy)	

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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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

Certified correct by:*	Certified correct by: (for Service Patients)
(Printed name and signature) Attending Pediatric Nephrologist	(Printed name and signature) Please tick appropriate box
PhilHealth Accreditation No. ☐☐☐☐☐-☐☐☐☐☐☐-☐	□ Head, Peritoneal Dialysis Unit OR □ Chair, Dept. of Adult Nephrology OR □ Chair, Dept. of Pediatric Nephrology OR □ Chair, Dept. of Organ Transplantation OR □ Executive Director/Chief of Hospital/ Medical Director/Medical Center Chief
Date signed (mm/dd/yyyy)	PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐☐-☐ Date signed (mm/dd/yyyy)

*for PRIVATE PATIENTS, the signature of the Attending Nephrologist is sufficient.