Annex E3.1: Rectal Cancer Pre-Operative Clinical Stage I with Post-Operative Pathologic Stage II to III – Post-surgery

Revised as of December 2022

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, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

TRANCHE REQUIREMENTS CHECKLIST

Rectal cancer pre-operative clinical stage I with post-operative pathologic stage II - III
Post Surgery

	Please Check
1. Tranche Requirements Checklist (Annex *E3.1* – Rectal CA)	
2. Photocopy of approved Pre-Authorization Checklist & Request (Annex A2—Rectal CA)	
3. Photocopy of completely accomplished ME FORM (Annex B)	
4. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF2	
5. Checklist of Mandatory and Other Services (Annex *C3.1*- Rectal CA)	
6. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
7. Photocopy of the Multidisciplinary-interdisciplinary team (MDT) Plan	
8. Original or certified true copy (CTC) of the Statement of Account (SOA)	
9. Photocopy of accomplished surgical operative record	
10. Photocopy of accomplished anesthesia report	
11. *Photocopy of the* histopathology result after definitive surgery	
DATE COMPLETED (mm/dd/yyyy)	
DATE FILED (mm/dd/yyyy)	

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:	Certified correct 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)	