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 "E – RF/RHD"

HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
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)	1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT
Rheumatic Fever/Rheumatic Heart Disease

Requirements	**Please Check**
1. Checklist of Requirements for Reimbursement (Annex E-RF/RHD)	
2. Photocopy of approved Pre –Authorization Checklist & Request (Annex A- RF/RHD)	
3. Photocopy of completely accomplished ME FORM (Annex B)	
4. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) at the time of pre-authorization application and CF 2	
5. Checklist of Mandatory and Other Services (Annex C- RF/RHD)	
6. Photocopy of completed Satisfaction Questionnaire (Annex D)	
DATE COMPLETED: (mm/dd/yyyy)	
DATE FILED: (mm/dd/yyyy)	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physician	(Printed name and signature) Parent/Guardian
PhilHealth Accreditation No. ☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	