Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre Building, 709 Shaw Boulevard, Pasig City
Healthline 441-7444 www.philhealth.gov.ph

Annex A-1

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

PRE-AUTHORIZATION CHECKLIST
Orthopedic Implants: Hip Arthroplasty

(Place a ✓opposite appropriate answer)

SITE OF INJURY	☐ Left side ☐ Right side ☐ Both sides
AGE	☐ Less than or equal to 65 years and 364 days ☐ Age more than or equal to 66 years

Conforme by Patient/Parent/Guardian:

_____
Printed name and signature

ATTESTED BY ATTENDING PHYSICIAN

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

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

CLINICAL FEATURES	**Yes**
Hip fracture presenting with avascular necrosis of the femoral head; or neglected fracture of the hip; or hip fracture with pre-existing cox-arthritis; or displaced hip fracture	
For avascular necrosis of the femoral head, necrosis should be classified as FICAT Stage III or IV	
Hip dysplasia	
Severe osteoarthritis	
Severe inflammatory joint disease affected by rheumatoid arthritis, gouty arthritis, psoriatic arthritis or ankylosing spondylitis	

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.

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PRE-AUTHORIZATION REQUEST
Orthopedic Implants: Hip Arthroplasty

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: _____ Date endorsed to BAS: _____ Date (Approved/Disapproved): _____ Date endorsed to LHIO: _____ Date released to Hospital: _____	☐ APPROVED ☐ DISAPPROVED (State Reason/s) _____ Date endorsed to BAS: _____ 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.