Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "E1 – CABG"

HEALTHCARE *PROVIDER (HCP)*		
ADDRESS OF *HCP*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	*SEX* ☐ *Male* ☐ *Female*
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	☐ *Same as patient* *(Answer the following only if the patient is a dependent)* 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 1)
Standard Risk Elective Coronary Artery Bypass Graft Surgery (CABG)

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Tranche 1) (Annex E-CABG)	
2. Photocopy of approved Pre –Authorization Checklist & Request (Annex A-CABG)	
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. Completed Checklist of Mandatory and Other Services (Annex C-CABG)	
6. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
7. Photocopy of accomplished surgical operative report	
8. Photocopy of accomplished anesthesia report	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Cardiologist	(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)

Conforme by:
(Printed name and signature) Patient
Date signed (mm/dd/yyyy)