**Annex E4.2: Rectal Cancer Pre-treatment Clinical Stage II to III: Post-surgery**

*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 Discharge from Surgery***

| | **Please Check** |
|---|---|
| 1. Tranche Requirements Checklist (Annex *E4.2* – 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 *C4.2*- 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. 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)<br>Attending Surgeon | (Printed name and signature)<br>Patient |
| PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐ | Date signed (mm/dd/yyyy) |
| Date signed (mm/dd/yyyy) | |