Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "E2 – TOF"

HEALTH CARE *PROVIDER (HCP)*		
ADDRESS OF *HCP*		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	*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, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OR REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2)
Tetralogy of Fallot – Elective TOF Repair

Place a check mark (✓)

Requirements	**YES**
1. Checklist of Requirements for Reimbursement (Annex E2-TOF)	
2. *Properly accomplished PhilHealth Claim Form 2*	
3. Completed Cardiac Rehabilitation Form	
4. Medical certificate of OPD consultation	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending *Pediatric 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)

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)