**Annex “H”**

**TRANSMITTAL FORM**

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| NAME OF CONTRACTED HEALTH CARE INSTITUTION (HCI) | ADDRESS OF HCI |
|  |  |

**Instructions for filling out this Transmittal Form. Use additional sheets if necessary.**

1. Use CAPITAL letters or UPPER CASE letters in filling out the form.
2. For the period of confinement, follow the format (mm/dd/yyyy).
3. For the Z Benefit Package Code, include the code for the order of tranche payment. Example: breast cancer, second tranche should be written as “Z0022”.
4. For the Case Number, copy the case number that is provided in the approved pre-authorization checklist and request.
5. The Remarks column may include some relevant notes which pertain to the filed claim that need to be relayed to PhilHealth.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Case Number** |  | **Name of Patient** |  | **Period of Confinement** | **Z Benefit Package** |  | **Remarks** |
|  | (Last, First, Middle Initial, Extension) | **Date admitted** | **Date discharged** | **Code** |  |  |  |  |  |  |
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| 8. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 9. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 10. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Certified correct by authorized representative of the HCI** |  | **For PhilHealth Use Only** |  |  | **Initials** |  |  | **Date** |  |
|  |  |  | Designation |  |  | Received by Local Health Insurance Office (LHIO) |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Printed Name and Signature |  | Date signed (mm/dd/yyyy) |  | Received by the Benefits Administration Section (BAS) |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| As of October 2015 |  |  |  |  |  |  |  |  | Page **1** of **1** of **Annex H** |

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