Annex E4.1: Rectal Cancer Pre-treatment Clinical Stage II to III – After completion of Chemoradiotherapy

Revised as of December 2022

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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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-treatment clinical stage II-III
After completion of chemoradiotherapy

	Please Check
1. Tranche Requirements Checklist (Annex E4.1 – 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 C4.1- 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. Copy of radiation treatment summary form	
10. Copy of chemotherapy treatment summary form	
DATE COMPLETED *(mm/dd/yyyy)*	
DATE FILED *(mm/dd/yyyy)*	

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 ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

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)	