*Republic of the Philippines*
**PHILIPPINE HEALTH INSURANCE CORPORATION**
Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center: (02) 8441-7442 | Trunkline: (02) 8441-7444
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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

**Case No. _____**

**Annex E – PD First**

| | | |
|---|---|---|
| HEALTHCARE *PROVIDER (HCP)* | | |
| ADDRESS OF *HCP* | | |
| 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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐ | |

## TRANCHE REQUIREMENTS CHECKLIST
## PD FIRST Z BENEFITS

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

| TRANCHE REQUIREMENTS | Status |
|---|---|
| I. To be submitted once a year, upon filing claims for the 1st tranche | |
| a. *Photocopy* of approved Pre-authorization Checklist and Request (Annex A-PD First) | |
| b. Photocopy of completely accomplished Member Empowerment (ME) Form (Annex B) | |
| c. *Properly accomplished* PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)* and CF 2 | |
| II. To be submitted every filing of tranche (every two weeks) | |
| a. Accomplished Tranche Requirement Checklist (Annex E-PD First) | |
| *b. Properly accomplished CF 2* | |
| c. *Photocopy of PD Passport (Annex F-PD First)* | |
| III. To be submitted *upon availment of the first transfer set for the year* | |
| Z Satisfaction Questionnaire (Annex D) | |

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

| Certified correct by:** | Certified correct by: (for Service Patients)*** |
|---|---|
| (Printed name and signature)<br>Attending Nephrologist | (Printed name and signature)<br>Please tick appropriate box<br>☐ Head, Peritoneal Dialysis Unit OR<br>☐ Chair, Dept. of Adult Nephrology OR<br>☐ Chair, Dept. of Pediatric Nephrology OR<br>☐ 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 CO-PAY PATIENTS, the signature of the Attending Nephrologist is sufficient.
****for SERVICE PATIENTS, the signature of PD Unit head, other nephrologists or executive director, etc. would suffice.*



CERTIFIED ISO 9001:2015 COMPANY