Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 Trunkline (02) 441-7444
www.philhealth.gov.ph

Case No. _____

Annex "E1 – TOF"

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐ - ☐
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐ - ☐

CHECKLIST OR REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 1)
Tetralogy of Fallot – Elective TOF Repair

Place a check mark (✓)

Requirements	**YES**
1. Transmittal form (Annex H)	
2. Checklist of Requirements for Reimbursement (Annex E1-TOF)	
3. Photocopy of approved Pre –Authorization Checklist & Request (Annex A-TOF)	
4. Photocopy of completed ME FORM (Annex B)	
5. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
6. Signed Checklist of Mandatory and Other Services (Annex C1-TOF)	
7. Photocopy of completed and signed Z Satisfaction Questionnaire (Annex D)	
8. Complete Surgical Operative Report (certified true copy)	
9. Complete Anaesthesia Report (certified true copy)	
10. Intraoperative TEE Report/ Transthoracic within 3days post op (Attach result)	
DATE COMPLETED (mm/dd/yyyy) DATE FILED (mm/dd/yyyy)	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Physician	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Documents received by:	Conforme by:
(Printed name and signature) Z Benefits Coordinator	(Printed name and signature) Parent/Guardian
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)