

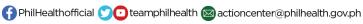
Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION

UNIVERSAL HEALTH CARE
KAUSUOM AT KAUNGA TAKA SA LAMAT

Citystate Centre, 709 Shaw Boulevard, Pasig City Call Center: (02) 8441-7442 | Trunkline: (02) 8441-7444 www.philhealth.gov.ph

Case No					
		A	"A CARC"		
HEALTHCAR	LE PROVIDER (HCP)	Annex	"A – CABG"		
	ETROVIDER (ITCI)				
ADDRESS OF	F HCP				
A. PATIENT	1. Last Name, First Name, Suffix,	Middle Name SEX			
		\square M	ale 🗆 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	-			
Fulfilled sele	ections criteria	oceed to pre-authorization applic	cation		
		ecify reason/s and encode			
Stan	PRE-AUTHORIZATI				
Star	dard Risk Elective Coronary Arte	ery bypass Graft (CABG) Surg	gery		
		Place a c	heck mark (🗸)		
QUALIFICA'	ΓΙΟΝS		YES		
At least 19 year	s of age				
ATTESTED	BY ATTENDING CARDIOLOG	GIST or CARDIOVASCULAR	SURGEON		
		Place a c	heck mark (🗸)		
QUALIFICA'	ΓΙΟΝS		YES		
	nary artery disease requiring ELECT	TIVE ISOLATED CABG with			
	pased on coronary anatomy, sympto-				
	nd/or viability tests; non-invasive te				
with patien					
	ent medical status:				
a. NOT in severe decompensated heart failure by New York Functional					
Classification (NYFC IV) b. NOT with severe angina by Canadian Cardiovascular Society (CCS					
	ss IV)	Cardiovascular Society (CCS			
c. NO other cardiac/vascular procedures/interventions planned to be					
done with coronary artery bypass graft surgery during this admission					
	history of dialysis and NO current				





Place a check mark (✓)

	i lace a cii	cen main ()
QUALIFICATIONS		YES
3.	Based on past history:	
	a. NO previous thoracic/cardiac surgery through median sternotomy	
	b. NO previous transcutaneous cardiac intervention within 30 days before	
	contemplated schedule of coronary artery bypass graft surgery	
4.	ONLINE EUROSCORE II and Society of Thoracic Surgeons (STS) scoring	
	predictive of low mortality risk (< 5%)	

Place a check mark (✓)

DIAGNOSTICS*	YES	DATE DONE (mm/dd/yy)
1. Coronary Angiography: coronary anatomy amenable for CABG and consistent with Class I and IIa indications for CABG surgery and discussed with patient		
2. Current status of myocardial viability consistent with benefit from CABG and discussed with patient		

^{*}Must be done at least within one fiscal (1) year from date of receipt of pre-authorization checklist and request by the Local Health Insurance Office (LHIO) or the PhilHealth Regional Office (PRO).

Certified correct by:	Certified correct by:		
(Printed name and signature)	(Printed name and signature)		
Attending Cardiologist	Attending Cardiovascular Surgeon		
PhilHealth Accreditation No.	PhilHealth Accreditation No.		
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)		
	Conforme by:		
	(Printed name and signature)		

Note:

Once approved, the contracted HCP 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 LHIO or 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.







Patient

Date signed (mm/dd/yyyy)



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PRE-AUTHORIZATION REQUEST Standard Risk Elective Coronary Artery Bypass Graft (CABG) Surgery

DATE OF REQUEST (mm/						
This is to request approval for provision of services under the Z benefit package for						
in						
(Patient's last, first, suffix, mi	ddle name)		(Name of HCP))		
, ,	,	ed for av	railment of the Z Benefit Packag	je.		
The patient is aware of the PhilHed appropriate box): Without co-payment With co-payment, for the purpo	1 3	on co-payn	ment and agreed to avail of the benefit	package (p	olease tick	
Certified correct by:			Certified correct by:			
(Printed name and sig	gnature)		(Printed name and signature)			
Attending Cardiologist			Attending Cardiovascular Surgeon			
PhilHealth Accreditation No.		4-	PhilHealth Accreditation No.			
Conforme by:		7	Certified correct by:	7/		
(Printed name and signature)		(Printed name and signature)				
Patient			Executive Director/Chief of Hospital/			
			Medical Director/ Medical Center Chief PhilHealth			
			Accreditation No.			
	·					
□ APPROVED	(Fo	r PhilHe	alth Use Only)			
☐ DISAPPROVED (State re	ason/s)					
	a oon, o, <u>.</u>					
(Printed name and sign	,	A 1 · ·				
Head or authorized representative,	Benefits	Adminis	tration Section (BAS)			
INITIAL APPLICATION			COMPLIANCE TO REQUIREMENTS			
Activity	Initial	Date	□ APPROVED□ DISAPPROVED (State reaso	m /a)		
Received by LHIO/BAS:			DISAFFROVED (State leaso	11/8)		
Endorsed to BAS (if received by LHIO):		(Printed name and signature)				
☐ Approved ☐ Disapproved		Head or authorized BAS rep Activity	Initial	Date		
Released to HCP:			Received by BAS:			
This pre-authorization is valid for one hundred		☐ Approved ☐ Disapproved				
eighty (180) calendar days from date of approval of request.		Released to HCP:				

