Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center: (02) 8441-7442 | Trunkline: (02) 8441-7444
www.philhealth.gov.ph

UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")*** 1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF MANDATORY AND OTHER SERVICES
***Rectal* cancer pre-treatment clinical stage II - III**
Post Surgery

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

MANDATORY SERVICES	OTHER SERVICES as indicated/ as needed
Procedure	
☐ Surgery (definitive)	☐ Proctoscopy
	☐ Biopsy
Diagnostic	
☐ Complete blood count	☐ Pelvic MRI or endorectal ultrasound
☐ Albumin	☐ CT scan of whole abdomen CT scan of whole abdomen *preferably with contrast*[a, b]
☐ Creatinine	
	☐ Chest CT
	☐ ECG
	☐ CP clearance
	☐ SGPT
	☐ Prothrombin time
	☐ Alkaline phosphatase
	☐ Bilirubin
	☐ CEA for monitoring
	☐ SGPT for monitoring
	☐ Creatinine for monitoring

[a] *should be done within 60 calendar days before the date of submission of the pre-authorization checklist and request to PhilHealth*
[b] *PET scan may be accepted in place of CT scan*

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

MANDATORY SERVICES	OTHER SERVICES as indicated/ as needed
	Medicines
	☐ Antiemetics, specify _____
	☐ *Antimicrobials,* specify _____
	☐ Pain relievers, specify _____
	☐ Others: Blood support

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)	