**Case No. ______________**

**Republic of the Philippines**

**PHILIPPINE HEALTH INSURANCE CORPORATION**

Citystate Centre Building, 709 Shaw Boulevard, Pasig City

Healthline 441-7444    www.philhealth.gov.ph

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**ANNEX E – PD First**

**TRANCHE REQUIREMENTS CHECKLIST**

**PD FIRST Z BENEFITS**

**HEALTH CARE INSTITUTION (HCI)**

**ADDRESS OF HCI**

**PATIENT (Last name, First name, Middle name, Suffix)**

**PHILHEALTH ID NUMBER OF PATIENT**

**MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)**

**PHILHEALTH ID NUMBER OF MEMBER**

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

<table>
<thead>
<tr>
<th>TRANCHE REQUIREMENTS</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. To be submitted once a year, upon filing claims for the 1st tranche</td>
<td></td>
</tr>
<tr>
<td>a. Original copy of approved Pre-authorization Checklist and Request (Annex A-PD First)</td>
<td></td>
</tr>
<tr>
<td>b. Photocopy of completely accomplished Member Empowerment (ME) Form (Annex B)</td>
<td></td>
</tr>
<tr>
<td>c. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)* and CF 2</td>
<td></td>
</tr>
<tr>
<td>II. To be submitted every filing of tranche (every two weeks)</td>
<td></td>
</tr>
<tr>
<td>a. Transmittal Form (Annex H)</td>
<td></td>
</tr>
<tr>
<td>b. Accomplished Tranche Requirement Checklist (Annex E-PD First)</td>
<td></td>
</tr>
<tr>
<td>c. Accomplished PD First Z Benefit Checklist of Services Provided (Annex C-PD First)</td>
<td></td>
</tr>
<tr>
<td>III. To be submitted along with the last tranche application for the calendar year</td>
<td></td>
</tr>
<tr>
<td>Z Satisfaction Questionnaire (Annex D)</td>
<td></td>
</tr>
</tbody>
</table>

*not required if pre-authorization is submitted through the HCI Portal

**Date Completed:**

**Date Filed:**

**Certified correct by:**

(Printed name and signature)

Attending Nephrologist

**PhilHealth Accreditation No.**

Date signed (mm/dd/yyyy)

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**Certified correct by:**

(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.**

Date signed (mm/dd/yyyy)

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**As of May 2016**

Page 1 of 1 of Annex E – PD First

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**For CO-PAY PATIENTS, the signature of the Attending Nephrologist is sufficient.**