Bawat Pilipino MIYEMBRO
Bawat miyembro PROTEKTADO
Kalusugan natin SEGURADO

Case No. ______________

Annex A – "Rectum CA"

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER *(if patient is a dependent)* (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

Fulfilled selections criteria ☐ **Yes** *If yes, proceed to pre-authorization application*
☐ **No** *If no, HCI to specify reason/s and encode*
____

PRE-AUTHORIZATION CHECKLIST
Rectum Cancer
Stages I to III (clinically T1-4, N0-2, M0)

Place a check mark (✓)

QUALIFICATIONS	**Yes**
Biopsy proven tissue diagnosis of rectal cancer	
No evidence of systemic metastasis from chest x-ray and abdominal ultrasound or CT scan of whole abdomen	
No previous pelvic radiation	

CLINICAL STAGE (Choose one stage)
☐ Stage I ☐ Stage II ☐ Stage III

OTHER QUALIFICATIONS	**Yes**
1. Normal or with mild systemic disease (ASA I or II)	
2. Fully active, able to carry on all pre-disease performance without restriction, OR restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g. light house work, office work, OR ambulatory and capable of all self-care (ECOG Performances 0-2)	

Certified correct by Attending Surgeon:

____
Printed name and signature
PhilHealth Accreditation No.
☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐

Certified correct by Attending Medical Oncologist:

____
Printed name and signature
PhilHealth Accreditation No.
☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐

teamphilhealth www.facebook.com/PhilHealth www.youtube.com/teamphilhealth actioncenter@philhealth.gov.ph

Certified correct by Attending Radiation Oncologist:	Conforme by:
Printed name and signature	Printed name and signature

PhilHealth Accreditation No.

				–							–	

Note:
Once approved, the contracted HCI shall print the approved pre-authorization form and have this signed by the patient, parent or guardian and health care providers, as applicable. This form shall be submitted to the Local Health Insurance Office (LHIO) or the PhilHealth Regional Office (PRO) when filing the first tranche.

There is no need to attach laboratory results. However, these should be included in the patient's chart and may be checked during the field monitoring of the Z Benefits. Please do not leave any item blank.

RRepublic 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

PRE-AUTHORIZATION REQUEST
Rectum Cancer

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z benefit package for ______________________ in ______________________
(NAME OF PATIENT) (NAME OF HCI)
under the terms and conditions as agreed for availment of the Z Benefit Package.

The patient belongs to the following category (please tick appropriate box):
- ☐ No Balance Billing (NBB)
- ☐ Co-pay (indicate amount) Php ______________

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No. _ _ _ _ – _ _ _ _ _ _ _ – _	PhilHealth Accreditation No. _ _ _ _ – _ _ _ _ _ _ _ – _

Certified correct by:	Certified correct by:
(Printed name and signature) Radiation Oncologist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. _ _ _ _ – _ _ _ _ _ _ _ – _	PhilHealth Accreditation No. _ _ _ _ – _ _ _ _ _ _ _ – _

Conforme by:
(Printed name and signature) Patient

(For PhilHealth Use Only)

- ☐ APPROVED
- ☐ DISAPPROVED (State reason/s) ______________________

Noted by:

____
(Printed name and signature)
Head, Benefits Administration Section (BAS)

INITIAL APPLICATION			**COMPLIANCE TO REQUIREMENTS**		
Activity	**Initial**	**Date**	☐ APPROVED ☐ DISAPPROVED (State reason/s)		
Received by LHIO/BAS:					
Endorsed to BAS (if received by LHIO):					
☐ Approved ☐ Disapproved			**Activity**	**Initial**	**Date**
Released to HCI:			Received by BAS:		
This pre-authorization is valid for sixty (60) calendar days from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to HCI:		

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