

## Annex C2.1: Rectal Cancer Stage I (clinical and pathologic stage)

– Post-surgery

*Revised as of December 2022*



*Republic of the Philippines*  
**PHILIPPINE HEALTH INSURANCE CORPORATION**

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[www.philhealth.gov.ph](http://www.philhealth.gov.ph)



**UNIVERSAL HEALTH CARE**  
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. \_\_\_\_\_

HEALTH FACILITY (HF)																	
ADDRESS OF HF																	
<b>A. PATIENT</b>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; border-bottom: 1px solid black;">1. Last Name, First Name, Suffix, Middle Name</td> <td style="width: 30%; border-bottom: 1px solid black;">SEX <input type="checkbox"/> Male <input type="checkbox"/> Female</td> </tr> <tr> <td style="border-bottom: 1px solid black;">2. PhilHealth ID Number</td> <td style="border-bottom: 1px solid black;"> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; border: 1px solid black; text-align: center;"> </td> <td style="width: 10%; border: 1px solid black; text-align: center;"> </td> <td style="width: 10%; border: 1px solid black; text-align: center;">-</td> <td style="width: 10%; border: 1px solid black; text-align: center;"> </td> <td style="width: 10%; border: 1px solid black; text-align: center;"> </td> <td style="width: 10%; border: 1px solid black; text-align: center;"> </td> <td style="width: 10%; border: 1px solid black; text-align: center;"> </td> <td style="width: 10%; border: 1px solid black; text-align: center;"> </td> <td style="width: 10%; border: 1px solid black; text-align: center;"> </td> <td style="width: 10%; border: 1px solid black; text-align: center;"> </td> <td style="width: 10%; border: 1px solid black; text-align: center;">-</td> <td style="width: 10%; border: 1px solid black; text-align: center;"> </td> </tr> </table> </td> </tr> </table>	1. Last Name, First Name, Suffix, Middle Name	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	2. PhilHealth ID Number	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; border: 1px solid black; text-align: center;"> </td> <td style="width: 10%; border: 1px solid black; text-align: center;"> </td> <td style="width: 10%; border: 1px solid black; text-align: center;">-</td> <td style="width: 10%; border: 1px solid black; text-align: center;"> </td> <td style="width: 10%; border: 1px solid black; text-align: center;"> </td> <td style="width: 10%; border: 1px solid black; text-align: center;"> </td> <td style="width: 10%; border: 1px solid black; text-align: center;"> </td> <td style="width: 10%; border: 1px solid black; text-align: center;"> </td> <td style="width: 10%; border: 1px solid black; text-align: center;"> </td> <td style="width: 10%; border: 1px solid black; text-align: center;"> </td> <td style="width: 10%; border: 1px solid black; text-align: center;">-</td> <td style="width: 10%; border: 1px solid black; text-align: center;"> </td> </tr> </table>			-								-	
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<b>B. MEMBER</b>	<p><i>(Answer only if the patient is a dependent; otherwise, write, "same as above")</i></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; border-bottom: 1px solid black;">1. Last Name, First Name, Middle Name, Suffix</td> </tr> <tr> <td style="border-bottom: 1px solid black;">2. PhilHealth ID Number</td> </tr> </table>	1. Last Name, First Name, Middle Name, Suffix	2. PhilHealth ID Number														
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### CHECKLIST OF MANDATORY AND OTHER SERVICES Rectal Cancer Stage I (clinical and pathologic stage) Post Surgery

Specify the following:

Clinical stage prior to initiation of treatment	cT:	N:	M:
Pathologic stage	pT:	N:	M:

Place a (✓) in the appropriate tick box if DONE or GIVEN.

MANDATORY SERVICES	OTHER SERVICES as needed/ as indicated
<b>Procedure</b>	
<input type="checkbox"/> Colonoscopy <sup>a</sup>	<input type="checkbox"/> Surgery for closure of colostomy/ileostomy <sup>b</sup>
<input type="checkbox"/> Biopsy with histopathology	
<input type="checkbox"/> Surgery (definitive)	
<b>Diagnostics</b>	
<input type="checkbox"/> Chest CT or Chest x-ray (PA-L) <sup>a</sup>	<input type="checkbox"/> ECG
<input type="checkbox"/> Pelvic MRI or endorectal ultrasound	<input type="checkbox"/> 2D echocardiogram
<input type="checkbox"/> CT scan of whole abdomen preferably with contrast <sup>a, c</sup>	<input type="checkbox"/> CP clearance
<input type="checkbox"/> Fasting blood sugar (FBS)	<input type="checkbox"/> SGPT
<input type="checkbox"/> Carcinoembryonic antigen (CEA), as baseline	<input type="checkbox"/> Prothrombin time
<input type="checkbox"/> Complete blood count	<input type="checkbox"/> Alkaline phosphatase
<input type="checkbox"/> Blood typing	<input type="checkbox"/> Bilirubin
<input type="checkbox"/> Albumin	<input type="checkbox"/> CEA for monitoring
<input type="checkbox"/> Creatinine	<input type="checkbox"/> SGPT for monitoring
	<input type="checkbox"/> Creatinine for monitoring

<sup>a</sup> should be done within 60 calendar days before the date of submission of the pre-authorization checklist and request to PhilHealth

<sup>b</sup> shall be covered under the Z Benefits within two (2) years from the date of surgery; patients may be charged co-payment within the allowable limit as indicated in the contract of the HF

<sup>c</sup> PET scan may be accepted in place of CT scan

MANDATORY SERVICES	OTHER SERVICES as needed/ as indicated
	Medicines
	<input type="checkbox"/> Antimicrobials, specify _____
	<input type="checkbox"/> Pain relievers, specify _____
	Others:
	<input type="checkbox"/> Blood support, <i>such as cross-matching, screening, and processing</i>

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No.         -                     -	PhilHealth Accreditation No.         -                     -
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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