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 - Exit site infection and Peritonitis Prevention Care – Pediatric Patient

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

REQUIREMENTS	Status
A. Transmittal Form (Annex K)	
B. Accomplished Checklist of Requirements for Reimbursement (Annex G.2C)	
C. Properly accomplished Claim form (CF) 2	
D. Photocopy of PD passport (Annex D)	
E. Accomplished Checklist of Essential Health Services for Exit Site Infection and Peritonitis Prevention Care (Annex I.2C)	
F. Original or Certified true copy (CTC) of the Statement of Account (SOA)	
G. Z Satisfaction Questionnaire (Annex H)	
Date Completed (mm/dd/yyyy)	
Date Filed (mm/dd/yyyy)	

Certified correct by:*	Certified correct by: (for Service Patients)
(Printed name and signature) Attending Pediatric Nephrologist	(Printed name and signature) Please tick appropriate box ☐ 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
PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐ - ☐	PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐ - ☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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