



HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
MEMBER <i>(if patient is a dependent)</i> (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER <input type="text"/> <input type="text"/> - <input type="text"/> - <input type="text"/>

**PRE-AUTHORIZATION CHECKLIST**  
**Orthopedic Implants: Femoral Shaft Fractures**

(Place a ✓ opposite appropriate answer)

<b>SITE OF INJURY</b>	<input type="checkbox"/> Left side	<input type="checkbox"/> Right side	<input type="checkbox"/> Both sides
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Conforme by Patient/Parent/Guardian:

\_\_\_\_\_  
 Printed name and signature

**ATTESTED BY ATTENDING PHYSICIAN**

(Place a ✓ if YES, or NA if not applicable)

<b>QUALIFICATIONS</b>	<b>Yes</b>
Ambulatory prior to injury	
Normal or with mild systemic disease or no functional limitation (ASA I & II)	

<b>CLINICAL FEATURES</b>	<b>Yes</b>
Femoral shaft fracture without malignant/metastatic pathologic feature and with any complete fracture of the femur	

Attested by Attending Orthopedic Surgeon:

\_\_\_\_\_  
 Printed name and signature

**Note: There is no need to attach laboratory results. These may be checked during monitoring and post-audit. Do not leave any items blank.**



**PRE-AUTHORIZATION REQUEST**  
**Orthopedic Implants: Femoral Shaft Fractures**

DATE OF REQUEST:

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

\_\_\_\_\_ in \_\_\_\_\_  
 (NAME OF PATIENT) (NAME OF HOSPITAL)

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)  
 Fixed Co-pay (indicate amount) Php \_\_\_\_\_

Conforme by:	Certified correct by:
(Printed name and signature) Patient/Parent/Guardian	(Printed name and signature) Attending Orthopedic Surgeon

Certified correct by:
(Printed name and signature) Executive Director/Chief of Hospital

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 (For PhilHealth Use Only)

- APPROVED  
 DISAPPROVED (State reason/s) \_\_\_\_\_

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

INITIAL APPLICATION	COMPLIANCE OF REQUIREMENTS
Date received by Local Health Insurance Office (LHIO): _____	<input type="checkbox"/> APPROVED
Date endorsed to BAS: _____	<input type="checkbox"/> DISAPPROVED (State Reason/s)
Date (Approved/Disapproved): _____	_____
Date endorsed to LHIO: _____	Date endorsed to BAS: _____
Date released to Hospital: _____	Date (Approved/Disapproved) _____
	Date endorsed to LHIO: _____
	Date released to Hospital: _____

**This pre-authorization is valid for thirty (30) calendar days from date of approval of pre-authorization.**