## **Annex G.2A: Checklist of Requirements for Reimbursement Using CAPD - Pediatric**



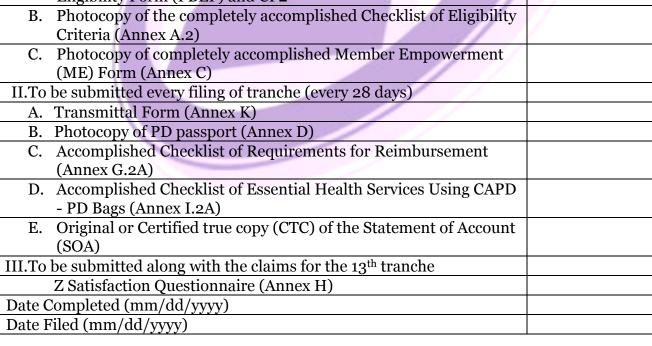


Republic of the Philippines

## PHILIPPINE HEALTH INSURANCE CORPORATION

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- PhilHealthOfficial 
   X teamphilhealth

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Case No	<u> </u>			
HEALTH FACIL	ITY (HF)			
ADDRESS OF H	F			
A. PATIENT	NT 1. Last Name, First Name, Suffix, Middle Name SEX Male Male Female			
	2. PhilHealth ID Number	<b>3</b>		
B. MEMBER  □ Same as	me as			
patient (Answer only if the patient is a dependent)	2. PhilHealth ID Number	<b>-</b>		
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 1 <sup>st</sup> tranche				
A. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF2				
B. Photocop Criteria (				
	y of completely accomplished Member Empowerment m (Annex C)			





HEALTH FACILITY (HF)				
ADDRESS OF HF				
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name SEX Male Male Female			
	2. PhilHealth ID Number			
B. MEMBER  □ Same as	1. Last Name, First Name, Suffix, Middle Name			
patient (Answer only if the patient is a dependent)	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.  Date signed (mm/dd/yyyy)		<ul> <li>Head, Peritoneal Dialysis Unit OR</li> <li>Chair, Dept. of Adult Nephrology OR</li> <li>Chair, Dept. of Pediatric Nephrology OR</li> <li>Chair, Dept. of Organ Transplantation OR</li> <li>Executive Director/Chief of Hospital/ Medical Director/Medical Center Chief</li> </ul>		
		PhilHealth Accreditation No		

<sup>\*</sup>for PRIVATE PATIENTS, the signature of the Attending Nephrologist is sufficient.