# Annex E.1: Checklist of Requirements for Reimbursement (Tranche 1)

Republic of the Philippines
**PHILIPPINE HEALTH INSURANCE CORPORATION**
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8441-7442 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

**Case No. _____**

| | | |
|---|---|---|
| HEALTH *FACILITY (HF)* | | |
| ADDRESS OF *HF* | | |
| A. PATIENT | 1. Last Name, First Name, Middle Name, Suffix | 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 REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 1)

### Selected Orthopedic Implants

| Requirements | Please Check |
|---|---|
| 1. Checklist of Requirements for Reimbursement (Annex E.1) | |
| 2. Photocopy/ies of approved Pre –Authorization Checklist/s & Request/s (Annex A) | |
| 3. Photocopy of completely accomplished ME FORM (Annex B) | |
| 4. Properly accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2 | |
| 5. Checklist of mandatory and other services (Tranche 1) (Annex C.1) | |
| 6. Photocopy of completed Z Satisfaction Questionnaire (Annex D) | |
| 7. Photocopy of operative report | |
| 8. Photocopy of anesthesia report | |
| 9. Original or certified true copy of the Statement of Account | |

| | |
|---|---|
| Certified correct by: | Certified correct by: |
| (Printed name and signature)<br>Attending Orthopedic Surgeon | (Printed name and signature)<br>Executive Director/Chief of Hospital/<br>Medical Director/ Medical Center Chief |
| PhilHealth Accreditation No. ☐☐☐☐ – ☐☐☐☐☐☐☐ – | PhilHealth Accreditation No. ☐☐☐☐ – ☐☐☐☐☐☐☐ – |
| Date signed (mm/dd/yyyy) | Date signed (mm/dd/yyyy) |

| |
|---|
| Conforme by: |
| (Printed name and signature)<br>Patient/Parent/Guardian |
| Date signed (mm/dd/yyyy) |