Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre Building, 709 Shaw Boulevard, Pasig City
Healthline 441-7444 www.philhealth.gov.ph

Case No. _____

Annex "G – PD First"

DATE (mm/dd/yyyy)
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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

LETTER OF INTENT FOR TRANSFER OF PD CARE TO A REFERRAL PD CENTER

This is to certify that I, _____, born on _____,
(Name of Patient) *(Date of Birth)*
age _____ years old, residing at _____,
(Address)
was diagnosed with End Stage Renal Disease and was initiated on peritoneal dialysis at the
_____ on _____.
(Name of Referring PD Center) *(Date of PD Initiation)*
I perform _____ exchanges per day. I would like to request for transfer of PD Care to
(indicate number)
_____ under the care of _____.
(Name of Referral PD Center) *(Name of Nephrologist)*

I understand that upon transfer to a referral PD Center, I will have to surrender my PD Passport to the PD Coordinator of my referring PD Center as well as waive all my subsequent PD claims in my referring PD Center. In case I decide to return to the referring PD Center to resume my PD Care, I will have to abide by the policies set by them as a new PD patient.

Conforme by:	Certified correct by:
(Printed name and signature) Patient/ Parent/ Guardian	(Printed name and signature) Nephrologist, Referring PD Center PhilHealth Accreditation No. ☐☐☐☐–☐☐☐☐☐☐–☐

Certified correct by:	Certified correct by:
(Printed name and signature) Billing Representative, Referring PD Center	(Printed name and signature) PD Coordinator, Referring PD Center

Acknowledged by:	Acknowledged by:
(Printed name and signature) Head/PD Coordinator, Referral PD Center	(Printed name and signature) BAS Head, PhilHealth Regional Office ____