Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "E – Prostate CA"

HEALTH CARE *PROVIDER (HCP)*		
ADDRESS OF *HCP*		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	*SEX* ☐ *Male* ☐ *Female*
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	☐ *Same as patient* *(Answer the following only if the patient is a dependent)* 1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT
Prostate Cancer

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E-Prostate CA)	
2. Photocopy of Approved Pre –Authorization Checklist & Request (Annex A-Prostate CA)	
3. Photocopy of Accomplished ME FORM (Annex B)	
4. *Properly accomplished* PhilHealth Claim Form 1 (CF1) or PhilHealth Benefit Eligibility Form (PBEF) and CF2	
5. Checklist of Mandatory and Other Services for Prostate CA (Annex C-Prostate CA)	
6. Photocopy completed Z Satisfaction Questionnaire (Annex D)	
7. Photocopy of accomplished surgical operative report	
8. Photocopy of accomplished anesthesia report	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physician	(Printed name and signature) Patient/Parent/Guardian
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐ Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)