Annex G.3A: Checklist of Requirements For Reimbursement – PD-related Ancillary Services (PD Catheter Insertion and Initiation)

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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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 – PD-related Ancillary Services (PD Catheter Insertion and Initiation)

(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.3A)	
C. Properly accomplished Claim form (CF) 2	
D. Photocopy of PD passport (Annex D)	
E. Accomplished Checklist of Essential Health Services for PD-related Ancillary Services – PD Catheter Insertion and Initiation (Annex I.3A)	
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 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 ☐☐☐☐–☐☐☐☐☐☐☐–☐	PhilHealth Accreditation ☐☐☐☐–☐☐☐☐☐☐☐–☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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