

Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION

UNIVERSAL HEALTH CARE

Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center: (02) 8441-7442 | Trunkline: (02) 8441-7444

www.philhealth.gov.ph

HEALTH CARE PROVIDER (HCP) ADDRESS OF HCP A. PATIENT 1. Last Name, First Name, Middle Name, Suffix 2. PhilHealth ID Number 1. Last Name, First Name, Middle Name, Suffix 2. PhilHealth ID Number 1. Last Name, First Name, Middle Name, Suffix 2. PhilHealth ID Number 1. Last Name, First Name, Middle Name, Suffix 2. PhilHealth ID Number CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 1) Ventricular Septal Defect – Elective VSD Closure Place a check mark (*) Requirements 1. Checklist of Requirements for Reimbursement (Annex E1-VSD) 2. Photocopy of approved Pre – Authorization Checklist & Request (Annex A-VSD) 3. Photocopy of completed ME FORM (Annex B) 4. Properly accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2 5. Signed Checklist of Mandatory and Other Services (Annex C1-VSD) 6. Photocopy of completed and signed Z Satisfaction Questionnaire (Annex D) 7. Photocopy of accomplished anesthesia report Certified correct by: Certified anne and signature) Attending Pediatric Cardiologist Medical Director/ Medical Center Chief PhilHealth Accordination No.	Case No									
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