Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center: (02) 8441-7442 | Trunkline: (02) 8441-7444
www.philhealth.gov.ph

UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
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; otherwise, write, "same as above")*** 1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

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

PRE-AUTHORIZATION CHECKLIST FOR ZMORPH FITTING OF EXTERNAL LOWER LIMB PROSTHESIS BELOW THE KNEE

Place a check mark (✓) on the appropriate lower limb:
☐ Right lower limb ☐ Left lower limb ☐ Right & left lower limbs

Place a (✓) if yes or NA if not applicable

	QUALIFICATIONS	
1.	Age	☐ *≥18 years*
2.	Status of post-amputation	☐ at least three months post-amputation, if acquired
3.	Wheelchair independent, community-ambulator (Any of the following)	☐ with or without crutches ☐ cane or walker
4.	Absence of the following on physical examination	☐ fresh or non-healing wound ☐ neuroma or painful residual limb
5.	Tick involved limb	☐ right limb ☐ left limb ☐ both limb

Conforme by Patient/Parent/Guardian:

_____
Printed name and signature

Attested by Attending Rehabilitation Medicine Specialist

_____
Printed name and signature

PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐ - ☐

Note:
Once approved, the contracted hospital 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.

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PRE-AUTHORIZATION REQUEST FOR ZMORPH FITTING OF EXTERNAL LOWER LIMB PROSTHESIS BELOW THE KNEE

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z benefit package for

_____ in _____
(Patient's last, first, suffix, middle name) (Name of *HF*)
under the terms and conditions as agreed for availment of the Z Benefit Package.

The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the benefit package (please tick appropriate box):
☐ Without co-payment
☐ With co-payment, for the purpose of: _____

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Rehabilitation Medicine Specialist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No.	PhilHealth Accreditation No.

(Printed name and signature)
Patient/Parent/Guardian

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

_____
(Printed name and signature)
Head or authorized representative, 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 *HF:*			Received by BAS:		
This pre-authorization is valid for one hundred eighty (180) calendar days from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to *HF:*		